

**UNITED STATES DISTRICT COURT**  
**SOUTHERN DISTRICT OF FLORIDA**  
**22-80103-CR-MIDDLEBROOKS/MATTHEWMAN**  
 Case No. \_\_\_\_\_

18 U.S.C. § 371  
 18 U.S.C. § 982(a)(7)

**UNITED STATES OF AMERICA**

**vs.**

**TODD SHULL,**

**Defendant.**

\_\_\_\_\_ /

**INFORMATION**

The 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 and below-cost health care benefits to 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 & Medicaid Services (“CMS”), oversaw and administered Medicare. Individuals who received benefits under Medicare were commonly referred to as Medicare “beneficiaries.”

2. 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).

3. Medicare covered different types of benefits and was separated into different program “parts.” Medicare “Part A” covered, among others, health services provided by hospitals, skilled nursing facilities, hospices, and home health agencies. Medicare “Part B” covered, among other things, medical items and services provided by physicians, medical clinics, laboratories, and other qualified health care providers, such as office visits, minor surgical procedures, durable medical equipment (“DME”), and laboratory testing, that were medically necessary and ordered by licensed medical doctors or other qualified health care providers.

4. Medicare “providers” included independent clinical laboratories, physicians, DME companies, and other health care providers who provided items and services to beneficiaries. To bill Medicare, a provider was required to submit a Medicare Enrollment Application Form (“Provider Enrollment Application”) to Medicare. The Provider Enrollment Application contained certifications that the provider was required to make before the provider could enroll with Medicare. Specifically, the Provider Enrollment Application required the provider to certify, among other things, that the provider would abide by the Medicare laws, regulations, and program instructions, including the Federal Anti-Kickback Statute, and that the provider would not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare.

5. A Medicare “provider number” was assigned to a provider upon approval of the provider’s Medicare Enrollment Application. A health care provider that received a Medicare provider number was able to file claims with Medicare to obtain reimbursement for items and services provided to beneficiaries.

6. A Medicare claim was required to contain certain important information, including: (a) the beneficiary’s name and Health Insurance Claim Number (“HICN”); (b) a description of the health care benefit, item, or service that was provided or supplied to the beneficiary; (c) the billing

codes 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 ("UPIN") or National Provider Identifier ("NPI"). The claim form could be submitted in hard copy or electronically via interstate wire.

7. 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 items and services that were purportedly provided, as set forth in the claims, were medically necessary.

8. Medicare claims were required to be properly documented in accordance with Medicare rules and regulations. Medicare would not reimburse providers for claims that were procured through the payment of kickbacks and bribes.

### **Part B Coverage and Regulations**

9. CMS acted through fiscal agents called Medicare administrative contractors ("MACs"), which were statutory agents for CMS for Medicare Part B. The MACs were private entities that reviewed claims and made payments to providers for items and services rendered to beneficiaries. The MACs were responsible for processing Medicare claims arising within their assigned geographical area, including determining whether the claim was for a covered service.

10. Payments under Medicare Part B were often made directly to the health care provider rather than to the patient or beneficiary. For this to occur, the beneficiary would assign the right of payment to the health care provider. Once such an assignment took place, the health care provider would assume the responsibility for submitting claims to, and receiving payments from, Medicare.

**Medicare Coverage for Genetic Testing**

11. Cancer genetic (“CGx”) testing used DNA sequencing to detect mutations in genes that could indicate a higher risk of developing certain types of cancers in the future. CGx testing was not a method of diagnosing whether an individual presently had cancer.

12. Cardiovascular genetic testing (“cardio genetic testing”) used DNA sequencing to detect mutations in genes that could indicate an increased risk of developing serious cardiovascular conditions in the future and could assist in the treatment or management of a patient who presently had signs or symptoms of a cardiovascular disease or condition. Cardio genetic testing was not a method of diagnosing whether an individual presently had a cardiac condition.

13. For both CGx and cardio genetic testing, the patient provided a saliva sample, cheek swab, or nasal swab containing DNA material. Tests were then run on different “panels” of genes. Genetic testing typically involved multiple lab procedures that resulted in billing Medicare using certain billing codes, each with its own reimbursement rate.

