

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA	:	Hon.
	:	
v.	:	Crim. No. 26-
	:	
E. BRUCE DIDONATO	:	18 U.S.C. § 1349
	:	18 U.S.C. § 1347
	:	18 U.S.C. § 371
	:	42 U.S.C. § 1320a-7b(b)(2)(A)
	:	18 U.S.C. § 2

INDICTMENT

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

COUNT ONE

(Conspiracy to Commit Health Care Fraud)

1. Unless otherwise indicated, at all times relevant to this Indictment:

Individuals and Entities

a. Defendant E. BRUCE DIDONATO ("DIDONATO"), a resident of New Jersey, was a licensed optometrist and the founder and an owner of an eye care practice (the "Practice") and an ambulatory surgical center (the "ASC") located in Hamilton, New Jersey.

b. The Practice was an optometry practice that provided eye care and diagnostic testing and was an enrolled Medicare provider that submitted claims to Medicare for payment.

c. The ASC was an outpatient surgical facility used to perform ambulatory eye surgeries and procedures, including cataract surgery, corneal surgery, and YAG capsulotomy.

d. Provider-1, a resident of New Jersey, was a licensed optometrist who managed both the Practice and the ASC.

e. Provider-2, a resident of Pennsylvania, was a licensed medical doctor who maintained his own ophthalmology practice. Provider-2 referred patients to the Practice, performed eye surgeries at the ASC, and, beginning in or around 2019, was the medical director of the Practice.

f. Provider-3, a resident of New Jersey, was a licensed medical doctor who maintained his own ophthalmology practice. Provider-3 referred patients to the Practice and performed eye surgeries at the ASC. Provider-3 also referred patients to Provider-2 for eye surgery at the ASC.

g. DIDONATO, Provider-1, Provider-2, and Provider-3 were enrolled Medicare providers and submitted claims to Medicare. DIDONATO maintained and controlled a business bank account through which he received reimbursements from Medicare (the "DIDONATO Account").

Background on the Medicare Program

h. Medicare was a federally funded program established to provide medical insurance benefits for individuals aged 65 and older and certain disabled individuals who qualified under the Social Security Act.

i. 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 received benefits under Medicare were referred to as Medicare “beneficiaries.”

j. Medicare was divided into four parts, which covered specific services: Part A (hospital insurance), Part B (medical insurance), Part C (Medicare Advantage), and Part D (prescription drug coverage).

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

l. To participate in Medicare, providers were required to submit an application in which the provider agreed to abide by the policies, 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 online access to Medicare manuals and services bulletins describing proper billing procedures and billing rules and regulations.

m. A Medicare claim was required to contain certain information, including: (a) the beneficiary’s name and Health Insurance Claim Number; (b) a description of the health care benefit, item, or service that was provided or supplied to the beneficiary; (c) the billing code(s) for the benefit, item, or service; (d) the date upon which the benefit, item, or service was provided or supplied to the beneficiary; (e) the name of the referring physician or other health care provider; and (f) the

referring provider's unique identifying number, known either as the Unique Physician Identification Number or National Provider Identifier. The claim form could be submitted in hard copy or electronically.

n. Medicare did not cover diagnostic testing that was "not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Title 42, United States Code, Section 1395y(a)(1)(A). Except for certain statutory exceptions, Medicare did not cover "examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint or injury." Title 42, Code of Federal Regulations, Section 411.15(a)(1).

o. If diagnostic testing was necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, Medicare imposed additional requirements before covering the testing. Section 410.32(a) of Title 42 of the Code of Federal Regulations provided that "[a]ll diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary."

p. When submitting claims to Medicare for reimbursement, providers were required to certify that: (1) the contents of the forms were true, correct, and complete; (2) the forms were prepared in compliance with the laws and

regulations governing Medicare; and (3) the services that were purportedly provided, as set forth in the claims, were medically necessary for the treatment or diagnosis of the patient's illness or injury, documented, and actually provided as represented.

q. Medicare claims were required to be properly documented in accordance with Medicare rules and regulations. Medicare would not pay for items and services that were procured through kickbacks and bribes.

2. From in or around 2015 through in or around March 2023, in Mercer County, in the District of New Jersey and elsewhere, the defendant,

E. BRUCE DIDONATO,

did knowingly and intentionally combine, conspire, confederate, and agree with Provider-1, Provider-2, Provider-3, and others known and unknown, to knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud Medicare, a Federal 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, said 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.

