SMS/2021R00506

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA	:	Hon.
	:	
v.	:	Criminal No. 23-
	:	
ALEXANDER SCHLEIDER	:	18 U.S.C. § 1349
	:	18 U.S.C. § 1343

I N F O R M A T I O N

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

COUNT ONE
(Conspiracy to Commit Health Care Fraud)

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

Background on the Medicare Program

a. Medicare was a federally-funded program established to provide medical insurance benefits for individuals age 65 and older and certain disabled individuals who qualified under the Social Security Act. Individuals who receive benefits under Medicare were referred to as "Medicare beneficiaries."

b. 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.

c. 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).

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

e. 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.

f. 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.

g. 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 was 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 be presented a false or fraudulent claim for payment by

Medicare and submitting claims with deliberate ignorance or reckless disregard of their truth or falsity. The Medicare Form CMS-855S also requires that those with an ownership interest in the DMEPOS supplier disclose, among other things, any federal convictions within the preceding ten years.

h. Medicare-authorized suppliers of healthcare services and supplies, such as DME, can only submit claims to Medicare for reasonable and medically necessary services. Medicare will not reimburse claims for services that it knows are procured through kickbacks or bribes. Such claims are deemed false and fraudulent because they violate Medicare laws, regulations, and program instructions, as well as federal criminal law. For example, where a prescription for DME is procured through the payment of a kickback in violation of the AKS, a claim to Medicare for reimbursement for that DME is fraudulent. By implementing these restrictions, Medicare aims to preserve its resources, which are largely funded by United States taxpayers, for those elderly and other qualifying beneficiaries who have a genuine need for medical services.

Telemedicine

i. Telemedicine allows health care providers, such as physicians, to evaluate, diagnose, and treat patients remotely—without the need for an in-person visit—by using telecommunications technology, such as the internet or telephone to interact with a patient.

j. Medicare deemed telemedicine an appropriate means to provide certain health care related services ("telehealth services") to beneficiaries, including, among other services, consultations and office visits, only when

certain requirements were met. These requirements included, among others, that: (a) that the beneficiary was located in a rural area (outside a metropolitan area or in a rural health professional shortage area); (b) that the services were delivered via an interactive audio and video telecommunications system; and (c) that the beneficiary was at a licensed provider's office or a specified medical facility—not at a beneficiary's home—¬during the telehealth service furnished by a remote provider.

k. Telehealth services could be covered by and reimbursable under Medicare, but only if telemedicine was generally appropriate, as outlined above, and only if the services were both ordered by a licensed provider and were reasonable and medically necessary to diagnose and treat a covered illness or condition

Relevant Individuals and Entities

l. Defendant ALEXANDER SCHLEIDER ("defendant SCHLEIDER") was a resident of New Jersey. Defendant SCHLEIDER owned, operated, and had a financial or controlling interest in multiple DME supply companies, including DME Company-1 and DME Company-2 (collectively, the "Subject DME Companies"). The Subject DME Companies primarily supplied DME such as knee, ankle, back, wrist, and shoulder braces to Medicare beneficiaries. Defendant SCHLEIDER concealed his affiliation with the Subject DME Companies by failing to disclose himself as owner to Medicare.

The Conspiracy

2. From at least as early as April 2019 through in or around April 2021, in the District of New Jersey, and elsewhere, defendant

ALEXANDER SCHLEIDER

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 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, a 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 SCHLEIDER and others to profit by submitting or causing the submission of false and fraudulent claims for DME to federal and private health care benefit programs.

Manner and Means of the Conspiracy

4. The manner and means by which defendant SCHLEIDER and others sought to accomplish the goal of the conspiracy included, among other things, the following:

a. Defendant SCHLEIDER conspired with others in a scheme to defraud health care benefit programs by offering and paying kickbacks and bribes to individuals and entities (collectively, the "Suppliers") in exchange for

completed doctors' orders for DME ("DME Orders"), which were subsequently fraudulently billed to Medicare and other health care benefit programs. As the term was used during the course of the scheme, a DME Order was comprised of the name of a patient covered by one or more health care benefit or private insurance programs, as well as that patient's contact information, insurance details, and a doctor's order or prescription for DME for that particular patient. A DME Order amounted to a guarantee that the patient's prescription would be reimbursed by Medicare or other federal or private health care programs.

b. Generally, DME Order Suppliers generated DME Orders by identifying 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 Suppliers utilized the services of telemedicine companies to secure RX Orders, regardless of whether the prescriptions were medically justified for the beneficiaries.