14. 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.” 42 U.S.C. § 1395y(a)(1)(A). Except for certain statutory exceptions, Medicare did not cover “[e]xaminations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint or injury.” 42 C.F.R. § 411.15(a)(1).

15. 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. Title 42, Code of Federal Regulations, Section 410.32(a) provided: “[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." *Id.* "Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary." *Id.*

16. Because neither CGx nor cardio testing diagnosed diseases or conditions (such as cancer or cardiovascular diseases), Medicare only covered such tests in limited circumstances. For CGx testing, such limited circumstances included when a beneficiary had cancer and the beneficiary's treating physician deemed such testing necessary for the beneficiary's treatment of that cancer. Medicare did not cover CGx testing for beneficiaries who did not have cancer or lacked symptoms of cancer.

17. For cardio testing, such limited circumstance included when a beneficiary experienced sudden cardiac death, was revived, and the sudden cardiac death resulted from a genetic anomaly. In this rare occurrence, Medicare may have covered cardio testing for immediate first-degree family members of the surviving patient to screen for genetic mutations. Medicare did not pay for cardio tests merely because a patient had hypertension or a history of cardiovascular conditions.

### 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. In or around March 2020, in response to the COVID-19 pandemic, some of these requirements were amended temporarily to, among other things, cover telehealth services for certain office and hospital visits, even if the beneficiary was not located in a rural area or a health professional shortage area and even if the telehealth services were furnished to beneficiaries in their home.

**The Defendants, Related Entities, and Relevant Persons**

21. Broad Street Lifestyles, LLC ("BROAD STREET") was a limited liability company formed under the laws of Florida, with a listed place of business in Palm Beach County, Florida. BROAD STREET held an account at Bank 1 ending in x1906 ("Broad Street Account").

22. Sunrise Consulting Group, LLC ("SUNRISE") was a limited liability company formed under the laws of Florida, with a listed place of business in Broward County, Florida. SUNRISE held an account at Bank 2 ending in x3693 ("Sunrise Account").

23. MDA Consumers, Inc. ("MDA CONSUMERS") was a corporation formed under the laws of Florida, with a listed place of business in Palm Beach County, Florida. MDA CONSUMERS held an account at Bank 3 ending in x8815 ("MDA Consumers Account").

24. MC Mission, Inc. ("MC MISSION") was a corporation formed under the laws of Florida, with a listed place of business in Palm Beach County, Florida. MC MISSION held an account at Bank 4 ending in x9746 ("MC Mission Account").

25. Metropolis Unlimited, LLC (“METROPOLIS”) was a limited liability company formed under the laws of Florida, with a listed place of business in Broward County, Florida. METROPOLIS held an account at Bank 4 ending in x2130 (“Metropolis Account 1”).

26. Company A was a limited liability company formed under the laws of Colorado, with a listed place of business in Colorado. Company A owned and controlled Laboratory 1—an independent clinical laboratory enrolled with Medicare—and held an account at Bank 5 ending in x6733 (“Company B Account”).

27. Defendant **TODD SHULL** was a resident of Broward County, Florida. **SHULL** was the owner of SUNRISE and a signatory on the Sunrise Account.

28. DANIEL M. CARVER was a resident of Palm Beach County, Florida. CARVER was a beneficial owner of BROAD STREET and MDA CONSUMERS, and he was a signatory on MDA Consumers Account.

29. THOMAS DOUGHERTY was a resident of Palm Beach County, Florida. DOUGHERTY was a beneficial owner of BROAD STREET and MC MISSION, and he was a signatory on Broad Street Account and MC Mission Account.

30. JOHN PAUL GOSNEY JR. was a resident of Palm Beach County, Florida. GOSNEY was a beneficial owner of METROPOLIS and he was a signatory on Metropolis Account.

