UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 21-60270-CR-SINGHAL/SNOW

18 U.S.C. § 1349
18 U.S.C. § 982

UNITED STATES OF AMERICA

v.

STEVEN CAPLAN,

Defendant.
_____/

INFORMATION

The Acting United States Attorney charges that:

GENERAL ALLEGATIONS

At all times material to this Information:

The Medicare Program

1. The Medicare Program ("Medicare") was a federally funded program that provided free or below-cost health care benefits to certain individuals, primarily the elderly, blind, and disabled. The benefits available under Medicare were governed by federal statutes and regulations. The United States Department of Health and Human Services ("HHS"), through its agency, the Centers for Medicare and Medicaid Services ("CMS"), oversaw and administered Medicare. Individuals who received benefits under Medicare were commonly referred to as Medicare "beneficiaries."

2. Medicare was subdivided into multiple program "parts." Medicare Part A covered health services provided by hospitals, skilled nursing facilities, hospices, and home health agencies. Medicare Part B covered physician services and outpatient care, including an

individual's access to durable medical equipment ("DME"), such as orthotic devices and wheelchairs. Medicare Part C, also known as the "Medicare Advantage" Program, provided Medicare beneficiaries with the option to receive their Medicare benefits through private managed health care plans, including health maintenance organizations and preferred provider organizations.

3. Medicare and Medicare Advantage were "health care benefit program[s]," as defined by Title 18, United States Code, Section 24(b), and "Federal health care program[s]," as defined by Title 42, United States Code, Section 1320a-7b(f).

Part C – Medicare Advantage

4. Beneficiaries enrolled in Medicare Advantage plans received all of the same services provided by an original fee-for-service Medicare plan, in addition to mandatory supplemental benefits and optional supplemental benefits.

5. To receive Medicare Advantage benefits, a beneficiary was required to enroll in a managed care plan operated by a private company approved by Medicare. Those companies were often referred to as Medicare Advantage plan "sponsors." A beneficiary's enrollment in a Medicare Advantage plan was voluntary.

6. Rather than reimbursing based on the extent of the services provided, as CMS did for providers enrolled in original fee-for-service Medicare, CMS made fixed, monthly payments to a plan sponsor for each beneficiary enrolled in one of the sponsor's plans, regardless of the services rendered to the beneficiary that month or the cost of covering the beneficiary's health benefits that month. To receive payment, providers submitted or caused the submission of claims to private health insurance companies electronically via interstate wires, either directly or through

a billing company. The private health insurance companies then reimbursed the provider based on the services that were purportedly provided.

7. Beneficiaries chose to enroll in a managed care plan administered by private health insurance companies, health maintenance organizations, or preferred provider organizations. A number of entities were contracted by CMS to provide managed care to Medicare beneficiaries through various approved plans. Such plans covered DME and related health care benefits, items, and services. Among its responsibilities, these Medicare Advantage plans received, adjudicated, and paid the claims of authorized providers seeking reimbursements for the cost of DME and related health care benefits, items, or services supplied to beneficiaries.

Durable Medical Equipment

8. Orthotic devices were a type of DME that included rigid and semi-rigid devices, such as knee braces, back braces, shoulder braces, ankle braces, and wrist braces.

9. DME suppliers, physicians, and other health care providers that provided services to beneficiaries were referred to as Medicare "providers." To participate in Medicare, providers were required to submit an application, CMS Form 855S, which contained a certification that stated:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in Section 1B of this application. The Medicare laws, regulations, and program instructions are available through the fee-for-service contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations and program instructions[,] including, but not limited to, the Federal Anti-Kickback Statute, 42 U.S.C. section 1320a-7b(b)[.]
>
> I 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.

10. CMS Form 855S also required applicants to disclose to Medicare any individual or organization with an ownership interest, partnership interest, or managing control of a DME supplier. This included: (i) all individuals and organizations with five percent or more of an ownership stake, either direct or indirect, in the DME supplier; (ii) all individuals or organizations with a partnership interest in the DME supplier, regardless of the partner's percentage of ownership; (iii) all organizations with "managing control" of the DME supplier; and (iv) all "managing employees."

