FILED
At Albuquerque NM
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MATTHEW J. DYKMAN
CLERK

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF NEW MEXICO

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	CRIMINAL NO. 15-2030 WJ
	)	
vs.	)	Counts 1-21: 18 U.S.C. § 1347(a)(2):
	)	Health Care Fraud;
ROY G. HEILBRON,	)	
	)	Counts 22-24: 18 U.S.C. § 1343:
Defendant.	)	Wire Fraud.

INDICTMENT

The Grand Jury charges:

General Allegations

At all times material to this indictment:

1. Defendant **ROY G. HEILBRON** was a physician licensed to practice medicine in New Mexico. Defendant **HEILBRON** specialized in cardiology. He described his approach as "holistic." Defendant **HEILBRON** and another physician operated a medical clinic together in Santa Fe, New Mexico.

2. Defendant **HEILBRON** was a participating physician for Medicare and for a number of private health insurance plans, which for various lengths of time included Blue Cross and Blue Shield of New Mexico ("Blue Cross"), Lovelace Health Plan ("Lovelace"), and Presbyterian Health Plan ("Presbyterian"). Medicare and each of these private insurers were health care benefit programs as defined in 18 U.S.C. § 24(b).

3. The Medicare program was a federal health care program providing benefits to persons who were over the age of 65 or disabled. Medicare covered only services that were medically necessary, meaning that the services were required to diagnose or treat an illness,

injury, or malformed body member. In general, Medicare did not cover screening exams – that is, tests performed for the purpose of detecting hidden disease in individuals who displayed no signs or symptoms. A limited list of screening exams, not relevant to this indictment, was covered by Medicare under certain circumstances.

4. Blue Cross, Presbyterian, and Lovelace were private insurance companies that provided health insurance plans to individuals and groups. Each plan had agreements with participating medical providers to furnish medical services to patients insured by the plan. The agreements allowed the participating providers to bill the plans directly for services provided to insured patients. Like Medicare, the private plans covered only medically necessary services and did not cover screening exams except in limited circumstances not relevant to this indictment.

5. To bill Medicare or one of the private plans for services rendered, a provider submitted a claim to the plan. When a claim was submitted on the CMS-1500 form, the provider certified that the claimed services were medically indicated and necessary for the health of the patient. A warning on the form advised providers that knowingly filing a claim containing any misrepresentation or any false, incomplete, or misleading information was against the law.

6. A provider could hire another person or company to perform the task of submitting claims for payment; however, the provider remained responsible for ensuring that Medicare and the private plans were billed only for services that the provider actually rendered and that were medically necessary.

7. Providers were not required to attach copies of medical records or other forms of proof to justify the claims submitted. Although Medicare and the private plans did not generally scrutinize claims before payment, they retained the right to audit claims or providers. Providers were obligated to retain complete and accurate medical records reflecting the medical assessment

and diagnoses of their patients, as well as records documenting actual treatment of the patients for whom claims for reimbursement were submitted. In the event that Medicare or a private plan discovered that a claim was not supported by the medical documentation, it could recover from the provider the funds paid.

8. Medicare and the private plans required their providers to report their professional services on claim forms with a set of codes called the Current Procedural Terminology, or CPT codes. A CPT code was a five-digit code that corresponded to a particular medical service, such as an office visit, test, or treatment.

9. Medicare and the private plans required their providers to report a diagnosis along with each professional service rendered. Diagnoses were reported with a set of codes called ICD-9 codes. Each diagnosis code corresponded to a particular symptom, condition, or disease.

10. For billing purposes, a diagnosis code was used to document the reason a medical service was provided. If a patient had more than one symptom or condition that led to the service performed, a provider could list more than one diagnosis code per service.

11. Medicare maintained a list of CPT codes that normally should not be billed together by the same provider for a single date of service. Code pairs might appear on the list, for example, if they overlapped with each other, if they were mutually exclusive, or if one was included in the other as a "bundled" code. Pairs of codes that should not normally be billed together were called "edits." Blue Cross, Presbyterian, and Lovelace also used CPT edits. Submitting a claim for a pair of CPT codes that were on the list of edits would generally result in the rejection of the claim.

