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ATTORNEY FOR PLAINTIFF
UNITED STATES OF AMERICA

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

UNITED STATES OF AMERICA, **Plaintiff,** **vs.** **RONALD DAVID DEAN,** **Defendant.**	**CR 24- 33 -M- DLC** **INFORMATION** **CONSPIRACY TO COMMIT WIRE FRAUD** **(Count 1)** **Title 18 U.S.C. § 1349** **(Penalty: 10 years imprisonment, $1,000,000 fine, and three years supervised release)**

THE UNITED STATES ATTORNEY CHARGES:

The Defendant and Related Entities

1. In or around the charged period, defendant RONALD DAVID DEAN, a resident of Whitefish, Montana, was a licensed physician who signed prescriptions and other Medicare-required documents for certain tests and medical

devices, as the defendant knew and intended, that were, among other things, not legitimately prescribed, not needed, not used, or induced through unlawful kickbacks and bribes.

2. In or around the charged period, Company A and Company B were limited liability companies organized under the laws of the State of Florida purportedly providing telemedicine and staffing services.

3. In or around the charged period, Person A and Person B owned and operated Company A and Company B.

The Medicare Program

4. The Medicare Program ("Medicare") was a federal health care program providing benefits to individuals who were the age of 65, or older, or disabled. The benefits available under Medicare were governed by federal statutes and regulations. Individuals who received benefits under Medicare were commonly referred to as Medicare "beneficiaries."

5. Medicare was a "health care benefit program," as defined by Title 18, United States Code, Section 24(b) and a "Federal health care program," as defined by Title 42, United States Code, Section 1320a-7b(f).

6. Medicare covered, among other things, medical services provided by physicians, medical clinics, laboratories, and other qualified health care providers, and office services and outpatient care—including the ordering of durable medical

equipment, prosthetics, orthotics, and supplies ("DME")—that were medically necessary and ordered by licensed medical doctors or other qualified health care providers.

7. Physicians, clinics, laboratories, and other health care providers that provided services to Medicare beneficiaries were able to apply for and obtain a "provider number." A health care provider that received a Medicare provider number was able to file claims with Medicare to obtain reimbursement for services provided to beneficiaries.

8. To receive Medicare reimbursement, providers had to apply and execute a written provider agreement, known as CMS Form 855. The Medicare application was required to be signed by an authorized representative of the provider. The application contained certifications that the provider agreed to abide by the Medicare laws and regulations, including the Anti-Kickback Statute, and that the provider "will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity."

The Railroad Retirement Board

9. The Railroad Retirement Board ("RRB") administers benefit programs for railroad workers and their families, including health insurance. 45 U.S.C. § 231f. The railroad retirement system provides Medicare coverage on the same basis

as the social security system, except these Medicare premiums and payments are administered by the Railroad Retirement Board.

The CHAMPVA Program

10. The Civilian Health and Medical Program of the Department of Veterans Affairs ("CHAMPVA") is a comprehensive health care program in which the Department of Veterans Affairs ("VA") shares the cost of covered health care services and supplies with eligible beneficiaries. The program is administered by Health Administration Center from its offices located in Denver, Colorado.

11. In general, the CHAMPVA program's operations are substantially similar to Medicare. For example, the CHAMPVA program covers most health care services and supplies, but only if they are medically necessary. CHAMPVA specifically excludes from coverage "[s]ervices and supplies that are not medically or psychologically necessary for diagnosis or treatment of a covered condition (including mental disorder) or injury." 38 C.F.R. § 17.272(a)(4).

Durable Medical Equipment

12. Medicare covered an individual's access to DME, such as off-the-shelf ("OTS") ankle braces, knee braces, back braces, elbow braces, wrist braces, and hand braces (collectively, "braces"). OTS braces require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit the individual.

13. A claim for DME submitted to Medicare qualified for reimbursement only if it was medically necessary for the treatment of the beneficiary's illness or injury and prescribed by a licensed physician.

14. For certain DME products, Medicare promulgates additional requirements that a DME order must meet for an order to be considered "reasonable and necessary." For example, for OTS knee braces billed to Medicare under the Healthcare Common Procedures Coding System ("HCPCS") Codes L1833 and L1851, an order will be deemed "not reasonable and necessary" and reimbursement will be denied unless the ordering/referring physician documents the beneficiary's knee instability using an objective description of joint laxity determined through a physical examination of the beneficiary.

Telemedicine

15. Telemedicine provided a means of connecting patients to doctors by using telecommunications technology to interact with a patient.

16. Legitimate telemedicine companies provided telemedicine services to individuals by hiring doctors and other health care providers. Legitimate telemedicine companies typically paid doctors a fee to conduct consultations with patients. To generate revenue, legitimate telemedicine companies typically either billed insurance or received payment from patients who utilized the services of the telemedicine company.