11. CMS Form 855S defined an organization with "managing control" of a DME supplier as "[a]ny organization that exercises operational or managerial control" over the DME supplier, or "conducts the day-to-day operations" of the DME supplier. CMS Form 855S defined "managing employee" as "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations" of the DME supplier, "either under contract or through some other arrangement, whether or not the individual is a W-2 employee" of the DME supplier.

12. CMS Form 855S also required the disclosure of "Adverse Legal Actions" against individuals or organizations with an ownership interest, partnership interest, or managing control of a DME supplier. CMS Form 855S defined "Adverse Legal Actions" as, among other things, any federal or state felony conviction within the previous ten years, and any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

13. If Medicare approved a provider's application, Medicare assigned the provider a Medicare "provider number." A health care provider with a Medicare provider number could file claims with Medicare to obtain reimbursement for services rendered to beneficiaries.

14. Enrolled Medicare providers agreed to abide by the policies, procedures, rules, and regulations governing reimbursement. To receive Medicare funds, enrolled providers were required to abide by the Federal Anti-Kickback Statute and other laws and regulations. Providers were given access to Medicare manuals and services bulletins describing billing procedures, rules, and regulations.

15. Medicare reimbursed DME suppliers and other health care providers for items and services rendered to beneficiaries. To receive payment from Medicare, providers submitted or caused the submission of claims to Medicare electronically via interstate wires, either directly or through a billing company.

16. A Medicare claim for DME reimbursement was required to set forth, among other things, the beneficiary's name and unique Medicare identification number, the DME provided to the beneficiary, the date the DME was provided, the cost of the DME, and the name and unique physician identification number of the physician who prescribed or ordered the equipment.

17. 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 medical professional.

Telemedicine

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

19. Telemedicine companies provided telemedicine services, or telehealth 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 received payment from patients who utilized the services of the telemedicine company.

20. Medicare Part B covered expenses for specific 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 in a practitioner's office or a specified medical facility – not at a beneficiary's home – during the telehealth service with a remote practitioner.

The Defendant and Related Entities and Individuals

21. West Bay Medical Supply, Inc. ("West Bay") was a company incorporated under the laws of Florida, with its principal place of business in Pinellas County, Florida. West Bay was a DME supplier that purportedly provided DME to patients, including Medicare and Medicare Advantage plan beneficiaries.

22. LeadCreations.com, LLC ("Lead Creations") was a limited liability company formed under the laws of Florida, with its principal place of business in Broward County, Florida.

23. Defendant **STEVEN CAPLAN** was a resident of Broward County, Florida, and an owner and manager of West Bay.

24. Jeremy Waxman was a resident of Miami-Dade County, Florida, and an owner and manager of West Bay.

Conspiracy to Commit Health Care Fraud
(18 U.S.C. § 1349)

From in or around May 2018, and continuing through in or around April 2019, in Broward County, in the Southern District of Florida, and elsewhere, the defendant,

STEVEN CAPLAN,

did knowingly and willfully, that is, with the intent to further the object of the conspiracy, combine, conspire, confederate, and agree with Jeremy Waxman, and with others known and unknown to the Acting United States Attorney, to commit an offense against the United States, that is, to knowingly and willfully execute a 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 Medicare Advantage, 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 programs, in connection with the delivery of and payment for health care benefits, items, and services, in violation of Title 18, United States Code, Section 1347.