12. In appropriate cases, a provider could override a CPT edit by adding to the claim a separate two-digit code, called a modifier. A provider was required to maintain documentation in the medical file that demonstrated the appropriateness of the use of coding modifiers.

Counts 1 through 21 (Health Care Fraud)

1. Beginning in or about January 2010, and continuing through in or about May 2011, defendant **HEILBRON** knowingly and willfully executed and attempted to execute a scheme and artifice to obtain money and property owned by, and under the custody and control of, health care benefit programs in connection with the delivery of and payment for health care benefits, items, and services, by means of false and fraudulent pretenses, representations, and promises, which scheme is further described below.

The Scheme and Artifice

2. It was part of the scheme that defendant **HEILBRON** ordered and performed medically unnecessary tests on new patients and submitted claims to health care benefit programs for those tests with false diagnosis codes to justify those tests.

3. It was further part of the scheme that defendant **HEILBRON** inserted false symptoms, observations, and diagnoses into patients' medical charts to provide written support for the tests he ordered or performed.

4. It was further part of the scheme that when defendant **HEILBRON** saw new patients, he frequently submitted claims for two consecutive dates of service when the patients only visited the office on one date. The procedures billed on the second date were often similar or identical to the procedures billed on the first date and would have been denied by the insurance plans if billed as the same date of service.

5. It was further part of the scheme that defendant **HEILBRON** misused coding modifiers in order to increase his rate of reimbursement.

6. It was further part of the scheme that defendant **HEILBRON** caused claims to be submitted to health care benefit programs for procedures or treatments that were never performed.

7. It was further part of the scheme that to fabricate a written record of procedures that either were not performed or for which no documentation was created, defendant **HEILBRON** placed and caused to be placed in patients' medical charts clinical notes, diagnostic test results, and ultrasound images that were photocopies of other patients' records. In many cases, the patient's own name would be handwritten at the top of the copy to make it appear that the notes or results belonged to that patient. Photocopies commonly used by defendant **HEILBRON** include the following reports, each of which was found in the medical charts of more than one hundred patients:

a. *Abdominal Ultrasound Report*. Each report stated that the ultrasound was performed because of "abdominal pain/mass." Each report concluded that the ultrasound results were normal and recommended further evaluation if the alleged symptoms persisted.

b. *Holter Report*. A "Holter monitor" is a small device worn by a patient for at least 24 hours that continuously records the patient's heart rhythms. Each report stated that the Holter monitoring was performed because of "palpitations" reported by the patient. Each report contained identical results, including the same number of heart beats reported over the 24 hour period. Each report concluded that the patient suffered from an identical list of abnormalities.

c. *Ultrasound Retroperitoneal Duplex Complete*. Each photocopied report noted an initial diagnosis of "HTN/abdominal mass." HTN is shorthand for hypertension. Each report noted normal results and stated that "no evidence of cause of malignant hypertension [was] seen." Malignant hypertension is a life-threatening condition in which a patient experiences extremely high blood pressure. It is usually a medical emergency that requires hospitalization.

d. *Lower Extremity Venous Doppler*. One of the indications listed on each report is "DVT," which is shorthand for deep vein thrombosis. A deep vein thrombosis is a blood clot in a deep vein; it is a serious medical condition that can become life-threatening. Each photocopied report noted normal results.

e. *Thyroid Ultrasound Examination*. Each report stated that the test was performed because of enlargement of the thyroid. Each report concluded that the ultrasound results were normal and recommended further evaluation if the alleged symptoms persisted.

f. *Transcranial Ultrasound Examination*. Each report stated that "[t]he patient has suspected severe intracranial arterial stenosis." Intracranial artery stenosis is a narrowing of arteries inside the brain that can lead to a stroke or to a temporary loss of blood flow to part of the brain. Each report concluded the ultrasound was "unremarkable" and recommended further evaluation if the alleged symptoms persisted.

8. It was further part of the scheme that to create a paper record to justify the procedures that he billed, defendant **HEILBRON** used photocopied order sheets that contained pre-filled symptoms or diagnosis codes.

9. It was further part of the scheme that when Medicare or the private plans requested additional documentation to support the claims submitted, defendant **HEILBRON** submitted these photocopied notes, reports, images, and order sheets.

