2018R00919/DCH

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA	:	Hon. Peter G. Sheridan
	:	Crim. No. 19-CR-249-PGS
v.	:	18 U.S.C. §§ 1349, 1347, and 2
JOSEPH DECORSO	:	

INDICTMENT

The Grand Jury in and for the District of New Jersey, sitting at Newark, charges:

1. At all times relevant to this Indictment:

a. Defendant JOSEPH DECORSO resided in Toms River, New Jersey, was a medical doctor licensed to practice in New Jersey and Arizona, and was a telemedicine doctor at various purported telemedicine companies, as described below. JOSEPH DECORSO worked as an independent contractor for the Integrated and [redacted] telemedicine companies.

b. Willie McNeal operated a purported telemedicine company, Integrated Support Plus, Inc. ("Integrated"). Integrated was a Florida profit corporation with its principal office in Spring Hill, Florida.

c. [redacted] and [redacted] operated a purported telemedicine company, [redacted], and its affiliated entities [redacted] and [redacted] (together, "[redacted]"). The [redacted] entities were each Florida profit corporations with principal offices in Pompano Beach, Florida.

The Medicare Program

d. The Medicare Program ("Medicare") was a federal health care program providing benefits to persons who were 65 years or older, or disabled. Medicare was administered by the Centers for Medicare and Medicaid Services ("CMS"), a federal agency under the United States Department of Health and Human Services. Individuals who receive Medicare benefits are referred to as Medicare beneficiaries.

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

f. Medicare was divided into four parts which helped cover specific services: hospital insurance (Part A), medical insurance (Part B), Medicare Advantage (Part C), and prescription drug benefits (Part D).

g. Specifically, Medicare Part B covered medically necessary physician office services and outpatient care, including the ordering of durable medical equipment, prosthetics, orthotics, and supplies ("DMEPOS"), 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 to the individual.

h. CMS contracted with various companies to receive, adjudicate, process, and pay Part B claims, including claims for braces. CMS also contracted with the Program Safeguard Contractor, or ZPIC, which are

contractors that investigate fraud, waste, and abuse. As part of an investigation, the Program Safeguard Contractor or ZPIC may conduct a clinical review of medical records to ensure that payment is made only for services that meet all Medicare coverage and medical necessity requirements.

i. DMEPOS companies, physicians, and other healthcare providers that provided services to Medicare beneficiaries were referred to as Medicare "providers." To participate in Medicare, providers were required to submit an application in which the providers agreed to abide by the policies and procedures, rules, and regulations governing reimbursement. To receive Medicare funds, enrolled providers, together with their authorized agents, employees, and contractors, were required to abide by all provisions of the Social Security Act, the regulations promulgated under the Act, and applicable policies, procedures, rules, and regulations issued by CMS and its authorized agents and contractors. Health care providers were given and provided with online access to Medicare manuals and services bulletins describing proper billing procedures and billing rules and regulations.

j. If Medicare approved a provider's application, Medicare assigned the provider a Medicare Provider Identification Number ("PIN" or "provider number"). A health care provider who was assigned a Medicare PIN and provided services to beneficiaries was able to submit claims for reimbursement to the Medicare contractor/carrier that included the PIN assigned to that medical provider. Payments under the Medicare program were often made directly to a provider of the goods or services, rather than to a Medicare beneficiary. This payment occurred when the provider submitted the claim to Medicare for payment, either directly or through a billing company.

k. Under Medicare Part B, claims for DMEPOS were required to be reasonable and medically necessary for the treatment or diagnosis of the patient's illness or injury. Medicare uses the term "ordering/referring" provider to identify the physician or nurse practitioner who ordered, referred, or certified an item or service reported in that claim. Individuals ordering or referring these services were required to have the appropriate training, qualifications, and licenses to provide such services. A Medicare claim was required to set forth, among other things, the beneficiary's name, the date the services were provided, the cost of the services, the name and identification number of the physician or other health care provider who had ordered the services, and the name and identification number of the DMEPOS provider that had provided the services. Providers conveyed this information to Medicare by submitting claims using billing codes and modifiers.

l. To be reimbursed from Medicare for DMEPOS, the items or services had to be reasonable, medically necessary, documented, and actually provided as represented to Medicare. Medicare would not pay claims procured through kickbacks and bribes.