Purpose of the Conspiracy

25. It was a purpose of the conspiracy for the defendant and his co-conspirators to unlawfully enrich themselves by, among other things: (a) offering, paying, soliciting, and receiving kickbacks and bribes in exchange for the referral of Medicare beneficiaries and doctors' orders for DME to West Bay; (b) paying and causing the payment of kickbacks and bribes to telemedicine companies in exchange for ordering and arranging for the ordering of DME for Medicare beneficiaries, without regard to the medical necessity of the prescribed DME or whether the DME was eligible for Medicare and Medicare Advantage reimbursement; (c) submitting and causing the submission of false and fraudulent claims to Medicare and Medicare Advantage through West Bay for DME that was medically unnecessary, ineligible for Medicare and Medicare Advantage reimbursement, and not provided as represented; (d) concealing and causing the concealment of false and fraudulent claims; and (e) diverting fraud proceeds for their personal use and benefit, the use and benefit of others, and to further the fraud.

Manner and Means of the Conspiracy

The manner and means by which the defendant and his co-conspirators sought to accomplish the object and purpose of the conspiracy included, among other things:

26. **STEVEN CAPLAN** falsely certified to Medicare that he, as well as West Bay, would comply with all Medicare rules and regulations and federal laws, including the Federal Anti-Kickback Statute, the requirement not to knowingly present or cause to be presented a false and fraudulent claim for payment by Medicare, and the requirement not to submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

27. **STEVEN CAPLAN** failed to disclose to Medicare that Jeremy Waxman acquired a beneficial ownership and management interest in West Bay.

28. **STEVEN CAPLAN** and Jeremy Waxman paid and caused to be paid kickbacks and bribes to patient recruiters, including Lead Creations, and others, in exchange for referring beneficiaries and doctors' orders for DME to West Bay.

29. **STEVEN CAPLAN**, Jeremy Waxman, and other co-conspirators offered and paid, and caused to be paid, illegal kickbacks and bribes to telemedicine companies in exchange for doctors' orders for DME that was not medically necessary and not eligible for Medicare and Medicare Advantage reimbursement. The orders were written by doctors contracted with the telemedicine companies, even though those doctors had no prior relationship with the beneficiaries, were not treating the beneficiaries, and did not conduct a proper telemedicine visit.

30. **STEVEN CAPLAN**, Jeremy Waxman, and other co-conspirators disguised the nature and source of these kickbacks and bribes by designating payments as legitimate services, such as "marketing" or "business process outsourcing" services, entering into sham contracts, and generating and causing the generation of fraudulent invoices.

31. **STEVEN CAPLAN**, Jeremy Waxman, and other co-conspirators provided, and caused the provision of, DME to beneficiaries that was medically unnecessary, ineligible for reimbursement, did not fit, and that the beneficiaries did not request.

32. In total, from in or around May 2018 to in or around April 2019, **STEVEN CAPLAN**, Jeremy Waxman, and other co-conspirators caused West Bay to submit false and fraudulent claims to Medicare and Medicare Advantage in at least the approximate amount of $2,271,639, of which approximately $1,272,432 was paid.

33. **STEVEN CAPLAN**, Jeremy Waxman, and other co-conspirators used the fraud proceeds received from Medicare and Medicare Advantage to benefit themselves and others, and to further the fraud.

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

FORFEITURE ALLEGATIONS
(18 U.S.C. § 982)

1. The allegations of this Information are re-alleged and by this reference fully incorporated herein for alleging criminal forfeiture to the United States of certain property in which the defendant, **STEVEN CAPLAN**, has an interest.

2. Upon conviction of a violation of Title 18, United States Code, Section 1349, as alleged in this Information, the defendant shall forfeit to the United States, pursuant to Title 18, United States Code, Section 982(a)(7), any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to such violation.

All pursuant to Title 18, United States Code, Sections 982(a)(1), 982(a)(2)(A), and 982(a)(7), and the procedures outlined at Title 21, United States Code, Section 853, as made applicable by Title 18, United States Code, Section 982(b)(1).