Patient A

10. It was further part of the scheme that on or about April 14, 2010, defendant **HEILBRON** ordered tests on a new patient, Patient A, that were not medically necessary and made false entries in Patient A's medical chart.

11. It was further part of the scheme that on or about April 20, 2010, defendant **HEILBRON** caused claims to be submitted to Presbyterian for an initial office visit for Patient A and 34 separate procedures allegedly performed on April 14, 2010. Defendant **HEILBRON** also billed Presbyterian for eight procedures allegedly performed for Patient A the next day, April 15, 2010.

12. It was further part of the scheme that the claims submitted for Patient A contained false diagnoses and listed procedures that had not been performed.

Patient B

13. It was further part of the scheme that on or about May 6, 2010, defendant **HEILBRON** ordered tests on a new patient, Patient B, that were not medically necessary and made false entries in Patient B's medical chart.

14. It was further part of the scheme that on or about May 11, 2010, defendant **HEILBRON** caused claims to be submitted to Medicare for an initial office visit for Patient B and 34 separate procedures allegedly performed on May 6, 2010. Defendant **HEILBRON** also billed Medicare for five procedures allegedly performed for Patient B the next day, May 7, 2010.

15. It was further part of the scheme that the claims submitted for Patient B contained false diagnoses and listed procedures that had not been performed.

Patient C

16. It was further part of the scheme that on or about July 9, 2010, defendant **HEILBRON** ordered tests on a new patient, Patient C, that were not medically necessary and made false entries in Patient C's medical chart.

17. It was further part of the scheme that on or about July 13, 2010, defendant **HEILBRON** caused claims to be submitted to Medicare for an initial office visit for Patient C and 34 separate procedures allegedly performed on Friday, July 9, 2010. Defendant **HEILBRON** also billed Medicare for five procedures, allegedly performed for Patient C the next day, Saturday, July 10, 2010.

18. It was further part of the scheme that the claims submitted for Patient C contained false diagnoses and listed procedures that had not been performed.

Patient D

19. It was further part of the scheme that on or about August 24, 2010, defendant **HEILBRON** ordered tests on a new patient, Patient D, that were not medically necessary and made false entries in Patient D's medical chart.

20. It was further part of the scheme that on or about August 26, 2010, defendant **HEILBRON** caused claims to be submitted to Medicare for an initial office visit for Patient D and 34 separate procedures allegedly performed on August 24, 2010. Defendant **HEILBRON** also billed Medicare for five procedures allegedly performed for Patient D the next day, August 25, 2010.

21. It was further part of the scheme that the claims submitted for Patient D contained false diagnoses and listed procedures that had not been performed.

Patient E

22. It was further part of the scheme that on or about September 2, 2010, defendant **HEILBRON** ordered tests on a new patient, Patient E, that were not medically necessary and made false entries in Patient E's medical chart. One of the false entries was titled Thyroid Ultrasound Examination. The indication listed was "enlargement" of the thyroid. In fact, Patient E's thyroid had been surgically removed several years prior. The photocopied report stated that the patient's thyroid gland was "normal in size, shape and contour" and concluded that the thyroid was "unremarkable."

23. It was further part of the scheme that on or about September 8, 2010, defendant **HEILBRON** caused claims to be submitted to Blue Cross for an initial office visit for Patient E and 32 separate procedures allegedly performed on September 2, 2010. Defendant **HEILBRON** also billed Blue Cross for five procedures allegedly performed for Patient E the next day, September 3, 2010.

24. It was further part of the scheme that the claims submitted for Patient E contained false diagnoses and listed procedures that had not been performed.

Patient F

25. It was further part of the scheme that on September 3, 2010, defendant **HEILBRON** ordered tests on a new patient, Patient F, that were not medically necessary and made false entries in Patient F's medical chart.

26. It was further part of the scheme that on or about September 9, 2010, defendant **HEILBRON** caused claims to be submitted to Blue Cross for an initial office visit for Patient F

and 23 separate procedures allegedly performed on Friday, September 3, 2010. Defendant **HEILBRON** also billed Blue Cross for five procedures allegedly performed for Patient F the next day, Saturday, September 4, 2010.

27. It was further part of the scheme that the claims submitted for Patient F contained false diagnoses and listed procedures that had not been performed.