**Conspiracy to Receive Health Care Kickbacks  
(18 U.S.C. § 371)**

From in or around March 2020, and continuing through in or around August 2021, in Palm Beach County, in the Southern District of Florida, and elsewhere, the defendant,

**TODD SHULL,**

did knowingly and willfully, that is, with the intent to further the object of the conspiracy, combine, conspire, confederate, and agree with others known and unknown to the United States Attorney, including with DANIEL M. CARVER, THOMAS DOUGHERTY, and JOHN PAUL GOSNEY JR., to violate Title 42, United States Code, Section 1320a-7b(b)(1)(A), by soliciting and receiving any remuneration, including kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind, including by wire transfer, 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, that is, Medicare.

#### **Purpose of the Conspiracy**

31. It was a purpose of the conspiracy for the defendant and his co-conspirators to unlawfully enrich themselves by, among other things: (a) soliciting and receiving kickbacks and bribes in exchange for the referral of Medicare beneficiaries and doctors' orders for genetic testing to Laboratory 1; (b) offering and paying kickbacks and bribes to telemedicine companies in exchange for ordering and arranging for the ordering of genetic tests for Medicare beneficiaries; (c) submitting and causing the submission of claims to Medicare through Laboratory 1 for genetic testing; (d) concealing and causing the concealment of the kickbacks and bribes; and (e) diverting kickback proceeds for their personal use and benefit, the use and benefit of others, and to further the conspiracy.

#### **Manner and Means**

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, the following:

32. **TODD SHULL** and others solicited and received kickbacks and bribes from Laboratory 1, in the approximate amount of \$1,391,500, in exchange for recruiting and referring



Medicare beneficiaries, and providing doctors' orders, for genetic testing, knowing that the laboratories would bill Medicare for genetic testing purportedly provided to the recruited beneficiaries.

33. **TODD SHULL** and others negotiated the kickback and bribe arrangements with laboratories, to include Laboratory 1, and disguised the nature and source of these kickbacks and bribes through sham contracts and otherwise concealed such kickbacks and bribes by describing them as payments for legitimate services, such as "handling customer service inquiries."

34. **TODD SHULL** and others offered and paid kickbacks and bribes to telemedicine companies in exchange for the ordering and arranging for the ordering of genetic testing for Medicare beneficiaries.

35. **TODD SHULL** and others caused Laboratory 1 to submit claims to Medicare for genetic testing, and Medicare made payments on those claims to Laboratory 1 in the approximate amount of at least \$3,440,000.

36. **TODD SHULL** and others used the kickback payments received from laboratories to benefit themselves and others, and to further the conspiracy.

#### **Overt Acts**

In furtherance of the conspiracy, and to accomplish its object and purpose, at least one co-conspirator committed and caused to be committed, in the Southern District of Florida, at least one of the following overt acts, among others:

1. On or about August 3, 2020, **TODD SHULL**, through **SUNRISE**, transferred approximately \$30,000, via wire transfer, from Sunrise Account to Broad Street Account, which constituted a kickback payment for Medicare beneficiary referrals.

2. On or about April 30, 2021, Company A transferred approximately \$75,000, via wire transfer, from Company A Account to Sunrise Account, which constituted a kickback payment for Medicare beneficiary referrals.

3. On or about May 4, 2021, **TODD SHULL** transferred approximately \$26,000 from the Sunrise Account to DOUGHERTY, through MC Mission Account, which constituted a kickback payment for Medicare beneficiary referrals.

4. On or about May 4, 2021, **TODD SHULL** transferred approximately \$16,600 from Sunrise Account to CARVER, through MDA Consumers Account, which constituted a kickback payment for Medicare beneficiary referrals.

5. On or about May 4, 2021, **TODD SHULL** transferred approximately \$16,600 from Sunrise Account to GOSNEY, through Metropolis Account, which constituted a kickback payment for Medicare beneficiary referrals.