JUAN ANTONIO GONZALEZ
ACTING UNITED STATES ATTORNEY
SOUTHERN DISTRICT OF FLORIDA

JOSEPH S. BEEMSTERBOER
ACTING CHIEF
CRIMINAL DIVISION, FRAUD SECTION
U.S. DEPARTMENT OF JUSTICE

ALLAN MEDINA
DEPUTY CHIEF
CRIMINAL DIVISION, FRAUD SECTION
U.S. DEPARTMENT OF JUSTICE

JAMIE DE BOER
TRIAL ATTORNEY
CRIMINAL DIVISION, FRAUD SECTION
U.S. DEPARTMENT OF JUSTICE

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

UNITED STATES OF AMERICA

v.

STEVEN CAPLAN,

Defendant. /

CASE NO. _____

CERTIFICATE OF TRIAL ATTORNEY*

Superseding Case Information:

Court Division: (Select One)
☐ Miami ☐ Key West ☑ FTL
☐ WPB ☐ FTP

New defendant(s) ☐ Yes ☐ No
Number of new defendants _____
Total number of counts _____

1. I have carefully considered the allegations of the indictment, the number of defendants, the number of probable witnesses and the legal complexities of the Indictment/Information attached hereto.
2. I am aware that the information supplied on this statement will be relied upon by the Judges of this Court in setting their calendars and scheduling criminal trials under the mandate of the Speedy Trial Act, Title 28 U.S.C. Section 3161.
3. Interpreter: (Yes or No) No
   List language and/or dialect _____
4. This case will take 0 days for the parties to try.
5. Please check appropriate category and type of offense listed below:

	(Check only one)		(Check only one)	
I	0 to 5 days	☑	Petty	☐
II	6 to 10 days	☐	Minor	☐
III	11 to 20 days	☐	Misdemeanor	☐
IV	21 to 60 days	☐	Felony	☑
V	61 days and over	☐		

6. Has this case previously been filed in this District Court? (Yes or No) No
   If yes: Judge _____ Case No. _____
   (Attach copy of dispositive order)
   Has a complaint been filed in this matter? (Yes or No) No
   If yes: Magistrate Case No. _____
   Related miscellaneous numbers: _____
   Defendant(s) in federal custody as of _____
   Defendant(s) in state custody as of _____
   Rule 20 from the District of _____
   Is this a potential death penalty case? (Yes or No) No
7. Does this case originate from a matter pending in the Central Region of the U.S. Attorney's Office prior to August 9, 2013 (Mag. Judge Alicia O. Valle)? (Yes or No) No
8. Does this case originate from a matter pending in the Northern Region of the U.S. Attorney's Office prior to August 8, 2014 (Mag. Judge Shaniek Maynard? (Yes or No) No
9. Does this case originate from a matter pending in the Central Region of the U.S. Attorney's Office prior to October 3, 2019 (Mag. Judge Jared Strauss)? (Yes or No) No

for:
JAMIE DE BOER
DOJ Trial Attorney
Court ID No. A5502601

*Penalty Sheet(s) attached

REV 3/19/21

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

PENALTY SHEET

Defendant's Name: **STEVEN CAPLAN**

Case No:

Count #: 1

Title 18, United States Code, Section 1349

Conspiracy to Commit Health Care Fraud

***Max Penalty**: Ten (10) years' imprisonment

***Refers only to possible term of incarceration, does not include possible fines, restitution, special assessments, parole terms, or forfeitures that may be applicable.**

AO 455 (Rev. 01/09) Waiver of an Indictment

UNITED STATES DISTRICT COURT

for the

Southern District of Florida

United States of America)
v.) Case No.
)
Steven Caplan,)
Defendant)

WAIVER OF AN INDICTMENT

I understand that I have been accused of one or more offenses punishable by imprisonment for more than one year. I was advised in open court of my rights and the nature of the proposed charges against me.

After receiving this advice, I waive my right to prosecution by indictment and consent to prosecution by information.

Date: _____

_____
Defendant's signature

_____
Signature of defendant's attorney

DANIEL GELBER, ESQ.
Printed name of defendant's attorney

_____
Judge's signature

_____
Judge's printed name and title