

IN THE UNITED STATES DISTRICT COURT  
FOR THE MIDDLE DISTRICT OF TENNESSEE  
NASHVILLE DIVISION

FILED  
U.S. DISTRICT COURT  
MIDDLE DISTRICT OF TN  
JUN 11 2025  
KP  
DEPUTY CLERK

UNITED STATES OF AMERICA )

v. )

[1] XUHAN ZHANG, M.D.  
a/k/a "Shelia Zhang"  
a/k/a "Xuhan Mei" )

[2] JING QI MEI )

No. 3:25-cr-00129

18 U.S.C. § 2  
18 U.S.C. § 1028A  
18 U.S.C. § 1035  
18 U.S.C. § 1347  
18 U.S.C. § 1349  
18 U.S.C. § 1956(h)  
18 U.S.C. § 1957

## INDICTMENT

THE GRAND JURY CHARGES:

### INTRODUCTION

At all times material to this Indictment:

1. The Medicare Program ("Medicare") was a federal health insurance program that provided medical benefits, items, and services to individuals who were sixty-five years of age and older, or disabled. The benefits available under Medicare were governed by federal statutes and regulations. The United States Department of Health and Human Services ("HHS"), through its agency the Center for Medicare and Medicaid Services ("CMS"), oversaw and administered Medicare. Individuals who received benefits under Medicare were commonly referred to as Medicare "beneficiaries."

2. Medicare programs covering different types of benefits were separated into different program "parts." For example, "Part A" of the Medicare program covered health services provided by hospitals, skilled nursing facilities, hospices and home health agencies, "Part B" covered medical services by physicians, outpatient care, diagnostic testing, durable medical

equipment (“DME”) and other medical items and services not covered by Part A. “Part C” covered Medicare Advantage Plans. “Part D” covered prescription drugs.

3. To participate in Medicare, providers were required to submit applications in which the provider agreed to abide by the Medicare laws, policies, procedures, rules, and regulations governing reimbursement. To receive Medicare funds, enrolled providers were required to abide by all Medicare-related laws and regulations. Providers were given, and provided with online access to, Medicare manuals and services bulletins describing proper billing procedure, rules, and regulations.

4. Physicians, clinics, and other health care providers, that rendered items or provided services to Medicare beneficiaries were known as Medicare providers and were able to apply for and obtain a national provider identifier (“NPI”). A provider that received an NPI and was enrolled in Medicare was able to file claims with Medicare to obtain reimbursement for services or items provided to beneficiaries.

5. Medicare reimbursed health care providers and suppliers for services and items rendered to beneficiaries. To receive payment from Medicare, providers submitted or caused the submission of claims to Medicare, either directly or through a billing company.

6. A Medicare claim was required to be properly documented in accordance with Medicare rules and regulations. To receive payment from Medicare, providers submitted or caused the submission of claims to CMS that were required to set forth, among other things, the beneficiary’s name and Medicare identification number, the item or service provided to the beneficiary, the date on which the items or services were provided, the cost of the items or services, the name and identification number of the physician or other health care provider who ordered or prescribed the items or services, and the name and identification number of the Provider who

provided the items or services. Providers conveyed this information to Medicare by submitting claims using billing codes and modifiers.

7. When a medical service is allegedly rendered, an electronic health care claim was generally submitted, and the claim included a code of what was allegedly rendered. Reimbursement was based on standard codes set out in the Healthcare Common Procedure Coding System (“HCPCS”). HCPCS codes for physician and non-physician services utilized “Current Procedural Terminology” codes or “CPT” codes. The American Medical Association documented and maintained the Current Procedural Terminology manual, which consisted of a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by a physician for a patient. Payment amounts from health care benefit programs to a provider were determined by the CPT code that a provider billed to the program.