m. Medicare regulations required health care providers enrolled with Medicare to maintain complete and accurate patient medical records reflecting the medical assessment and diagnoses of their patients, as well as records documenting actual treatment of the patients to whom services were provided and for whom claims for payment were submitted by the physician. Medicare requires complete and accurate patient medical records so that Medicare may verify that the services were provided as described on the claim form. These records were required to be sufficient to permit Medicare, through

its contractors, to review the appropriateness of Medicare payments made to the health care provider.

n. To receive reimbursement for a covered service from Medicare, a provider must submit a claim, either electronically or using a form (e.g., a CMS-1500 form or UB-92), containing the required information appropriately identifying the provider, patient, and services rendered, among other things.

Telemedicine

o. Telemedicine provided a means of connecting patients to doctors by using telecommunications technology, such as the internet or the telephone, to interact with a patient.

p. Telemedicine companies provided telemedicine services to individuals by hiring doctors and other health care providers. Telemedicine companies typically paid doctors a fee to conduct consultations with patients. In order to generate revenue, telemedicine companies typically either billed insurance or offered a membership program to customers.

q. Medicare Part B covered expenses for specified telehealth services if certain requirements were met. These requirements included that (a) the beneficiary was located in a rural or health professional shortage area; (b) services were delivered via an interactive audio and video telecommunications system; and (c) the beneficiary was at a practitioner's office or a specified medical facility – not at a beneficiary's home – during the telehealth consultation with a remote practitioner.

COUNT ONE

(Conspiracy to Commit Health Care Fraud)

2. The allegations set forth in paragraph 1 of the Indictment are re-alleged and incorporated herein.

3. From in or around July 2017 through on or about March 15, 2019, in the District of New Jersey, and elsewhere, the defendant,

JOSEPH DECORSO,

did knowingly and intentionally conspire and agree with others known and unknown, to knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud a health care benefit program, as that term is defined under Title 18, United States Code, Section 24(b), and to obtain, by means of false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of, any health care benefit program in connection with the delivery of and payment for health care benefits, items, and services, contrary to Title 18, United States Code, Section 1347.

Object of the Conspiracy

4. It was the object of the conspiracy for defendant JOSEPH DECORSO and others to unlawfully enrich themselves by, among other things, (a) submitting and causing the submission of false and fraudulent claims to Medicare that were (i) procured through the payment of kickbacks and bribes; (ii) medically unnecessary, (iii) not eligible for Medicare reimbursement, and/or (iv) not provided as represented; (b) concealing the submission of false and fraudulent claims and the receipt and transfer of the proceeds from the fraud;

and (c) diverting proceeds of the fraud for the personal use and benefit of the defendant and his coconspirators.

Manner and Means of the Conspiracy

5. The manner and means by which the defendant and his co-conspirators sought to accomplish the purpose of the conspiracy included, among others, the following:

a. JOSEPH DECORSO falsely certified to Medicare that he would comply with all Medicare rules and regulations, and federal laws, including that he would not knowingly present or cause to be presented a false and fraudulent claim for payment by Medicare and that he would comply with the Anti-Kickback statute.

b. JOSEPH DECORSO gained access to Medicare beneficiary information for thousands of vulnerable Medicare beneficiaries from Integrated, [redacted], and others, in order for JOSEPH DECORSO to sign DMEPOS orders for those beneficiaries.

c. Integrated, [redacted], and others paid or caused payments to be made to JOSEPH DECORSO and others to sign DMEPOS orders and cause the submission of DMEPOS claims regardless of medical necessity, in order to increase revenue for themselves and their co-conspirators.

d. JOSEPH DECORSO ordered DMEPOS regardless of medical necessity, in the absence of a pre-existing doctor-patient relationship, without a physical examination, and frequently based solely on a short telephonic conversation with the beneficiary or no conversation at all.

e. JOSEPH DECORSO and others falsified, fabricated, altered, and caused the falsification, fabrication, and alteration of patient files, DMEPOS orders, and other records, all to support claims to Medicare for DMEPOS that were obtained through illegal kickbacks and bribes, medically unnecessary, ineligible for Medicare reimbursement, and/or not provided as represented.

f. JOSEPH DECORSO and others concealed and disguised the scheme by preparing or causing to be prepared false and fraudulent documentation, and/or submitting or causing the submission of false and fraudulent documentation to Medicare, including documentation stating that JOSEPH DECORSO had "discussion[s]" with Medicare beneficiaries and conducted various diagnostic tests prior to ordering DMEPOS, when, in fact, JOSEPH DECORSO rarely had a discussion with these Medicare beneficiaries and rarely conducted any diagnostic tests.

g. JOSEPH DECORSO and others submitted or caused the submission of false and fraudulent claims to Medicare in an amount in excess of approximately $13 million for braces that were procured through the payment of kickbacks and bribes, medically unnecessary, ineligible for Medicare reimbursement, and/or not provided as represented.

