2022R00546/KML

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA	:	Hon. (EP)
	:	
	:	Crim. No. 22- 482
v.	:	
	:	18 U.S.C. § 1347
	:	18 U.S.C. § 1035
	:	18 U.S.C. § 2
INGRID ESTEPHAN	:	

INDICTMENT

The Grand Jury in and for the District of New Jersey, sitting at Newark, charges:

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

The Defendant

a. Defendant INGRID ESTEPHAN resided in Wood Dale, Illinois, and was a nurse practitioner licensed to practice in Minnesota, Illinois, Florida, Oregon, Louisiana, Oklahoma, and Connecticut. Defendant INGRID ESTEPHAN worked as an independent contractor for purported telemedicine companies, as described below.

Relevant Entities

b. Integrated Support Plus, Inc., f/k/a WebDoctors Plus, Inc. ("Integrated"), was a purported telemedicine company with its principal office in Hernando County, Florida, that did business throughout the United States.

c. Royal Physicians Network, LLC and Envision it Perfect, LLC (together, "Royal Physicians Network"), were purported telemedicine companies

with their principal offices in Georgia, that did business throughout the United States.

d. DME Supplier 1 was a purported supplier of orthotic braces located in Fair Lawn, New Jersey.

The Medicare Program

e. The Medicare Program ("Medicare") was a federal health care program providing benefits to persons who were 65 years of age or older, or disabled. Medicare was administered by the Centers for Medicare and Medicaid Services ("CMS"), a federal agency under the United States Department of Health and Human Services. The benefits available under Medicare were governed by federal statutes and regulations. Individuals who received Medicare benefits were referred to as Medicare "beneficiaries."

f. Medicare was a "Federal health care program," as defined in Title 42, United States Code, Section 1320a-7b(f), and a "health care benefit program," as defined in Title 18, United States Code, Section 24(b).

g. Medicare was divided into four parts which helped cover specific services: hospital insurance (Part A), medical insurance (Part B), Medicare Advantage (Part C), and prescription drug benefits (Part D).

h. Specifically, Medicare Part B covered medically necessary physician office services and outpatient care, including the ordering of durable medical equipment ("DME"), prosthetics, orthotics, and supplies that were ordered by licensed medical doctors or other qualified health care providers.

i. CMS contracted with various companies to receive, adjudicate, process, and pay Part B claims, including claims for braces. CMS also contracted with Program Safeguard Contractors, and later with Zone Program Integrity Contractors ("ZPIC"), which were contractors that investigated fraud, waste, and abuse. As part of an investigation, the Program Safeguard Contractor or ZPIC could conduct a clinical review of medical records to ensure that payment was made only for services that met all Medicare coverage and medical necessity requirements.

j. Brace companies, physicians, and other health care providers that provided services to Medicare beneficiaries were referred to as Medicare "providers." To participate in Medicare, providers were required to submit an application and execute a written provider agreement, known as CMS Form 855, in which the providers agreed to abide by the policies and procedures, rules, and regulations governing reimbursement. To receive Medicare funds, enrolled providers, together with their authorized agents, employees, and contractors, were required to abide by all provisions of the Social Security Act, the regulations promulgated under the Act, and applicable policies, procedures, rules, and regulations issued by CMS and its authorized agents and contractors. Health care providers were given and provided with online access to Medicare manuals and services bulletins describing proper billing procedures and billing rules and regulations.

Durable Medical Equipment

k. Medicare covered Medicare beneficiaries' access to DME, such as off-the-shelf ("OTS") ankle braces, knee braces, back braces, elbow braces, wrist braces, and hand braces (collectively, "braces"). Braces required minimal self-adjustment for appropriate use and did not require expertise in training, bending, molding, assembling, or customizing to fit the individual.

l. Under Medicare Part B, claims for braces were required to be reasonable and medically necessary for the treatment or diagnosis of the patient's illness or injury. Medicare used the term "ordering/referring provider" to identify the physician or nurse practitioner who ordered, referred, or certified an item or service reported in a claim. Providers ordering or referring these items were required to have the appropriate training, qualifications, and licenses to provide such services and order and refer such items. A Medicare claim was required to set forth, among other things, the beneficiary's name, the date the items and services were provided, the cost of the items and services, the name and identification number of the physician or other health care provider who ordered or referred the items, and the name and identification number of the brace provider that provided the items.

m. To be reimbursed from Medicare for braces, the items or services had to be reasonable, medically necessary, documented, and actually provided as represented to Medicare. Medicare would not pay claims procured through kickbacks and bribes.

n. Medicare regulations required health care providers enrolled with Medicare to maintain complete and accurate patient medical records reflecting the medical assessment and diagnoses of their patients, as well as records documenting actual treatment of the patients to whom items and services were provided and for whom claims for payment were submitted by the physician. Medicare required complete and accurate patient medical records so that Medicare could verify that the items and services were provided as described on the claim form. These records were required to be sufficient to permit Medicare, through its contractors, to review the appropriateness of Medicare payments made to the health care provider.

o. Medicare claims were required to be properly documented in accordance with Medicare rules and regulations. For certain DME products, Medicare promulgated additional requirements that a DME order was required to meet for an order to be considered "reasonable and necessary." For example, for OTS knee braces billed to Medicare under the Healthcare Common Procedures Coding System ("HCPCS") Code L1851, an order would be deemed "not reasonable and necessary" and reimbursement would be denied unless the ordering physician documented the beneficiary's knee instability using an objective description of joint laxity determined through a physical examination of the beneficiary.

