IN THE UNITED STATES DISTRICT COURT FOR THE

WESTERN DISTRICT OF OKLAHOMA



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| UNITED STATES OF AMERICA, Plaintiff, | ) | |
| -vs- | ) | No. CR 25-208 R |
| ALEXANDER FRANK, Defendant. | ) | Violation: 18 U.S.C. § 1347 |

# INDICTMENT

The Federal Grand Jury charges:

At all times relevant to this Indictment:

## BACKGROUND

### The Medicare Program

1. The Medicare Program ("Medicare") was a federal "health care benefit program," as defined in Title 18, United States Code, Section 24(b), that provided health care benefits to persons over the age of 65 or with certain disabilities.

2. The Centers for Medicare and Medicaid Services ("CMS"), an agency of the U.S. Department of Health and Human Services, administered Medicare.

3. Individuals who qualified for Medicare benefits were referred to as Medicare "beneficiaries." Each beneficiary was given a unique health insurance claim number.

4. Health care providers, such as doctors and physicians, could apply to participate in Medicare. If approved, Medicare providers could receive reimbursement for health care services and items provided to Medicare beneficiaries.

5. Approved Medicare providers were required to comply with all Medicare-related laws and regulations and to submit claims for reimbursement only for services and items that were actually provided and medically necessary. Each Medicare provider was assigned a unique National Provider Identifier ("NPI"), which was used to process and pay claims.

6. Medicare was subdivided into multiple program "parts." Medicare Part B covered medical services provided by physicians, clinics, and laboratories, including outpatient care and home health care, that were medically necessary and ordered by licensed doctors or other qualified physicians.

7. When Medicare providers submitted claims for reimbursement, the claims described the services provided to beneficiaries by using billing codes known as current procedural terminology ("CPT") codes.

8. Medicare relied on submitted CPT codes to determine whether to issue or deny reimbursement for a claim.

**The Defendant**

9. **ALEXANDER FRANK** was a licensed medical doctor in Oklahoma and an approved Medicare provider.

10. Long Term Care Specialists ("LTCS") was a corporation based in Oklahoma City, Oklahoma. LTCS employed doctors to provide health care services to residents at skilled nursing facilities and assisted living centers in Oklahoma.

11. Since at least April 2012, LTCS employed **FRANK** on a full-time basis. **FRANK** submitted claims for reimbursement to Medicare through LTCS.

12. LTCS required doctors such as **FRANK** to follow certain procedures for submitting claims to Medicare. After providing health care services to a Medicare beneficiary, doctors were expected to approve a "progress note" that documented the patient's condition, treatment plan, and the services provided during the visit. LTCS billing staff used approved progress notes to submit claims for reimbursement to Medicare. Rendering doctors such as **FRANK** determined the applicable CPT code for each claim submitted to Medicare.

13. In addition to his employment with LTCS, **FRANK** was hired by dozens of skilled nursing facilities and assisted living centers to serve as their "medical director," typically for a monthly fee. In general, **FRANK**, as medical director, was to assist a facility in supervising its medical staff and ensure that its residents received quality care.

14. **FRANK** simultaneously served as medical director at certain facilities while also submitting and causing to be submitted claims to Medicare, as an LTCS employee, for services purportedly provided to the facilities' residents.

15. Most of the claims that **FRANK** submitted and caused to be submitted to Medicare were billed under CPT codes 99305, 99306, 99307, 99308, 99309, and 99310. Each one of these CPT codes required face-to-face services of varying lengths by a Medicare provider.

16. Providers were to bill CPT codes 99305 or 99306 when providing an initial evaluation and management of a nursing facility patient. A valid claim under CPT code 99305 required a moderate level of medical decision making and at least 35 minutes with a beneficiary. A valid claim under CPT code 99306 required a high level of medical decision making and at least 50 minutes with a beneficiary.

17. Providers were to bill CPT codes 99307, 99308, 99309, or 99310 for a subsequent evaluation and management of a patient at a nursing facility.

The four codes corresponded to services of differing complexity and length—ranging from at least 10 minutes to at least 45 minutes.

