SMS/RO/2021R00508

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA	:	Hon.
	:	
v.	:	Criminal No. 21-
	:	
CHRISTOPHER CIRRI	:	18 U.S.C. § 1349

INFORMATION

The defendant having waived in open court prosecution by Indictment, the Acting United States Attorney for the District of New Jersey charges:

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

The Defendant and Other Individuals and Entities

a. Defendant CHRISTOPHER CIRRI ("defendant CIRRI") was a resident of New Jersey. Defendant CIRRI and NICHOLAS DEFONTE ("DEFONTE"), a co-conspirator not charged in this Information, jointly owned, operated, and had a financial interest in various entities located in New Jersey (the "CIRRI/DEFONTE Supply Companies") through which defendant CIRRI and DEFONTE obtained doctors' orders for orthotic braces (also called durable medical equipment or "DME"), as well as prescriptions for compounded medications and other medical products reimbursable by federal and private health care benefit programs (collectively, the "RX Orders").

The Medicare Program

b. Medicare was a federally-funded program established by the Social Security Act of 1965 (codified as amended in various sections of Title 42,

United States Code) to provide medical insurance benefits for individuals age 65 and older and certain disabled individuals who qualify under the Social Security Act. Individuals who received benefits under Medicare were referred to as "Medicare beneficiaries."

c. Medicare was administered by the Center for Medicare and Medicaid Services ("CMS"), a federal agency under the United States Department of Health and Human Services.

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

e. Medicare Part B covered non-institutional care that included physician services and supplies, such as DME, that were needed to diagnose or treat medical conditions and that met accepted standards of medical practice.

f. Medicare was a "health care benefit program," as defined by 18 U.S.C. § 24(b), and a "Federal health care program," as defined by 42 U.S.C. § 1320a-7b(f), that affected commerce.

g. In order for a supplier of DME services to bill Medicare Part B, that supplier had to enroll with Medicare as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies ("DMEPOS") supplier by completing a Form CMS-855S.

h. As provided in the Form CMS-855S, to enroll as a DMEPOS supplier, every DMEPOS supplier had to meet certain standards to obtain and retain billing privileges to Medicare, such as, but not limited to, the following:

(1) provide complete and accurate information on the Form CMS-855S, with any changes to the information on the form reported within 30 days; (2) disclose persons and organizations with ownership interests or managing control; (3) abide by applicable Medicare laws, regulations, and program instructions, such as, but not limited to, the Federal anti-kickback statute ("AKS") (42 U.S.C. § 1320a-7b(b)); (4) acknowledge that the payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions; and (5) refrain from knowingly presenting or causing to present a false or fraudulent claim for payment by Medicare and submitting claims with deliberate ignorance or reckless disregard of their truth or falsity.

i. Medicare-authorized suppliers of health care services, such as DMEPOS suppliers, could only submit claims to Medicare for reasonable and medically necessary services. Medicare would not reimburse claims for services that it knew were procured through kickbacks or bribes. Medicare would not reimburse for services that were not medically necessary, procured through the payment of kickbacks and bribes, and not provided as represented. By implementing these restrictions, Medicare aimed to preserve its resources, which were largely funded by United States taxpayers, for those elderly and other qualifying beneficiaries who had a genuine need for medical services.

TRICARE

j. TRICARE was a health care program of the United States Department of Defense ("DoD") Military Health System that provided coverage for DoD beneficiaries worldwide, including active-duty service members, National Guard and Reserve members, retirees, their families, and survivors. The Defense Health Agency, an agency of the DoD, was the military entity responsible for overseeing and administering TRICARE.

k. TRICARE was a "health care benefit program," as defined by Title 18 United States Code § 24(b), and a "Federal health care program," as defined by Title 42 United States Code § 1320a-7b(f), that affected commerce.

CHAMPVA

l. The Civilian Health and Medical Program of the Department of Veterans Affairs ("CHAMPVA") was a federal health care benefit program within the Department of Veterans Affairs ("VA"). CHAMPVA was a comprehensive health care program in which the VA shared the cost of covered health care services and supplies with eligible beneficiaries. The eligible categories for CHAMPVA beneficiaries were the spouses or children of veterans who had been rated permanently and totally disabled for a service-connected disability and the surviving spouse or child of a veteran who died from a VA-rated service-connected disability.

m. In general, the CHAMPVA program covered most health care services and supplies that were medically and psychologically necessary. CHAMPVA was always the secondary payer to Medicare and reimbursed

beneficiaries for costs that Medicare did not cover. Health care claims had to have first been sent to Medicare for processing. Medicare electronically forwarded claims to CHAMPVA after Medicare had processed them. For Medicare supplemental plans, CHAMPVA processed the remaining portion of the claim after receiving Medicare's explanation of benefits.

n. CHAMPVA was a "health care benefit program," as defined by Title 18 United States Code § 24(b), and a "Federal health care program," as defined by Title 42 United States Code § 1320a-7b(f), that affected commerce.