All in violation of Title 18, United States Code, Section 1349.

COUNTS TWO THROUGH FOUR

(Health Care Fraud)

6. Paragraphs 1 and 5 of this Indictment are re-alleged and incorporated herein as a description of the scheme and artifice

Purpose of the Scheme and Artifice

7. It was the purpose of the scheme and artifice for JOSEPH DECORSO to unlawfully enrich himself and others by, among other things: (a) submitting or causing the submission of false and fraudulent claims to Medicare that were (i) procured by the payment of kickbacks and bribes; (ii) medically unnecessary; (iii) ineligible for Medicare reimbursement; and/or (iv) not provided as represented; (b) concealing the submission of false and fraudulent claims to Medicare and the receipt and transfer of the proceeds from the fraud; and (c) diverting the proceeds of the fraud for the personal use and benefit of the defendant and his accomplices.

Acts in Execution of the Scheme and Artifice

8. On or about the dates specified below as to each count, in the District of New Jersey and elsewhere,

JOSEPH DECORSO,

in connection with the delivery of and payment for health care benefits, items, and services, did knowingly and willfully execute, and attempt to execute, the above-described scheme and artifice to defraud a health care benefit program affecting commerce, as defined in Title 18, United States Code, Section 24(b), that is, Medicare, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of Medicare, in connection with the delivery of and payment for health care benefits, items, and services:

Count	Date	Description of Device(s) Billed	Approximate Amount Billed to Medicare
Two	June 12, 2018	Back, shoulder, and wrist braces	$2,227
Three	March 9, 2019	Back, knee, and shoulder braces	$3,713
Four	March 15, 2019	Back, shoulder, and wrist braces	$8,943

All in violation of Title 18, United States Code, Sections 1347 and 2.

FORFEITURE ALLEGATIONS

(18 U.S.C. § 981(a)(1)(C) and 28 U.S.C. § 2461; 18 U.S.C. §§982(a)(1) and (7) – Criminal Forfeiture)

9. The allegations contained in Counts 1-4 of this Indictment are re-alleged and incorporated by reference as though fully set forth herein for the purpose of alleging forfeiture against defendant,

JOSEPH DECORSO,

pursuant to Title 18, United States Code, Sections 981 and 982, and Title 28, United States Code, Section 2461.

10. Pursuant to Title 18, United States Code, Section 981(a)(1)(C), together with Title 28, United States Code, Section 2461, upon being convicted of the crime charged in Count 1 of this Indictment, the convicted defendant shall forfeit to the United States any property, real or personal, which constitutes or is derived from proceeds traceable to the commission of the offense.

11. Pursuant to Title 18, United States Code, Section 982(a)(7), upon being convicted of the crimes charged in Counts 1 through 4 of this Indictment, the convicted defendant shall forfeit to the United States any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.

Substitute Assets Provision

12. If any of the above-described forfeitable property, as a result of any act or omission of the defendant:

a. cannot be located upon the exercise of due diligence;

b. has been transferred or sold to, or deposited with, a third person;

c. has been placed beyond the jurisdiction of the Court;

d. has been substantially diminished in value; or

e. has been commingled with other property which cannot be subdivided without difficulty;

it is the intent of the United States, pursuant to Title 21, United States Code, Section 853(p), as incorporated by Title 18 United States Code, Section 982(b), to seek forfeiture of any other property of defendant JOSEPH DECORSO up to the value of the forfeitable property described above.

A True Bill,

Foreperson

CRAIG CARPENITO
United States Attorney

JOSEPH BEEMSTERBOER
Chief, Healthcare Fraud Unit
Criminal Division, Fraud Section

JACOB FOSTER
Acting Assistant Chief
Criminal Division, Fraud Section

DARREN C. HALVERSON
Trial Attorney
Criminal Division, Fraud Section