c. After obtaining the DME Orders, the Suppliers transmitted and caused to be transmitted the DME Orders to the Subject DME Companies. After receiving the DME Orders from the Suppliers, defendant SCHLEIDER (through the Subject DME Companies) arranged for the prescribed DME, such as orthotic braces, to be shipped to the individual Medicare beneficiaries pursuant to the DME Orders. Finally, defendant SCHLEIDER (through the Subject DME Companies) electronically submitted or caused the electronic submission of claims to Medicare and other federal and private health care

benefit programs from New Jersey and elsewhere for payment for each of the DME Orders.

d. Defendant SCHLEIDER and his co-conspirators paid kickbacks to the DME Order Suppliers for each DME Order that resulted in reimbursement from a paying health care benefit program. Specifically, defendant SCHLEIDER entered into kickback agreements with Suppliers to pay the Suppliers kickbacks ranging from approximately $100 to $300 in exchange for each DME Order depending upon the type of brace prescribed.

e. Defendant SCHLEIDER and his co-conspirators knew that the claims to Medicare and other federal and private health care benefit programs for each of the DME Orders were fraudulent because they were (i) procured through the payment of kickbacks and bribes and therefore not eligible for federal reimbursement; (ii) medically unnecessary; and/or (ii) approved by providers who did not treat the beneficiary.

f. To conceal the nature of the kickback arrangement, defendant SCHLEIDER entered into sham contracts with Suppliers (collectively, the "Sham Agreements"). The Sham Agreements falsely stated that the Suppliers were engaged in marketing services for the Subject DME Companies and provided, among other things, that the Suppliers would provide the Subject DME Companies with raw leads, not DME Orders. With respect to compensation, the Sham Agreements provided that the Suppliers would be paid a "fixed annual fee" and also would be paid based on "Marketing hours." Nowhere did the Sham

Agreements indicate that, in reality, the Suppliers were being paid kickbacks per DME Order.

g. To further conceal the nature of the kickback payments, the Suppliers submitted sham invoices to the Subject DME Companies that intentionally mischaracterized the nature of the payments sought. Specifically, the invoices sent by the Suppliers billed the Subject DME Companies for "marketing" on an hourly basis, when, in reality, the payments were being made on a per-DME Order basis.

h. In or around May 2014, before the health care scheme began, defendant SCHLEIDER pleaded guilty in the District of New Jersey to committing wire fraud related to a fraudulent real estate scheme. In or around December 2014, he was sentenced to one year of imprisonment and three years of supervised release for his role in the scheme. Accordingly, as an individual with an ownership interest in the Subject DME Companies, defendant SCHLEIDER was required to disclose his prior fraud conviction on the Form CMS-855S.

i. To conceal his involvement in this healthcare fraud scheme and to conceal his recent prior conviction from Medicare, SCHLEIDER's spouse was listed as the nominee owner of DME Company-1 and DME Company-2 and her name was provided to Medicare on the Form CMS-855Ss in lieu of his own.

j. As a result of defendant SCHLEIDER's participation in the health care fraud scheme, from at least as early as in or around April 2019 through in or around April 2021, Medicare and other health care benefit

programs paid the Subject DME Companies at least approximately $21,721,676.31 for DME Orders that were the product of the illicit scheme.

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

COUNT TWO
(Wire Fraud)

5. The allegations in paragraphs 1, 3, and 4 of Count One of this Information are re-alleged here.

Background: The CARES Act Provider Relief Fund

6. In March 2020, Congress passed the Coronavirus Aid, Relief, and Economic Security ("CARES") Act, which was designed to provide emergency financial assistance to the millions of Americans suffering due to the COVID-19 pandemic.

7. The CARES Act appropriated money to help Medicare providers that were financially impacted by COVID-19, as well as to provide care to individuals who were suffering from COVID-19 and compensate Medicare providers for the cost of that care (the "Provider Relief Fund"). The Department of Health and Human Services ("HHS"), through its agency, the Health Resources and Services Administration ("HRSA"), oversaw and administered the Provider Relief Fund.

8. In order to rapidly provide funding to Medicare providers during the pandemic, HRSA distributed payments under the Provider Relief Fund ("Provider Relief Payment") to Medicare providers who (a) billed Medicare Part A or Part B in Calendar Year 2019; (b) provided after January 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19; (c) were not currently terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D; (d) were not currently excluded from participation in Medicare, Medicaid, and other Federal health care

programs; and (e) did not currently have Medicare billing privileges revoked. Medicare providers meeting these criteria automatically received the Provider Relief Payment and did not have to apply for the funding but were required to comply with the terms and conditions of the Provider Relief Fund if they retained such funding.