Telemedicine

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

q. Telemedicine companies provided telemedicine 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 billed insurance or offered a membership program to customers.

r. Medicare Part B covered expenses for specified telehealth services if certain requirements were met. These requirements included that (i) the beneficiary was located in a rural or health professional shortage area; (ii) services were delivered via an interactive audio and video telecommunications system; and (iii) the beneficiary was at a practitioner's office or a specified medical facility – not at a beneficiary's home – during the telehealth consultation with a remote practitioner.

s. Medicare regulations regarding telehealth concerned payment for telehealth consultation services only and did not prohibit ordering DME where the consultation itself was not billed to Medicare. However, some Medicare contractors took the position that the failure to comply with these requirements could inform their determination of medical necessity for DME ordered.

t. Telemedicine membership programs generated revenue for telemedicine companies from customers who: (i) signed a contract with the telemedicine company; (ii) paid a set dollar amount per month; and (iii) paid a set dollar amount each time the customer had an encounter with a physician.

COUNTS 1 – 2
Health Care Fraud

2. Paragraph 1 of this Indictment is realleged here.

3. From in or around October 2018, and continuing through in or around May 2019, in the District of New Jersey and elsewhere, the defendant,

INGRID ESTEPHAN,

did knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud a health care benefit program, as that term is defined under Title 18, United States Code, Section 24(b), that is, Medicare, and to obtain, by means of false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of, Medicare, in connection with the delivery of and payment for health care benefits, items, and services.

Goal of the Scheme

4. It was the goal of the scheme and artifice for defendant INGRID ESTEPHAN and others to unlawfully enrich themselves by, among other things: (a) submitting and causing the submission of false and fraudulent claims to Medicare for DME products that were (i) procured through the payment of kickbacks and bribes, (ii) medically unnecessary, (iii) not eligible for Medicare reimbursement, and (iv) not provided as represented; (b) concealing the

submission of false and fraudulent claims and the receipt and transfer of the proceeds from the fraud; and (c) diverting proceeds of the fraud for their personal use and benefit.

The Scheme

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

a. Defendant INGRID ESTEPHAN certified to Medicare that she would comply with all Medicare rules and regulations, and federal laws, including that she would not knowingly present or cause to be presented a false and fraudulent claim for payment by Medicare. Despite this certification, defendant INGRID ESTEPHAN presented and caused to be presented false and fraudulent claims for payment by Medicare as described below.

b. Defendant INGRID ESTEPHAN agreed with others at Integrated and Royal Physicians Network to write brace orders for Medicare beneficiaries in exchange for approximately $15–30 per patient consultation and to provide few, if any, medical treatment options for patients besides braces during the purported telemedicine consultations.

c. Defendant INGRID ESTEPHAN gained access to Medicare beneficiary information for thousands of Medicare beneficiaries from Integrated, Royal Physicians Network, and other purported telemedicine companies, in order for defendant INGRID ESTEPHAN to sign brace orders for those beneficiaries.

d. Neither defendant INGRID ESTEPHAN, Integrated, nor Royal Physicians Network billed Medicare for telemedicine consultations with beneficiaries. Instead, Integrated, Royal Physicians Network, and others solicited illegal kickbacks and bribes from brace suppliers, including DME Supplier 1 and other brace suppliers located in the District of New Jersey, for brace orders that were signed by defendant INGRID ESTEPHAN and others.

e. Owners and operators of Integrated and Royal Physicians Network paid and caused payments to be made to defendant INGRID ESTEPHAN and others to sign brace orders and cause the submission of brace orders that were medically unnecessary and not eligible for reimbursement from Medicare, in order to increase revenue for themselves and their accomplices.

f. Defendant INGRID ESTEPHAN ordered braces that were medically unnecessary, for beneficiaries with whom she lacked a pre-existing doctor-patient relationship, without a physical examination, and frequently based solely on a short telephonic conversation with the beneficiary or without any conversation with the beneficiary at all.

g. Brace orders issued by defendant INGRID ESTEPHAN at the direction of Integrated and Royal Physicians Network were forwarded to brace suppliers for fulfillment. The brace suppliers, including DME Supplier 1 and other brace suppliers in the District of New Jersey, submitted and caused the submission of claims to Medicare based on the orders signed by defendant INGRID ESTEPHAN.

h. Defendant INGRID ESTEPHAN and others falsified, fabricated, altered, and caused the falsification, fabrication, and alteration of patient files, brace orders, and other records, all to support claims to Medicare for braces that were obtained through illegal kickbacks and bribes, medically unnecessary, ineligible for Medicare reimbursement, and not provided as represented.