Goal of the Conspiracy

3. The goal of the conspiracy was for DIDONATO and others to unlawfully enrich themselves by: (a) submitting and causing the submission of false and fraudulent claims to Medicare for services that were (i) medically unnecessary, (ii) procured through the payment of kickbacks and bribes, (iii) ineligible for

Medicare reimbursement, and (iv) not provided as represented; (b) concealing the kickbacks and bribes, 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

4. It was part of the conspiracy that:

a. DIDONATO 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. Despite this certification, DIDONATO proceeded to present and cause to be presented false and fraudulent claims to Medicare as described below.

b. DIDONATO and Provider-1 paid health care providers (the “Co-Conspirator Providers”), including Provider-2 and Provider-3, illegal kickbacks and bribes to induce the Co-Conspirator Providers to refer patients to the Practice for the performance of medically unnecessary diagnostic tests (the “Diagnostic Tests”).

c. DIDONATO and Provider-1 directed employees of the Practice to perform the medically unnecessary Diagnostic Tests. DIDONATO and Provider-1 did not review the results of the Diagnostic Tests.

d. Except in rare instances, the Co-Conspirator Providers did not review the results of the Diagnostic Tests or rely on those results to inform their treatment decisions, including whether or how to perform the surgeries that they

planned to perform at the ASC on or about the same day the Diagnostic Tests were performed.

e. Many of the Diagnostic Tests directed to be performed by DIDONATO on or about the day of surgery were duplicative of tests that the Co-Conspirator Providers previously ordered and reviewed for their patients before the day of surgery, and others were medically unnecessary for the type of surgery being performed.

f. In furtherance of the scheme, DIDONATO and Provider-1—rather than the Co-Conspirator Providers—billed Medicare for the Diagnostic Tests, through the Practice, to conceal from Medicare that many of the Diagnostic Tests performed on the Co-Conspirator Providers' patients and billed to Medicare were duplicative of tests that the Co-Conspirator Providers had previously ordered for their own patients.

g. To induce the Co-Conspirator Providers to refer their patients to the Practice so that DIDONATO could bill for the Diagnostic Tests, DIDONATO and Provider-1 paid illegal kickback and bribes to each Co-Conspirator Provider up to approximately 50% of the total Medicare reimbursement for Diagnostic Tests performed on patients that the Co-Conspirator Provider had referred for surgeries at the ASC.

h. DIDONATO and others concealed and disguised the illegal kickbacks and bribes by, among other ways: (1) creating sham agreements with providers that described the illegal kickbacks and bribes as fees for the fair market value of consulting services, or others services, that were not rendered; (2) paying the

Co-Conspirator Providers in even monthly installments, described as “flat fees,” that were based on a percentage of the amounts the Practice had collected for Diagnostic Tests performed on patients that the Co-Conspirator Providers had referred to the ASC in the previous fiscal year.

i. DIDONATO and Provider-1 submitted and caused to be submitted, through the Practice, at least approximately \$3.4 million in false and fraudulent claims to Medicare for Diagnostic Tests that were medically unnecessary, based on the payment of illegal kickbacks and bribes, and ineligible for reimbursement. Medicare paid at least approximately \$1 million based on those false and fraudulent claims.

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

COUNTS TWO THROUGH THREE
(Health Care Fraud)

1. The allegations in Paragraphs 1 and 4 of Count One of this Indictment are realleged and incorporated by reference as though fully set forth herein.

2. On or about the dates set forth below, in Mercer County, in the District of New Jersey and elsewhere, the defendant,

E. BRUCE DIDONATO,

did knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud Medicare, a health care benefit program as defined in Title 18, United States Code, Section 24(b), 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, said health care benefit program, in connection with the delivery of and payment for health care benefits, items, and services, that is, the submission of false and fraudulent claims for medically unnecessary diagnostic eye tests, each execution constituting a separate Count of this Indictment:

Count	Medicare Beneficiary	Approximate Date of Claim Submission	Approximate Amount Billed to Medicare	Approximate Amount Paid by Medicare
Two	S.L.	8/9/2021	\$200.00	\$26.72
Three	A.C.	12/3/2021	\$200.00	\$26.72

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

COUNT FOUR
(Conspiracy to Violate the Anti-Kickback Statute)

1. The allegations in Paragraph 1 of Count One of this Indictment are realleged and incorporated by reference as if fully set forth herein.

2. From in or around 2015 through in or around March 2023, in Mercer County, in the District of New Jersey, and elsewhere, the defendant,

E. BRUCE DIDONATO,

did knowingly and intentionally conspire and agree with Provider-1, Provider-2, Provider-3, and others known and unknown, to commit offenses against the United States, that is:

a. to knowingly and willfully offer and pay remuneration (including any kickback, bribe, and rebate), directly and indirectly, overtly and covertly, in cash and in kind, to any person to induce such person to refer an individual to a person for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole and in part under a Federal health care program, as defined in Title 42, United States Code, Section 1320a-7b(f), namely Medicare, contrary to Title 42, United States Code, Section 1320a-7b(b)(2)(A); and

b. to knowingly and willfully solicit and receive any remuneration (including any kickback, bribe, and rebate), directly and indirectly, overtly and covertly, in cash and in kind, in return for referring an individual to a person for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole and in part under a Federal health care program, as

defined in Title 42, United States Code, Section 1320a-7b(f), namely Medicare, contrary to Title 42, United States Code, Section 1320a-7b(b)(1)(A).

