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Owner of Health Care Software Company Sentenced to 19 Years in Prison for $1B Medicare Fraud

A Kansas CEO and owner of an internet platform was sentenced yesterday to 19 years in prison for his role in operating a platform that generated false doctors' orders and prescriptions to defraud Medicare and other federal health care benefit programs out of more than $1 billion.

"The Department of Justice and our agency partners dismantled one of the largest telemedicine fraud schemes ever, and yesterday's lengthy prison sentence holds the orchestrator of that scheme accountable," said Assistant Attorney General Colin M. McDonald of the Justice Department's National Fraud Enforcement Division. "The defendant's fraud scheme lured hundreds of thousands of elderly and disabled Americans into a sophisticated international telemarketing system with one goal: stealing as much as possible from the Medicare trust fund. The Fraud Division will continue to leverage its resources to take down complex fraud operations like Blackman's DMERx."

"This sentence delivers a decisive warning: anyone who exploits VA programs and services for personal profit will be found and held fully accountable," said Inspector General Cheryl L. Mason of the Department of Veterans Affairs. "The VA OIG remains committed to working alongside our law enforcement partners to uncover complex fraud schemes and protect our nation's veterans."

"This 19-year sentence sends an unmistakable message: those who exploit federal health care programs for personal enrichment will face serious consequences," said Acting Deputy Inspector General for Investigations Miranda L. Bennett of the U.S. Department of Health and Human Services, Office of Inspector General (HH-OIG). "Schemes that corrupt medical decision-making and siphon taxpayer dollars from programs serving vulnerable Americans undermine trust in our health care system. HHS-OIG and its law enforcement partners will continue to pursue those responsible and hold them accountable."

"This sentencing sends a clear message that those who exploit federal health care programs for personal gain will be held accountable," said Special Agent in Charge

Brett D. Skiles of the FBI Miami Field Office. “This scheme undermined the integrity of our health care system and defrauded taxpayer-funded programs designed to serve those in need. The FBI remains committed to working alongside our law enforcement partners to investigate complex health care fraud schemes, protect taxpayer dollars, and hold those responsible accountable. Through these efforts, we remain focused on defending the homeland and protecting the American people from those who seek to exploit our nation’s systems for personal gain.”

“This investigation reinforces DCIS’s steadfast commitment to protecting the integrity of the TRICARE program and ensuring that taxpayer-funded military health benefits are used appropriately,” said Acting Special Agent in Charge Nakia Martin Alexander of the DCIS Southeast Field Office. “Fraud schemes that divert TRICARE resources erode the support promised to our service members and their families. As the criminal investigative arm of the DoD Office of Inspector General, DCIS remains focused on identifying these schemes and holding those responsible fully accountable.”

According to court documents and evidence presented at trial, Brett Blackman, 43, of Johnson County, Kansas, and his co-conspirators aggressively targeted hundreds of thousands of Medicare beneficiaries across the United States to get them to accept medically unnecessary orthotic braces and other items. They then arranged for purported telemedicine doctors to sign bogus prescription orders for these items so that their co-conspirators could bill Medicare for them. All told, Blackman and his co-conspirators billed Medicare and other federal health care benefit programs over $1 billion for this unnecessary equipment.

Blackman owned, controlled, and was the CEO of HealthSplash, which acquired Power Mobility Doctor Rx, LLC (DMERx) in Sept. 2017. DMERx was an internet-based platform that generated false and fraudulent doctors’ orders for durable medical equipment (DME) and prescriptions for other items. As part of the scheme, Blackman and his co-conspirators connected pharmacies, DME suppliers, and marketers with telemedicine companies that would accept illegal kickbacks and bribes in exchange for signed doctors’ orders created using the DMERx platform. Blackman and his co-conspirators took a cut for themselves in exchange for the referrals.

The fraudulent doctors’ orders and prescriptions generated by DMERx falsely represented that a doctor had actually examined and treated the Medicare beneficiaries when, in fact, the doctors were simply paid to sign orders and prescriptions without any meaningful interaction with the beneficiary, and in some cases, no interaction at all. Testimony and evidence presented at trial from an undercover agent who posed as a Medicare beneficiary showed the scheme in action — starting with a foreign call center that pushed the undercover agent to agree to multiple braces to a doctor signing bogus orders for the braces using Blackman’s DMERx platform. The doctor’s order for one of these undercover agent beneficiaries

claimed that the doctor conducted various tests that can only be performed in person even though the doctor never even spoke with the undercover agent "patient."

The DME suppliers and pharmacies that were paying illegal kickbacks for these orders billed Medicare and other insurers more than $1 billion. Medicare and the other insurers paid more than $450 million based on these claims. According to evidence presented at trial, Blackman and his co-conspirators concealed the scheme through sham contracts and by manipulating the doctors' orders to avoid Medicare audits, including by removing references to telemedicine in the doctors' orders.

As a result of Blackman's scheme, Medicare was fraudulently billed for orthotic braces for more than 346,000 Medicare beneficiaries. On average, Medicare was billed for four braces per beneficiary, with Medicare being billed for at least 21 orthotics prescribed through Blackman's DMERx platform to over 1,200 beneficiaries.

Exhibit from Trial Summarizing the Number of Orthotics Billed per Medicare Beneficiary as a Result of Blackman's Fraud Scheme

After a 23-day jury trial ending in Apr. 2026, Blackman was convicted of conspiracy to commit health care fraud and wire fraud, conspiracy to pay and receive kickbacks, and conspiracy to defraud the United States and to make false statements in connection with health care matters. Blackman's restitution and forfeiture obligations will be determined by the Court at a later date.

In Dec. 2025, Blackman's co-defendant, Gary Cox, was sentenced to 15 years in prison .

HHS-OIG, FBI, VA-OIG, and DCIS investigated the case.

Assistant Deputy Chief Darren C. Halverson and Trial Attorney Reginald Cuyler Jr. of the Fraud Division's Health Care Fraud Section prosecuted the case.

On April 7, the Department of Justice announced the creation of the Fraud Division. The Fraud Division is laser-focused on investigating and prosecuting those who commit fraud against the American people. The Department's work to combat fraud supports President Trump's Task Force to Eliminate Fraud, a whole-of-government effort chaired by Vice President J.D. Vance to eliminate fraud, waste, and abuse within Federal benefit programs.

The Department of Justice's Health Care Fraud Strike Force Program, currently comprised of nine strike forces operating in federal districts across the country, has charged more than 6,200 defendants who collectively billed federal health care programs and private insurers more than $45 billion since 2007. In addition, the Centers for Medicare & Medicaid Services, working in conjunction with the Office of

the Inspector General for the Department of Health and Human Services, are taking steps to hold providers accountable for their involvement in health care fraud schemes. More information can be found at www.justice.gov/criminal-fraud/health-care-fraud-unit .