8. Blue Cross Blue Shield (“BCBS”) was a health insurance company. BCBS provided secondary insurance to Medicare recipients in the form of supplemental benefit plans. Medicare typically covered 80 percent of Part B claims submitted to Medicare for reimbursement. The remaining 20 percent was traditionally paid by a beneficiary, or their supplemental health insurance coverage, like the supplemental plans provided by BCBS, after deductibles. BCBS supplemental plans also covered certain out of pocket costs such as co-pays, depending upon the specific terms of the supplemental plan.

9. Medicare and BCBS both accepted CPT codes for billing and reimbursed providers for medically necessary items and services rendered to their beneficiaries in accordance with the coverage rules of each program. Medicare and BCBS did not reimburse for services that were not actually provided or services that were not rendered as represented.



10. Medicare and BCBS were both “health care benefit program[s],” as defined by Title 18, United States Code, Section 24(b).

#### **Inpatient Hospital Services**

11. Health care benefit programs covered inpatient services provided at hospitals. Hospitals submitted claims to Medicare Part A for the facility costs for an inpatient hospitalization, and the health care provider, such as the doctor, submitted separate claims to Medicare Part B for their professional services.

12. Certain CPT codes applied to hospital inpatient Part B services performed by physicians, including but not limited to CPT Code 99223 (inpatient hospital care), 99231, 99232, and 99233 (subsequent inpatient hospital care), 99291 and 99292 (critical care), and CPT Codes 99356, 99357 and HCPCS Code G0316 (prolonged inpatient hospital service).

#### **The Defendants, Related Entities, and Other Individuals**

13. Xuhan PC, LLP (“Xuhan PC”) was a purported health care provider located in Hendersonville, Tennessee. Xuhan PC was enrolled as a provider in health care benefit programs, including Medicare.

14. Hospital #1 was a long-term acute care hospital located in Nashville, Tennessee. Hospital #1 closed permanently in December 2020.

15. Defendant [1] **XUHAN ZHANG, a/k/a “Sheila Zhang,” a/k/a “Xuhan Mei”** was a medical doctor and a resident of Hendersonville, Tennessee, and was enrolled as a provider in health care benefit programs, including Medicare and BCBS, and was an actual or beneficial owner of Xuhan PC.

16. Defendant [2] **JING QI MEI** was a resident of Hendersonville, Tennessee, and was an actual or beneficial owner of Xuhan PC, was the biller for Xuhan PC, and was the husband of [1] **ZHANG**.

### **COUNT ONE**

THE GRAND JURY FURTHER CHARGES:

17. The allegations contained in Paragraphs 1 through 16 are re-alleged and incorporated by reference as though fully set forth herein.

18. From at least February 2017 and continuing through in or around May 2025, in the Middle District of Tennessee and elsewhere, the defendants, [1] **ZHANG** and [2] **MEI**, did knowingly combine, conspire, confederate, and agree with each other, and with others known and unknown to the Grand Jury, to commit certain offenses against the United States, that is, to knowingly and willfully execute a scheme and artifice to defraud a health care benefit program affecting commerce, as defined by Title 18, United States Code, Section 24(b), that is, Medicare and BCBS, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of, said health care benefit programs, in connection with the delivery of and payment for health care benefits, items, and services, in violation of Title 18, United States Code, Section 1347.

### **Purpose of the Conspiracy**

19. It was the purpose of the conspiracy for [1] **ZHANG** and [2] **MEI** to unlawfully enrich themselves by, among other things:

- a. submitting and causing the submission of false and fraudulent claims to Medicare and BCBS for inpatient hospital services that were not provided as represented;

b. concealing the submission of false and fraudulent claims to Medicare and BCBS; and

c. diverting fraud proceeds for their personal use and benefit, the use and benefit of others, and to further the fraud.

**Manner and Means**

20. The manner and means by which [1] ZHANG and [2] MEI and their co-conspirators sought to accomplish the purpose of the conspiracy included, among others, the following:

21. [1] ZHANG and [2] MEI formed and operated Xuhan PC as a company to bill health care benefit programs.