The Conspiracy

2. From in or around March 2018, and continuing through in or around April 2019, in the District of New Jersey, and elsewhere, defendant

CHRISTOPHER CIRRI

did knowingly and intentionally conspire and agree with others to knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud a health care benefit program , that is Medicare, TRICARE, CHAMPVA, and others and to obtain, by means of false and fraudulent pretenses, representations, and promises, any of the money owned by, and under the custody and control of, said health care benefit program, as defined by 18 U.S.C. § 24(b), in connection with the delivery of or 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 defendant CIRRI and his co-conspirators to unlawfully enrich themselves and others by causing the submission of false and fraudulent claims to health care benefit programs.

Manner and Means of the Conspiracy

4. It was a part of the conspiracy that:

a. Defendant CIRRI and DEFONTE had access to telemarking and telemedicine companies and were able to procure RX Orders. To generate RX Orders, defendant CIRRI and DEFONTE first identified qualified beneficiaries located in New Jersey and elsewhere through the use of marketing call centers under their direction. Once beneficiaries were identified by the marketers, the CIRRI/DEFONTE Supply Companies utilized the services of telemedicine companies to secure RX Orders, regardless of whether the prescriptions were medically justified for the beneficiaries.

b. Defendant CIRRI and DEFONTE obtained RX Orders by entering into kickback arrangements with telemedicine companies to use the doctors and nurse practitioners employed by those companies to write RX Orders. Specifically, defendant CIRRI and DEFONTE agreed to pay the telemedicine companies kickbacks for each RX Order that the telemedicine companies provided for those beneficiaries. The telemedicine companies, in turn, arranged to the pay health care providers under their control per consultation that resulted in an RX Order. For example, the CIRRI/DEFONTE Supply

Companies paid two telemedicine companies in excess of approximately $3.3 million for RX Orders for DME.

c. After obtaining RX Orders, defendant CIRRI and DEFONTE transmitted and caused to be transmitted the RX Orders to providers for processing, who in turn billed Medicare, TRICARE, CHAMPVA, and other federal and private health care benefit programs. Defendant CIRRI and DEFONTE received kickbacks from the providers for each RX Order that resulted in reimbursement from a paying health care benefit program.

d. In this manner, defendant CIRRI and DEFONTE submitted and caused the submission of claims to Medicare, TRICARE, CHAMPVA, and other health care benefit programs for completed RX Orders that were (i) medically unnecessary; (ii) obtained through the payments of kickbacks and bribes and therefore not eligible for federal reimbursement; and (iii) not provided as represented.

e. From in or around March 2018 through in or around April 2019, defendant CIRRI and DEFONTE received kickbacks in excess of approximately $7,850,545 for RX Orders. As a result of the kickback scheme, Medicare, TRICARE, and CHAMPVA paid in excess of approximately $17,000,000 in reimbursements for RX Orders that were procured by defendant CIRRI and DEFONTE.

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

FORFEITURE ALLEGATION

1. Upon conviction of the offense alleged in the Information, defendant CIRRI shall forfeit to the United States, pursuant to 18 U.S.C. § 982(a)(7), all property, real or personal, that constitutes or is derived, directly and indirectly, from gross proceeds traceable to the commission of the offense (as defined in 18 U.S.C. § 24) alleged in this Information, including, but not limited to, a sum of money equal to $7,850,545.

SUBSTITUTE ASSETS PROVISION
(Applicable to All Forfeiture Allegations)

2. 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;

the United States shall be entitled to forfeiture of substitute property, pursuant to 21 U.S.C. § 853(p), as incorporated by 18 U.S.C. § 982(b).

RACHAEL A. HONIG
Acting United States Attorney

/s/ Joseph S. Beemsterboer
JOSEPH S. BEEMSTERBOER
Acting Chief, Criminal Division,
Fraud Section