Goal of the Conspiracy

3. The goal of the conspiracy was for DIDONATO and others to unlawfully enrich themselves by: (a) submitting and causing the submission of false and fraudulent claims to Medicare for services that were procured through the payment of kickbacks and bribes; (b) concealing the kickbacks and bribes, 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 others.

Manner and Means of the Conspiracy

4. Paragraph 4 of Count One of this Indictment is realleged and incorporated by reference as though fully set forth herein.

5. It was additionally part of the conspiracy that:

a. DIDONATO paid Provider-3, as a kickback and bribe, approximately 50% of the total Medicare reimbursements for cataract surgeries performed on patients that Provider-3 referred to the ASC for such surgeries.

b. DIDONATO arranged for Provider-2 to perform the surgeries referred to the ASC by Provider-3.

c. DIDONATO and others caused the ASC to bill Medicare for the cataract surgeries performed on patients referred by Provider-3.

Overt Acts

6. In furtherance of the conspiracy and to effect its objects, DIDONATO and others committed the following overt acts, among others, in Mercer County, in the District of New Jersey and elsewhere:

a. On or about December 15, 2021, DIDONATO paid an illegal kickback and bribe in the form of a check for approximately \$2,632.45 from the DIDONATO Account to Provider-3.

b. On or about January 20, 2022, DIDONATO paid Provider-2 approximately \$9,501.97 from the DIDONATO Account, which included as an illegal kickback and bribe approximately \$2,756.93 in reimbursements from Medicare for medically unnecessary Diagnostic Tests for patients Provider-2 referred to the Practice.

c. On or about May 17, 2022, DIDONATO paid Provider-2 approximately \$8,034 from the DIDONATO Account, which included as an illegal kickback and bribe approximately \$3,000 in reimbursements from Medicare for medically unnecessary Diagnostic Tests for patients that Provider-2 referred to the Practice.

All in violation of Title 18, United States Code, Section 371.

COUNTS FIVE THROUGH SEVEN
(Violations of the Anti-Kickback Statute)

1. The allegations in Paragraph 1 of Count One of this Indictment are realleged and incorporated as if fully set forth herein.

2. On or about the dates listed below, in Mercer County, in the District of New Jersey and elsewhere, the defendant,

E. BRUCE DIDONATO,

did knowingly and willfully offer and pay remuneration (including any kickback, bribe, and rebate), directly and indirectly, overtly and covertly, in cash and in kind, to any person to induce such person to refer an individual to a person for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole and in part under a Federal health care program, as defined in Title 42, United States Code, Section 1320a-7b(f), namely Medicare:

Count	Approximate Date	Description
Five	December 15, 2021	Check payment for approximately \$2,632.45 from the DIDONATO Account to a bank account associated with Provider-3, which was a kickback for the referral of surgical patients
Six	January 20, 2022	Check payment for approximately \$9,501.97, of which approximately \$2,756.93 was a kickback for the referral of Medicare beneficiaries for diagnostic tests, from the DIDONATO Account to a bank account associated with Provider-2
Seven	May 17, 2022	Check payment for approximately \$8,034.30, of which approximately \$3,000 was a kickback for the referral of Medicare beneficiaries for diagnostic tests, from the DIDONATO Account to a bank account associated with Provider-2

Each in violation of Title 42, United States Code, Section 1320a-7b(b)(2)(A) and Title 18, United States Code, Section 2.

FORFEITURE ALLEGATION

Upon conviction of any of the offenses alleged in Counts One through Seven of this Indictment, the defendant,

E. BRUCE DIDONATO,

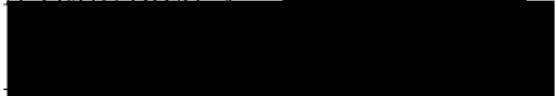
shall forfeit to the United States, pursuant to Title 18, United States Code, Section 982(a)(7), all property DIDONATO obtained that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of such offenses, and all property traceable to such property.

SUBSTITUTE ASSETS PROVISION

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

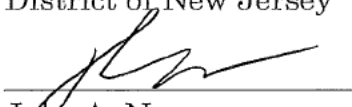
- (a) cannot be located upon the exercise of due diligence;
- (b) has been transferred or sold to, or deposited with, a third person;
- (c) has been placed beyond the jurisdiction of the Court;
- (d) has been substantially diminished in value; or
- (e) has been commingled with other property which cannot 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 the defendant up to the value of the forfeitable property described above.

A TRUE BILL. 


FOREPERSON

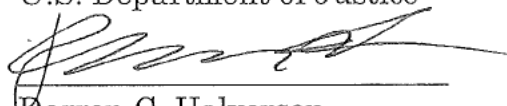
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18 U.S.C. § 1349

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18 U.S.C. § 371

42 U.S.C. § 1320a-7b(b)(2)(A)

18 U.S.C. § 2

A True Bill,

foreperson

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