UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

v.

HUGH G. DEERY II, M.D.,

Defendant. **INDICTMENT**

_____/

The Grand Jury charges:

INTRODUCTION

At times material to this Indictment:

Dr. Hugh G. Deery II and Company 1

1. The defendant, HUGH G. DEERY II, M.D., resided in Emmet County, Michigan and was a licensed physician in the State of Michigan.

2. Company 1 was a "marketing" company targeting the Medicare-aged population to promote durable medical equipment ("DME") including knee braces, wrist braces, and back braces.

3. Company 1 purchased "leads" generated by "marketers" and call centers, including many located overseas. "Leads" consisted of patient data and recordings of calls with consumers, who were mainly Medicare beneficiaries. During the calls, representatives typically inquired about the beneficiaries' Medicare eligibility and interest in receiving braces. The representatives harvested this information along with the beneficiaries' personally identifying

information to build the "leads," which Company 1 then converted into "detailed written orders" for braces and corresponding "exam notes" and "letters of medical necessity."

4. Company 1 paid medical practitioners, including HUGH G. DEERY II, M.D., sometimes through contracts with *locum tenens* companies, to review and sign the detailed written orders, exam notes, and letters of medical necessity. Company 1 also provided the medical practitioners access to the recorded phone calls between the beneficiaries and the call centers but did not require that the medical practitioners listen to the calls or contact the beneficiaries. Once the medical practitioners signed the detailed written orders, exam notes, and letters of medical necessity, Company 1 sold the brace orders to companies or persons who owned, managed, and/or controlled Medicare-enrolled DME supply companies. These DME supply companies submitted claims to Medicare for the braces, listing HUGH G. DEERY II, M.D, as the referring provider for the detailed written orders that he signed.

The Medicare Program

5. The Medicare Program ("Medicare") was a federal health care benefit program that provided items and services to individuals who were (a) age 65 or older, (b) had certain disabilities, or (c) had end-stage renal disease. Individuals who received Medicare benefits were called "beneficiaries."

6. Medicare was a "health care benefit program," as defined by Title 18, United States Code, Section 24(b), in that it was a public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service, for which payment may be made under the plan or contract.

7. The Centers for Medicare and Medicaid Services ("CMS"), which was an agency of the United States Department of Health and Human Services ("HHS"), administered Medicare.

8. To receive Medicare reimbursement, medical practitioners had to apply and execute a written provider agreement, known as a CMS Form 855.

9. HUGH G. DEERY II, M.D, was enrolled as a physician with Medicare. As part of his enrollment, HUGH G. DEERY II, M.D, certified that he agreed "to abide by the Medicare laws, regulations and program instructions" and acknowledged that "the Medicare laws, regulations, and program instructions are available through" the assigned Medicare contractor. Practitioners enrolled with Medicare had access to Medicare manuals, service bulletins, and local coverage determinations and policies describing Medicare coverage requirements for various services and items, including DME.

10. HUGH G. DEERY II, M.D, also certified as part of his enrollment that he "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." The Medicare enrollment application, signed by HUGH G. DEERY II, M.D, set forth various criminal offenses related to participation in Medicare and the delivery of and payment for health care benefits, items, or services. Specifically, the Enrollment Application addressed Title 18, United States Code, Section 1035, which authorized criminal penalties against an individual:

> in any matter involving a health care benefit program who knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact; or makes any materially false, fictitious, or fraudulent statements or misrepresentations, or makes or uses any materially false[,] fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items or services.

Medicare Part B and General Requirements for Durable Medical Equipment

11. Medicare was made up of several component "parts" that covered different items and services. Medicare Part B covered, among other items and services, outpatient care and supplies, including orthotic devices, referred to as DME. Medicare Part B covered claims submitted for DME, such as off-the-shelf knee braces, if the DME was medically reasonable and necessary for the treatment of the beneficiary's illness or injury and prescribed by a licensed medical practitioner.

12. To help administer Medicare, CMS contracted with private insurance companies called "Medicare Administrative Contractors" or "MACs." MACs performed many functions, such as enrolling DME suppliers into the Medicare program and processing Medicare claims.

13. Medicare claims for DME claims involving beneficiaries residing in Michigan were processed by CGS Administrators, LLC ("CGS"), the MAC for the jurisdiction including Michigan.

14. Under Medicare Part B, beneficiaries could only receive Medicare-covered DME from "suppliers" that were enrolled in Medicare.

15. DME supply companies submitted claims for payment of DME to CGS for beneficiaries in Michigan. Pursuant to Medicare requirements, DME supply companies had to submit certain information relating to the beneficiary receiving the DME supplies, including the following:

a. the type of service provided, identified by an "HCPCS" code (meaning "Healthcare Common Procedure Coding System");

b. the date of service or supply;

c. the referring physician's National Provider Identifier ("NPI");

d. the charge for such services;

e. the beneficiary's diagnosis;

f. the NPI for the DME entity seeking reimbursement; and

g. certification by the DME provider that the supplies are medically necessary.

