DMT/2023R00472

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA	:	Hon.
	:	
v.	:	Crim. No. 24-
	:	
CHRISTOPHER VEHOVEC	:	18 U.S.C. § 1349

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:

(Conspiracy to Commit Health Care Fraud)

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

Relevant Individuals and Entities

a. Defendant CHRISTOPHER VEHOVEC ("VEHOVEC") was a resident of Florida.

b. ALEXANDER SCHLEIDER ("SCHLEIDER"), a co-conspirator not charged in this Information, was a resident of New Jersey. SCHLEIDER owned, operated, and had a financial or controlling interest in multiple durable medical equipment ("DME") supply companies, including DME Company-1 and DME Company-2 (collectively, the "DME Companies"). The DME Companies primarily supplied DME such as knee, ankle, back, wrist, and shoulder braces to Medicare beneficiaries and beneficiaries of commercial health care benefit programs.

c. Individual-1, a co-conspirator not charged in this Information,

was a resident of Canada and India. Individual-1 owned call centers in India that were used to target individuals who received benefits under Medicare in order to generate orders for DME.

Background on Medicare

d. 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."

e. 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.

f. 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).

g. 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.

h. 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.

i. 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.

j. 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 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 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 required that those with an ownership interest in the DMEPOS supplier disclose, among other things, any federal convictions within the preceding ten years.

k. Medicare-authorized suppliers of healthcare services and supplies, such as DME, could only submit claims to Medicare for reasonable and medically necessary services. Medicare did not reimburse claims for services that it knew were procured through kickbacks or bribes. Such claims were deemed false and fraudulent because they violated Medicare laws, regulations, and program instructions, as well as federal criminal law. For example, where a

prescription for DME was procured through the payment of a kickback in violation of the AKS, a claim to Medicare for reimbursement for that DME was fraudulent. 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.

Telemedicine

l. Telemedicine allowed 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.

m. 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.

n. 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 reasonable and medically necessary to diagnose and treat a covered illness or condition.

The Conspiracy

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

CHRISTOPHER VEHOVEC

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 Title 18, United States Code, Section 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 VEHOVEC and others to profit by submitting or causing the submission of false and fraudulent claims for DME to federal and commercial health care benefit programs.

Manner and Means of the Conspiracy

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

a. Defendant VEHOVEC and Individual-1 agreed with SCHLEIDER and others to defraud health care benefit programs by soliciting and receiving kickbacks and bribes from SCHLEIDER and others in exchange

for providing the DME Companies with completed doctors' orders for medically unnecessary DME (the "DME Orders"). The DME Orders were later fraudulently billed to Medicare and other commercial health care benefit programs.

b. Typically, a DME Order contained the patient's name, contact information, federal or commercial insurance details, and a doctor's order or prescription for DME for the patient.

c. Individual-1 generated the DME Orders by identifying qualified beneficiaries in New Jersey and elsewhere using marketing call centers that he controlled. Once Individual-1 had identified beneficiaries, Individual-1 and his co-conspirators used telemedicine companies to secure signed DME Orders from physicians, regardless of medical necessity.

d. After obtaining the DME Orders, Individual-1 steered the DME Orders to the DME Companies. After receiving the DME Orders from Individual-1, SCHLEIDER used the DME Companies to ship orthotic braces to individual beneficiaries. SCHLEIDER then submitted claims to Medicare and other federal and commercial health care benefit programs for payment for each of the DME Orders.

e. Defendant VEHOVEC received kickbacks for each of the DME Orders that resulted in reimbursement from a health care benefit program. Specifically, SCHLEIDER paid defendant VEHOVEC kickbacks ranging from approximately $175 to $325 in exchange for each DME Order depending upon the type of brace ordered.

f. VEHOVEC then used a portion of each kickback he received

from SCHLEIDER to pay Individual-1 for the completed DME Orders.

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

h. As a result of defendant VEHOVEC's participation in the health care fraud scheme, Medicare and other federal and commercial health care benefit programs paid the DME Companies at least approximately $4,217,332.27 for DME Orders that were the product of the illicit scheme.

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

FORFEITURE ALLEGATION

1. Upon conviction of the Federal health care offense alleged in this Information, defendant VEHOVEC 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 such offense.

SUBSTITUTE ASSETS PROVISION

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).

Philip R. Sellinger

PHILIP R. SELLINGER
United States Attorney

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INFORMATION FOR

18 U.S.C. § 1349

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