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

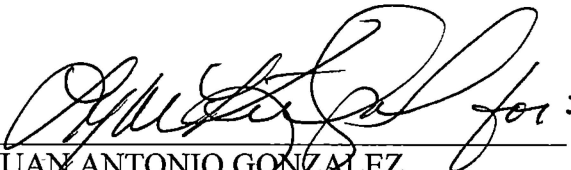
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**FORFEITURE ALLEGATIONS**

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

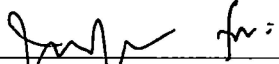
2. Upon conviction of a conspiracy to commit a violation of Title 42, United States Code, Section 1320a-7b, as alleged in this Information, the defendant shall forfeit to the United States any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense, pursuant to Title 18, United States Code, Section 982(a)(7).

All pursuant to Title 18, United States Code, Section 982(a)(7), and the procedures set forth in Title 21, United States Code, Section 853, as incorporated by Title 18, United States Code, Section 982(b)(1).

  
\_\_\_\_\_  
JUAN ANTONIO GONZALEZ  
UNITED STATES ATTORNEY

LORINDA I. LARYEA, ACTING CHIEF  
CRIMINAL DIVISION, FRAUD SECTION  
U.S. DEPARTMENT OF JUSTICE

DUSTIN DAVIS, ACTING CHIEF  
CRIMINAL DIVISION, FRAUD SECTION  
U.S. DEPARTMENT OF JUSTICE

  
\_\_\_\_\_  
PATRICK J. QUBENAN  
TRIAL ATTORNEY  
CRIMINAL DIVISION, FRAUD SECTION  
U.S. DEPARTMENT OF JUSTICE

UNITED STATES DISTRICT COURT  
SOUTHERN DISTRICT OF FLORIDA

UNITED STATES OF AMERICA

CASE NO.:

v.

**CERTIFICATE OF TRIAL ATTORNEY\***

TODD SHULL,

\_\_\_\_\_/

**Superseding Case Information:**

Defendant.

**Court Division (select one)**

- Miami       Key West       FTP
- FTL       WPB

New Defendant(s) (Yes or No)

Number of New Defendants

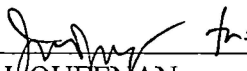
Total number of New Counts

**I do hereby certify that:**

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. §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 <input checked="" type="checkbox"/> 0 to 5 days	<input type="checkbox"/> Petty
II <input type="checkbox"/> 6 to 10 days	<input type="checkbox"/> Minor
III <input type="checkbox"/> 11 to 20 days	<input type="checkbox"/> Misdemeanor
IV <input type="checkbox"/> 21 to 60 days	<input checked="" type="checkbox"/> Felony
V <input type="checkbox"/> 61 days and over	
6. Has this case been previously filed in this District Court? (Yes or No) No  
If yes, Judge Case No.
7. Has a complaint been filed in this matter? (Yes or No) No  
If yes, Magistrate Case No.
8. Does this case relate to a previously filed matter in this District Court? (Yes or No) Yes  
If yes, Judge Cannon Case No. 22-CR-80022
9. Defendant(s) in federal custody as of
10. Defendant(s) in state custody as of
11. Rule 20 from the District of
12. Is this a potential death penalty case? (Yes or No) No
13. 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
14. 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

By:

  
\_\_\_\_\_

PATRICK J. QUEHENAN  
DOJ Trial Attorney

Court ID No. A5502715

UNITED STATES DISTRICT COURT  
SOUTHERN DISTRICT OF FLORIDA

PENALTY SHEET

Defendant's Name: TODD SHULL

Case No: \_\_\_\_\_

Count #: 1

Title 18, United States Code, Section 371

Conspiracy to Receive Health Care Kickbacks

\* **Max. Term of Imprisonment: 5 Years**

\* **Mandatory Min. Term of Imprisonment (if applicable): N/A**

\* **Max. Supervised Release: 3 Years**

\* **Max. Fine: \$250,000 or twice the gross gain or loss resulting from the offense**

**\*Refers only to possible term of incarceration, supervised release and fines. It does not include 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.

Todd Shull,

*Defendant*

)  
)  
)  
)  
)

Case No.

**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*

**BRUCE UDOLF, ESQ.**  
*Printed name of defendant's attorney*

\_\_\_\_\_  
*Judge's signature*

\_\_\_\_\_  
*Judge's printed name and title*