Patient G

28. It was further part of the scheme that on or about October 18, 2010, defendant **HEILBRON** ordered tests on a new patient, Patient G, that were not medically necessary and made false entries in Patient G's medical chart.

29. It was further part of the scheme that on or about October 21, 2010, defendant **HEILBRON** caused claims to be submitted to Medicare for an initial office visit for Patient G and 33 separate procedures allegedly performed on October 18, 2010. Defendant **HEILBRON** also billed Medicare for three procedures allegedly performed for Patient G the next day, October 19, 2010.

30. It was further part of the scheme that the claims submitted for Patient G contained false diagnoses and listed procedures that had not been performed or for which no documentation was generated.

Patient H

31. It was further part of the scheme that on or about January 5, 2011, and February 2, 2011, defendant **HEILBRON** ordered tests on Patient H that were not medically necessary and made false entries in Patient H's medical chart. Patient H was an undercover law enforcement officer. During her first visit, Patient H told defendant **HEILBRON** that she had no complaints about her health. Defendant **HEILBRON** performed a stress test on Patient H, ordered

extensive blood tests for her, and requested that she return for ultrasounds another day because the technician was out of the office. Patient H returned to the office on February 2, 2011, and had several ultrasound examinations performed.

32. It was further part of the scheme that on or about February 10, 2011, defendant **HEILBRON** caused claims to be submitted to Blue Cross for an office visit for Patient H and 23 separate procedures allegedly performed on February 1, 2011. Defendant **HEILBRON** also billed Blue Cross for three procedures allegedly performed for Patient H the following day, February 2, 2011.

33. It was further part of the scheme that the claims submitted for Patient H contained false diagnoses and listed procedures that had not been performed.

Patient I

34. It was further part of the scheme that on or about January 20, 2011, defendant **HEILBRON** ordered tests on a new patient, Patient I, that were not medically necessary and made false entries in Patient I's medical chart.

35. It was further part of the scheme that on or about January 26, 2011, defendant **HEILBRON** caused claims to be submitted to Lovelace for an initial office visit for Patient I and 43 separate procedures allegedly performed on January 20, 2011. Defendant **HEILBRON** also billed Lovelace for three procedures allegedly performed for Patient I the next day, January 21, 2011.

36. It was further part of the scheme that the claims submitted for Patient I contained false diagnoses and listed services not rendered to Patient I, including Holter monitoring, a CT scan of the heart, a CT scan of the chest, a sleep study, and smoking-cessation counseling for Patient I, who was a non-smoker.

Execution of the Scheme

37. On or about the dates listed below, in the District of New Mexico, defendant **HEILBRON** knowingly and willfully attempted to execute and did execute the scheme described above by submitting and causing to be submitted to the health care benefit program listed below the following items:

Claims

Count	Date Received	Benefit Program	Claims Submitted
1	July 13, 2010	Medicare	Claims for services for Patient C on July 9, 2010, and July 10, 2010
2	July 15, 2010	Medicare	Claims for services for Patient C on July 10, 2010
3	August 26, 2010	Medicare	Claims for services for Patient D on August 24, 2010, and August 25, 2010
4	September 8, 2010	Blue Cross	Claims for services for Patient E on September 2, 2010, and September 3, 2010
5	September 9, 2010	Blue Cross	Claims for services for Patient F on September 3, 2010, and September 4, 2010
6	October 21, 2010	Medicare	Claims for services for Patient G on October 18, 2010, and October 19, 2010
7	January 5, 2011	Blue Cross	Claims for services for Patient E on September 2, 2010
8	January 26, 2011	Lovelace	Claims for services for Patient I on February 20, 2011, and February 21, 2011
9	February 10, 2011	Blue Cross	Claims for services for Patient H on February 1, 2011, and February 2, 2011

Medical Records

Count	Date Received	Benefit Program	Records Submitted
10	June 30, 2010	Blue Cross	Medical records regarding services for Patient J on May 11, 2010
11	September 9, 2010	Blue Cross	Medical records regarding services for Patient K on May 19, 2010