16. Further, before submitting a claim for an orthotic brace to CGS, a DME supply company was required to have on file the following:

a. written documentation of a verbal order or a preliminary written order from a treating physician;

b. a detailed written order from the treating physician;

c. information from the treating physician concerning the beneficiary's diagnosis;

d. any information required for the use of specific modifiers;

e. a beneficiary's written assignment of benefits; and

f. proof of delivery of the orthotic brace to the beneficiary.

Medicare and CGS Requirements For Knee Braces

17. CGS issued a Local Coverage Determination ("LCD") for Knee Orthoses (L33318) effective October 1, 2015, and adopted nationally, which contains coverage requirements for various prefabricated and custom fabricated knee braces. One of the prefabricated knee braces addressed in this LCD is identified by HCPCS Code L1851. This LCD directs that L1851 is a covered item "for a beneficiary who is ambulatory and has knee instability" due to certain designated medical diagnoses. The list of designated diagnosis codes supporting coverage of L1851 includes diagnosis codes for osteoarthritis and chronic instability.

18. L33318 further directs that, for Medicare to cover the prefabricated knee brace identified by HCPCS Code L1851, "knee instability must be documented by examination of the beneficiary and objective description of joint laxity [looseness] (e.g. varus/valgus instability, anterior/posterior Drawer test)."

19. L33318 further directs that claims for L1851 "will be denied as not reasonable and necessary when the beneficiary does not meet the above criteria for coverage. For example, they will be denied if only pain or a subjective description of joint instability is documented."

COUNTS 1-17
(False Statements Relating to Health Care Matters)

20. Paragraphs One through Nineteen are incorporated by reference.

21. On or about the dates set forth below, in the Western District of Michigan, Southern Division, the defendant,

HUGH G. DEERY II, M.D.,

in matters involving a health care benefit program, specifically Medicare, knowingly and willfully made materially false, fictitious, and fraudulent statements and representations and used materially false writings and documents knowing the same to contain materially false, fictitious, and fraudulent statements and entries, in connection with the delivery of and payment for health care benefits, items, and services.

Count	Beneficiary	Date	False, Fictitious, and Fraudulent Statement/Entry
1	V.S.	12/21/18	Exam Notes and Letter of Medical Necessity state that, "Patient states the pain is due to Arthritis."
2	V.S.	12/21/18	Exam Notes and Letter of Medical Necessity state that, "Patient indicates noises in the knee joint, including: clicking, grinding and popping."
3	V.S.	12/21/18	Exam Notes and Letter of Medical Necessity state that, "Patient . . . has weakness of the knee."
4	V.S.	12/21/18	Exam Notes and Letter of Medical necessity state that, "No deformity of the knee noted."
5	V.S.	12/21/18	Exam Notes and Letter of Medical Necessity contain objective descriptions of physical tests performed on the knees including positive results for the "Pivot Shift test," the Cabot Maneuver test," and the "One-legged Stand test" and a negative result for the "Varus/Valus [sic] Genu Valgum test."
6	V.S.	12/21/18	Exam Notes and Letter of Medical Necessity state that Dr. Deery had a "conversation" with V.S. that he considered in ordering knee braces for V.S.
7	E.H.	3/9/19	Exam Notes and Letter of Medical Necessity state that, "Patient states they do not know the cause of the pain."
8	E.H.	3/9/19	Letter of Medical Necessity states that, "Knee pain has been intermittent persistent for 1 year."

9	E.H.	3/9/19	Exam Notes and Letter of Medical Necessity state that, "Patient indicates noises in the knee joint, including: clicking, grinding and popping."
10	E.H.	3/9/19	Exam Notes and Letter of Medical Necessity state that, "Patient . . . has weakness of the knee."
11	E.H.	3/9/19	Exam Notes and Letter of Medical Necessity state that, "No deformity of the knee noted."
12	E.H.	3/9/19	Exam Notes and Letter of Medical Necessity contain objective descriptions of physical tests performed on the knees including positive results for the "Pivot Shift test," the Cabot Maneuver test," and the "One-legged Stand test" and a negative result for the "Varus/Valus [sic] Genu Valgum test."
13	E.H.	3/9/19	Exam Notes and Letter of Medical Necessity state that Dr. Deery had a "conversation" with E.H. that he considered in ordering knee braces for E.H.
14	G.D.	1/31/19	Exam Notes and Letter of Medical Necessity state that, "Patient indicates noises in the knee joint, including: clicking, grinding and popping."
15	G.D.	1/31/19	Exam Notes and Letter of Medical Necessity state that, "Patient . . . has weakness of the knee."
16	G.D.	1/31/19	Exam Notes and Letter of Medical Necessity contain objective descriptions of physical tests performed on the knees including positive results for the "Pivot Shift test," the Cabot Maneuver test," and the "One-legged Stand test" and a negative result for the "Varus/Valus [sic] Genu Valgum test."
17	G.D.	1/31/19	Exam Notes and Letter of Medical Necessity state that Dr. Deery had a "conversation" with G.D. that he considered in ordering knee braces for G.D.

18 U.S.C. § 1035(a)(2)

A TRUE BILL

GRAND JURY FOREPERSON

ANDREW BYERLY BIRGE
United States Attorney

RAYMOND E. BECKERING III
Assistant United States Attorney