17. Medicare covered expenses for specified telemedicine services if certain requirements were met. These requirements included, but were not limited to, that services were delivered via a two-way, real-time interactive audio and video telecommunications system.

COVID-19 Tests

18. Starting on April 4, 2022, and continuing through the end of the COVID-19 public health emergency, Medicare covered and paid for over-the-counter COVID-19 tests at no cost to beneficiaries with Medicare Part B, including those with Medicare Advantage plans. This program was intended to ensure Medicare beneficiaries had access to COVID-19 tests they needed to stay safe and healthy during the COVID-19 pandemic. Eligible providers capable of providing ambulatory health care services were permitted to distribute to Medicare beneficiaries over-the-counter COVID-19 tests that were approved, authorized, or cleared by the United States Food and Drug Administration.

19. Medicare would not pay for more than eight over-the-counter COVID-19 tests per calendar month per Medicare beneficiary. Providers could distribute over-the-counter COVID-19 tests to Medicare beneficiaries who requested them. Providers were required to keep documentation showing a Medicare beneficiary's request for the tests.

COUNT 1

CONSPIRACY TO COMMIT WIRE FRAUD

The Conspiracy

From in or about January 2022, and continuing until in or about July 2023, in the Missoula Division of the District of Montana and elsewhere, the defendant RONALD DAVID DEAN did knowingly and willfully combine, conspire, and agree with Person A, Person B, and others, to commit offenses against the United States, that is to knowingly devise or intend to devise a scheme and artifice to defraud, by means of materially false and fraudulent pretenses, representations, and promises, to transmit and cause to be transmitted by means of wire communication in interstate and foreign commerce, any writings, signs, signals, pictures, and sounds, in violation of Title 18, United States Code, Section 1343.

The Object/Purpose of the Conspiracy

The object/purpose of the conspiracy was for the defendant, his co-conspirators Person A and Person B, and others, to unlawfully enrich themselves by, among other things: (a) paying and receiving kickbacks and bribes in exchange for signed doctors' orders for DME or over-the-counter COVID-19 tests that were not legitimately prescribed, not needed, not used, or induced through unlawful kickbacks and bribes; and (b) submitting and causing the submission via interstate wire communication of false and fraudulent claims to government health care programs such as Medicare and CHAMPVA for DME and over-the-counter

COVID-19 tests that were not medically necessary and not eligible for reimbursement.

The Manner and Means of the Conspiracy

In furtherance of the conspiracy and to accomplish its object/purpose, the defendant worked as an independent contractor for Person A and Person B. Specifically, the defendant worked with Company A and Company B, through Person A and Person B, to sign doctors' orders for DME or over-the-counter COVID-19 tests that were used to submit false and fraudulent claims to government health care programs such as Medicare and CHAMPVA.

For DME, the defendant received unsigned prescriptions which were transmitted via email from Person A, Person B, and others acting on behalf of Company A and Company B to the defendant to sign. The defendant electronically signed these DME orders for government health care beneficiaries: (a) without seeing, speaking to, or otherwise communicating with or examining them; and (b) without regard to whether beneficiaries needed the DME.

The defendant was not treating and did not examine the beneficiaries for whom he signed doctors' orders for DME. Despite this, the defendant signed a certification that stated: "I ... certify that I have personally performed the assessment of the patient for the prescribed treatment and device and verify that it is

reasonable and medically necessary, according to accepted standards of medical practice within the community, for this patient's medical conditions."

For over-the-counter COVID-19 tests, the defendant signed a form allowing Person A, Person B, and others acting on behalf of Company A and Company B to transmit orders or invoices for over-the-counter COVID-19 tests in the defendant's name. Person A, person B, and others acting on behalf of Company A and Company B billed government health care programs such as Medicare and CHAMPVA for over-the-counter covid tests which were not requested by the beneficiary and not otherwise eligible for reimbursement. Payments for over-the-counter COVID-19 tests went to the defendant, and much of that money was later paid back to Company A and Company B.

Person A and Person B, through Company A and Company B, paid illegal kickbacks and bribes to the defendant in exchange for signing doctors' orders for DME and over-the-counter COVID-19 tests. The defendant used a personal bank account at First Interstate Bank for the purpose of, among other things, receiving illegal kickbacks and bribes from Company A and Company B in exchange for signing doctors' orders for DME and over-the-counter covid tests.

In total, this conspiracy resulted in at least $39,626,171.70 in fraudulent billing to government health care programs such as Medicare and CHAMPVA, of which Medicare, CHAMPVA, and the RRB paid at least $18,043,360.72.

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