12	September 15, 2010	Blue Cross	Medical records regarding services for Patient L on July 29, 2010
13	September 20, 2010	Blue Cross	Medical records regarding services for Patient M on July 29, 2010
14	September 29, 2010	Blue Cross	Medical records regarding services for Patient N on August 25, 2010
15	September 29, 2010	Blue Cross	Medical records regarding for Patient O on July 8, 2010
16	September 29, 2010	Blue Cross	Medical records regarding services for Patient P on August 23, 2010
17	October 1, 2010	Blue Cross	Medical records regarding services for patient Q on August 25, 2010
18	January 5, 2011	Blue Cross	Medical records regarding services for Patient E on September 2, 2010, and September 3, 2010
19	January 5, 2011	Blue Cross	Medical records regarding services for Patient F on September 3, 2010
20	February 11, 2011	Presbyterian	Medical records regarding services for Patient R on January 27 and 28, 2010; for Patient S on March 19 and 20, 2010; for Patient T on May 7 and 8, 2010; for Patient U on June 1 and 2, 2010; for Patient V on June 21 and 22, 2010; for Patient W on July 26 and 27, 2010; for Patient X on November 11 and 12, 2010; for Patient Y on November 16 and 17, 2010; and for Patient Z on December 16 and 17, 2010.
21	May 5, 2011	Blue Cross	Medical records regarding services for Patient H on January 5, February 1, 2011, and February 2, 2011

In violation of 18 U.S.C. §§ 1347 and 2.

Counts 22-24 (Wire Fraud)

1. Paragraphs 1 through 12 of the General Allegations and paragraphs 2 through 37 of Counts 1 to 21 above are re-alleged here.

2. On or about the dates listed below, in the District of New Mexico, defendant **HEILBRON**, having devised a scheme and artifice for obtaining money and property by means

of false and fraudulent pretenses, representations, and promises, and for the purpose of executing such scheme and artifice, caused to be transmitted by means of wire communication in interstate and foreign commerce writings, signs, signals, pictures, and sounds:

Count	Date of Payment	Wire
22	July 27, 2010	Payment of $2,771.26 from Medicare to the account of A Well for Health Church, Inc., at Los Alamos National Bank, which included $2,087.10 in payment of claims for Patient C on July 9, 2010.
23	September 9, 2010	Payment of $4,798.42 from Medicare to the account of A Well for Health Church, Inc., at Los Alamos National Bank, which included $2,360.05 in payment of claims for Patient D on August 24 and 25, 2010.
24	November 4, 2010	Payment of $8,012.19 from Medicare to the account of A Well for Health Church, Inc., at Los Alamos National Bank, which included $2360.9 in payment of claims Patient G on October 18 and 19, 2010.

In violation of 18 U.S.C. §§ 1343 and 2.

FORFEITURE ALLEGATION

Counts 1 through 21 of this Indictment are incorporated as part of this section of the indictment as if fully re-alleged herein for the purpose of alleging forfeiture to the United States pursuant to 18 U.S.C. § 982(a)(7).

Counts 22 through 24 of this Indictment are incorporated as part of this section of the indictment as if fully re-alleged herein for the purpose of alleging forfeiture to the United States pursuant to U.S.C. § 981(a)(1)(C) and 28 U.S.C. § 2461.

Upon conviction of any offense in violation of 18 U.S.C. § 1347, defendant **ROY G. HEILBRON**, shall forfeit to the United States pursuant to 18 U.S.C. § 982(a)(7) any property, real or personal, which constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.

Upon conviction of any offense in violation of 18 U.S.C. § 1343, defendant **ROY G. HEILBRON**, shall forfeit to the United States pursuant to 18 U.S.C. § 981(a)(1)(C) and 28 U.S.C. § 2461 any property, real or personal, which constitutes or is derived from proceeds traceable to such violation.

The property to be forfeited to the United States includes, but is not limited, a money judgment, including any interest accruing to the date of the judgment, representing the amount of money constituting or derived from proceeds of the offense.

SUBSTITUTE ASSETS

If any of the above described forfeitable property, as a result of any act or omission of Defendant:

A. cannot be located upon 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 21 U.S.C. § 853(p), as incorporated by 18 U.S.C. § 982(b)(1) and 28 U.S.C. § 2461(c), to seek forfeiture of any other property of Defendant up to the value of the forfeitable property described above.

A TRUE BILL:

/s/
FOREPERSON OF THE GRAND JURY

Assistant United States Attorney

6/8/2015 8:27 AM