9. If a Medicare provider elected to retain the payment, it was required to abide by the terms and conditions of the program, including that (a) the payment shall reimburse the recipient only for health care related expenses or lost revenues that are attributable to COVID-19 and (b) that the payment would only be used for the diagnoses, testing, or care for individuals with possible or actual cases of COVID-19. Medicare providers would attest to the terms and conditions by logging into a portal on the HHS website or would be deemed to have agreed to the terms and conditions by keeping the funds for longer than 90 days. The requirement that the providers fully comply with the terms and conditions was material to HHS's decision to disburse Provider Relief Funds to the providers. Non-compliance with any term or condition could cause HHS to recoup some or all of the payment.

The Scheme

10. From in or around April 2020 through in or around April 2021, in the District of New Jersey, and elsewhere, defendant

ALEXANDER SCHLEIDER

did knowingly and intentionally devise and intend to devise a scheme and artifice to defraud and to obtain money and property by means of materially false and fraudulent pretenses, representations and promises.

Goal of the Scheme

11. The goal of the scheme was for defendant SCHLEIDER to unlawfully enrich himself by submitting or causing the submission of a false and fraudulent attestation to HRSA in order to unlawfully keep and divert Provider Relief Funds for his personal use and benefit.

Manner and Means of the Scheme

12. The manner and means by which defendant SCHLEIDER and others sought to accomplish the goal of the scheme included, among other things, the following:

a. On or about April 17, 2020, DME Company-1 received approximately $322,237 from the HRSA Provider Relief Fund.

b. On or about May 4, 2020, defendant SCHLEIDER submitted a fraudulent attestation electronically interstate to HRSA under the name of his

spouse (the nominal owner of DME Company-1) in relation to the Provider Relief Funds deposited with DME Company-1.

c. The attestation prepared by defendant SCHLEIDER falsely claimed that DME Company-1 provided diagnoses, testing, and care for individuals with possible or actual cases of COVID-19 after January 31, 2020. In reality, DME Company-1 had ceased billing for any services in or around April 2019.

d. The attestation prepared by defendant SCHLEIDER also falsely claimed that the payment would only be used to prevent, prepare for, and respond to coronavirus, and that the payment shall reimburse the recipient only for health care related expenses or lost revenues that are attributable to coronavirus. In reality, defendant SCHLEIDER did not use the funds for those purposes. Rather, after receiving those defendant SCHLEIDER transferred them into other accounts and subsequently used them to purchase real estate and vehicles, among other things.

13. On or about May 4, 2020, in furtherance of the scheme and artifice to defraud described above, and for the purpose of executing and attempting to execute the scheme and artifice to defraud, in the District of New Jersey, and elsewhere, defendant

ALEXANDER SCHLEIDER

knowingly and intentionally transmitted and caused to be transmitted by means of wire communication in interstate and foreign commerce certain writings, signs, signals, pictures, and sounds; namely, an electronic attestation to the

HRSA under the name of his spouse (the nominal owner of DME Company-1) in relation to the Provider Relief Funds deposited with DME Company-1.

In violation of Title 18, United States Code, Section 1343.

FORFEITURE ALLEGATIONS

1. Upon conviction of the Federal health care offense alleged in Count One of this Information, defendant SCHLEIDER shall forfeit to the United States, pursuant to 18 U.S.C. §982(a)(7), all property, real or personal, defendant SCHLEIDER obtained that constitutes or is derived, directly and indirectly, from gross proceeds traceable to the commission of such offense, which was at least approximately $21,721,676.31, and all property traceable to such property.

2. Upon conviction of the wire fraud offense alleged in Count Two of this Information, defendant SCHLEIDER shall forfeit to the United States, pursuant to 18 U.S.C. § 981(a)(1)(C) and 28 U.S.C. § 2461(c), all property, real and personal, defendant SCHLEIDER obtained that constitutes or is derived from proceeds traceable to the commission of such offense, which was at least approximately $322,237, and all property traceable to such property.

SUBSTITUTE ASSETS PROVISION
(Applicable to Both Forfeiture Allegations)

3. 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;

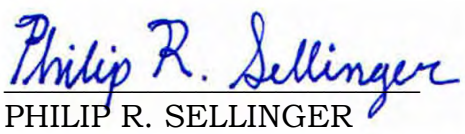
(b) has been transferred or sold to, or deposited with, a third person;

(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) and 28 U.S.C. § 2461(c).



PHILIP R. SELLINGER
United States Attorney

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UNITED STATES OF AMERICA

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INFORMATION FOR

18 U.S.C. § 1349
18 U.S.C. § 1343

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