18. From January 2021 through April 2023, **FRANK** submitted and caused to be submitted approximately 33,063 claims to Medicare for face-to-face-visits billed under CPT codes 99305, 99306, 99307, 99308, 99309, and 99310, together totaling approximately $3,023,428.77.

## COUNTS 1–25
## (Health Care Fraud)

19. The Federal Grand Jury realleges and incorporates by reference paragraphs 1 through 18 as though fully set forth herein.

### The Purpose of the Scheme and Artifice to Defraud

20. The purpose of the scheme and artifice to defraud Medicare was for **FRANK** to unlawfully enrich himself by submitting and causing to be submitted false and fraudulent claims to Medicare for services not rendered and rendered only in part.

### The Scheme and Artifice to Defraud

21. Beginning in at least January 2021 and continuing through at least April 2023, it was part of the scheme and artifice to defraud Medicare that:

A. **FRANK** created, caused to be created, and approved progress notes that documented health care services that he purportedly provided to

Medicare beneficiaries at facilities served by LTCS and at which he served as medical director. In fact, **FRANK's** progress notes—which served as the basis for reimbursement claims to Medicare—regularly described services that were never rendered and rendered only in part.

B. **FRANK** often submitted and caused to be submitted false claims to Medicare in which he represented, in a single day, to have provided face-to-face services to scores of beneficiaries at numerous facilities, amounting to 20 hours of work or more in a single day.

C. For example, **FRANK** submitted and caused to be submitted approximately 72 claims to Medicare for face-to-face services provided to beneficiaries on February 10, 2022. These claims were billed under CPT codes 99309, 99308, and 99305. In total, this single day's claims would have amounted to more than 35 hours of face-to-face visits with beneficiaries. Moreover, the beneficiaries **FRANK** purportedly treated on February 10, 2022, were living in numerous facilities throughout Oklahoma, including in Durant, Wewoka, Broken Bow, McAlester, and Eufaula. Visiting all these facilities in a single day would have additionally required hours of travel by car.

D. In 2022, specifically, **FRANK** submitted and caused to be submitted approximately 16,897 claims to all insurers for face-to-face services billed under CPT codes 99305, 99306, 99307, 99308, 99309, and 99310. Cumulatively, these claims amounted to approximately 8,372 hours of face-to-

face services, an average of 161 hours every week and 23 hours every day of the year.

E. **FRANK** submitted and caused to be submitted claims for face-to-face services to beneficiaries who were hospitalized at facilities not served by LTCS and could not have received the services **FRANK** claimed.

F. For example, **FRANK** claimed to have provided face-to-face services to Medicare beneficiary C.P. at a nursing home in Lawton on June 21, 2021. But the day before, C.P. had been admitted to a local hospital and remained there—and not at her Lawton nursing home—for several days.

G. **FRANK** submitted and caused to be submitted claims in which he represented to have treated a Medicare beneficiary, M.L., after M.L. had been discharged from a facility served by LTCS and could not have received the services **FRANK** claimed. M.L. was discharged from a skilled nursing facility on or about November 2, 2022, but **FRANK** submitted and caused to be submitted claims to Medicare falsely representing that he provided face-to-face services to M.L. on November 5 and 7, 2022.

H. **FRANK** also submitted and caused to be submitted to Medicare claims for face-to-face services to beneficiaries who had died before the purported date of service.

I. For example, **FRANK** claimed to have provided face-to-face services to Medicare beneficiary A.S. at a nursing home in Lawton, Oklahoma,

on November 5, 2022. One of the CPT codes **FRANK** billed was for the comprehensive assessment of and care planning for a patient with a cognitive impairment like dementia. A.S. had died on June 30, 2022, more than four months earlier.

J. Medicare reimbursed LTCS a portion of the claims **FRANK** submitted and caused to be submitted for services he did not in fact render and rendered only in part.

K. Under his employment agreement with LTCS, **FRANK** received up to 70 percent of the Medicare reimbursements LTCS received on his claims.