i. Defendant INGRID ESTEPHAN and others concealed and disguised the scheme by preparing and causing to be prepared false and fraudulent documentation that supported false and fraudulent claims to Medicare, including signed medical records and brace orders in which: (a) defendant INGRID ESTEPHAN falsely stated that she determined through her interaction with Medicare beneficiaries that a particular course of treatment, including the prescription of braces, was medically necessary; (b) defendant INGRID ESTEPHAN falsely stated that she had discussions with Medicare beneficiaries; (c) defendant INGRID ESTEPHAN falsely attested that the information in the medical records were true, accurate, and complete; (e) defendant INGRID ESTEPHAN falsely diagnosed Medicare beneficiaries with certain conditions to support the prescription of certain braces; (f) defendant INGRID ESTEPHAN falsely stated that she examined Medicare beneficiaries; and (g) defendant INGRID ESTEPHAN falsely represented that she had performed certain diagnostic tests on Medicare beneficiaries prior to ordering braces.

j. Defendant INGRID ESTEPHAN and others submitted and caused the submission of false and fraudulent claims to Medicare in excess of

approximately $4.6 million for braces that were procured through the payment of kickbacks and bribes, medically unnecessary, ineligible for Medicare reimbursement, and not provided as represented, for which Medicare paid approximately $2.5 million.

Executions of the Scheme

6. On or about the dates specified below, in the District of New Jersey and elsewhere, defendant INGRID ESTEPHAN, aided and abetted by, and aiding and abetting, others known and unknown to the Grand Jury, submitted and caused to be submitted through DME Supplier 1 the following false and fraudulent claims to Medicare for braces that were medically unnecessary, not provided as represented, and ineligible for reimbursement, in an attempt to execute, and in execution of, the scheme described in Paragraphs 3 through 5, with each execution set forth below forming a separate count:

Count	Medicare Beneficiary	Approximate Date of Claim	Procedure Codes	Approximate Amount Billed
1	L.P., an individual whose identity is known to the Grand Jury	3/25/2019	L1833, L2397	$1,857
2	L.P., an individual whose identity is known to the Grand Jury	3/25/2019	L3960	$1,066

Each in violation of Title 18, United States Code, Section 1347 and Section 2.

COUNTS 3 – 4
False Statements Relating to Health Care Matters

7. Paragraphs 1, 4, and 5 of this Indictment are realleged here.

8. On or about the dates specified below, in the District of New Jersey and elsewhere, the defendant,

INGRID ESTEPHAN,

in a matter involving a health care benefit program, did knowingly and willfully (a) falsify, conceal, and cover up by trick, scheme, and device material facts, and (b) make materially false, fictitious, and fraudulent statements and representations, and make and use 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, in that defendant INGRID ESTEPHAN prepared and signed medical records and brace orders in which (a) defendant INGRID ESTEPHAN falsely stated that she determined through her interaction with the Medicare beneficiary that a particular course of treatment, including the prescription of braces, was medically necessary; (b) defendant INGRID ESTEPHAN falsely stated that she had a discussion with the Medicare beneficiary; (c) defendant INGRID ESTEPHAN falsely attested that the information in the medical record was true, accurate, and complete; (e) defendant INGRID ESTEPHAN falsely diagnosed the Medicare beneficiary with certain conditions to support the prescription of certain braces; (f) defendant INGRID ESTEPHAN falsely stated that she examined the Medicare beneficiary;

and (g) defendant INGRID ESTEPHAN falsely represented that she had performed certain diagnostic tests on the Medicare beneficiary prior to ordering braces.

Count	Date	Medicare Beneficiary	Description of False Medical Record
3	3/22/2019	L.P., an individual whose identity is known to the Grand Jury	Medical records and detailed written order for knee brace
4	3/22/2019	L.P., an individual whose identity is known to the Grand Jury	Medical records and detailed written order for shoulder brace

Each in violation of Title 18, United States Code, Section 1035(a) and Section 2.

FORFEITURE ALLEGATIONS

1. The allegations contained in Counts 1 through 4 of this Indictment are realleged here for the purpose of alleging forfeiture against defendant INGRID ESTEPHAN.

2. Pursuant to Title 18, United States Code, Section 982(a)(7), upon being convicted of one or more of the offenses charged in Counts 1 through 4 of this Indictment, defendant INGRID ESTEPHAN 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.

Substitute Assets Provision

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;

it is the intent of the United States, pursuant to Title 21, United States Code, Section 853(p), as incorporated by Title 18 United States Code, Section 982(b), to seek forfeiture of any other property of the defendant up to the value of the forfeitable property described above.

A True Bill,

[redacted]

Foreperson

PHILIP R. SELLINGER
United States Attorney

LORINDA I. LARYEA
Acting Chief
Criminal Division, Fraud Section
United States Department of Justice

KELLY M. LYONS
Trial Attorney
Criminal Division, Fraud Section
United States Department of Justice

CASE NUMBER: _____

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA

v.

INGRID ESTEPHAN

INDICTMENT FOR

18 U.S.C. §§ 1347; 1035

A true bill,

[redacted]

Foreperson

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UNITED STATES ATTORNEY
FOR THE DISTRICT OF NEW JERSEY

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