**Executions of the Scheme and Artifice to Defraud**

22. On or about the dates specified below as to each count, in the Western District of Oklahoma,

**ALEXANDER FRANK**

knowingly and willfully executed and attempted to execute the above-described scheme and artifice to defraud Medicare, a health care benefit program affecting commerce, as defined in Title 18, United States Code, Section 24(b), and to obtain money from Medicare by means of materially false and fraudulent pretenses, representations, and promises, all in connection with the delivery of and payment for health care benefits, items, and services. In particular, **FRANK**, through LTCS, submitted and caused to be submitted

the following false and fraudulent claims for reimbursement to Medicare for services not rendered because the purported beneficiary was deceased:

| Count | Purported Date of Service | Purported Beneficiary | Date Claim Submitted | Claim Amount |
|---|---|---|---|---|
| 1 | 01/18/2021 | L.P. | 03/16/2021 | $86.32 |
| 2 | 01/25/2021 | L.P. | 02/12/2021 | $86.32 |
| 3 | 01/25/2021 | L.P. | 05/17/2021 | $86.32 |
| 4 | 01/31/2021 | M.C. | 03/03/2021 | $65.37 |
| 5 | 02/01/2021 | E.W. | 06/21/2021 | $86.32 |
| 6 | 10/06/2021 | C.G. | 11/10/2021 | $86.32 |
| 7 | 10/31/2021 | R.B. | 11/10/2021 | $86.32 |
| 8 | 10/31/2021 | G.M. | 11/10/2021 | $86.32 |
| 9 | 01/11/2022 | W.J. | 01/18/2022 | $86.32 |
| 10 | 02/10/2022 | W.S. | 02/16/2022 | $86.32 |
| 11 | 11/05/2022 | S.C. | 11/14/2022 | $93.86 |
| 12 | 11/05/2022 | S.C. | 11/14/2022 | $288.62 |
| 13 | 11/05/2022 | A.S. | 11/14/2022 | $93.86 |
| 14 | 11/05/2022 | A.S. | 11/14/2022 | $288.62 |

23. On or about the dates specified below as to each count, in the Western District of Oklahoma,

**ALEXANDER FRANK**

knowingly and willfully executed and attempted to execute the above-described scheme and artifice to defraud Medicare, a health care benefit program affecting commerce, as defined in Title 18, United States Code, Section 24(b), and to obtain money from Medicare by means of materially false and fraudulent pretenses, representations, and promises, all in connection with the delivery of and payment for health care benefits, items, and services. In particular, **FRANK**, through LTCS, submitted and caused to be submitted

the following false and fraudulent claims for reimbursement to Medicare for services not rendered because the purported beneficiary was hospitalized at facilities not served by **FRANK** and LTCS, and otherwise discharged from facilities served by **FRANK** and LTCS:

| Count | Purported Date of Service | Purported Beneficiary | Date Claim Submitted | Claim Amount |
|---|---|---|---|---|
| **15** | 06/21/2021 | C.P. | 06/29/2021 | $86.32 |
| **16** | 02/10/2022 | J.W. | 04/06/2022 | $86.32 |
| **17** | 05/14/2022 | B.W. | 05/23/2022 | $93.86 |
| **18** | 08/18/2022 | C.S. | 08/25/2022 | $93.86 |
| **19** | 11/05/2022 | M.L. | 11/09/2022 | $93.86 |
| **20** | 11/07/2022 | M.L. | 11/14/2022 | $93.86 |
| **21** | 12/05/2022 | M.L. | 12/13/2022 | $93.86 |
| **22** | 01/03/2023 | S.B. | 01/27/2023 | $93.86 |
| **23** | 01/30/2023 | M.C. | 02/06/2023 | $93.86 |
| **24** | 02/09/2023 | D.J. | 02/13/2023 | $93.86 |
| **25** | 03/17/2023 | N.D. | 03/27/2023 | $93.86 |

All in violation of Title 18, United States Code, Section 1347.

A TRUE BILL:

FOREPERSON OF THE GRAND JURY

ROBERT J. TROESTER
United States Attorney

D.H. DILBECK
Assistant United States Attorney