22. [1] ZHANG and [2] MEI signed applications personally, and on behalf of Xuhan PC, to enroll in Medicare as providers and promised that they would, among other things, comply with federal laws, and otherwise agreed not to submit or cause the submission of false or fraudulent claims.

23. [1] ZHANG and [2] MEI opened bank accounts in the name of Xuhan PC, and in their own names, for the purpose of obtaining Medicare, BCBS, and other reimbursement for inpatient hospital services they claimed were provided to Medicare beneficiaries and billed to Medicare and BCBS.

24. [1] ZHANG and [2] MEI obtained the personal health information of Medicare beneficiaries while [1] ZHANG worked at Hospital #1.

25. [1] ZHANG and [2] MEI used the patient information obtained from Hospital #1 and continued to submit claims to Medicare for inpatient hospital services to Medicare and BCBS

beneficiaries even after Hospital #1 closed in December 2020 and even though [1] ZHANG was not treating those patients.

26. [1] ZHANG and [2] MEI submitted claims for payment to Medicare, BCBS, and other health care benefit programs, through their company Xuhan PC, falsely representing that [1] ZHANG personally provided inpatient hospital physician services to patients, when [1] ZHANG and [2] MEI knew that information was false.

27. As [1] ZHANG and [2] MEI knew, Hospital #1 closed in December 2020, and the patients they claimed she treated were not in Hospital #1, nor was [1] ZHANG treating them in any other capacity as a physician. In many cases, the patients were actually in nursing homes or were deceased.

28. [2] MEI, on behalf of Xuhan PC and [2] ZHANG, made false and fraudulent statements, including to BCBS and to the Tennessee Attorney General's Office, in order to conceal and further the fraud.

29. [1] ZHANG and [2] MEI, through Xuhan PC, submitted claims for services using CPT codes to bill for inpatient hospital services that totaled more than twenty-four hours in a day, even though these claims were false and impossible.

30. [1] ZHANG and [2] MEI, through Xuhan PC, submitted claims for services provided by [1] ZHANG to beneficiaries who were deceased at the time they claimed to provide services, even though that was false and impossible.

31. [1] ZHANG and [2] MEI, through Xuhan PC, submitted claims for services that were performed by [1] ZHANG when she was out of the country at the time of the services, even though that was false and impossible.



32. As a result of such false and fraudulent claims, [1] **ZHANG** and [2] **MEI**, through Xuhan PC, caused approximately twenty million dollars to be billed to Medicare and BCBS for inpatient hospital services that were false and fraudulent because they were not actually provided.

33. Based on the false and fraudulent claims, Medicare and BCBS reimbursed Xuhan PC, controlled by [1] **ZHANG** and [2] **MEI**, over six and a half million dollars.

34. [1] **ZHANG** and [2] **MEI** diverted fraud proceeds from the scheme for their personal use and benefit, the use and benefit of others, and to further the fraud.

35. [1] **ZHANG** and [2] **MEI** took steps to conceal the fraud by falsely representing the circumstances of the purported services and claims to the health care benefit plans and investigators in an attempt to limit the repercussions of the fraudulent claims.

All in violation of Title 18, United States Code, Section 1349.

#### **COUNTS TWO THROUGH SEVEN**

##### **THE GRAND JURY FURTHER CHARGES:**

36. The allegations contained in Paragraphs 1 through 35 are re-alleged and incorporated by reference as though fully set forth herein.

37. On or about each date listed below, in the Middle District of Tennessee and elsewhere, the defendants, [1] **ZHANG** and [2] **MEI**, in connection with the delivery of and payment for health care benefits, items, and services, did knowingly and willfully execute a scheme and artifice to defraud a health care benefit program affecting commerce, as defined by Title 18, United States Code, Section 24(b), including Medicare and BCBS, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of, said health care benefit programs, by submitting or causing to be submitted, to Medicare and BCBS, false and fraudulent claims for



inpatient hospital services, representing that the services were actually provided to beneficiaries as claimed, with each claim forming a separate count as outlined in the table below:

Count	Medicare Beneficiary	Health Insurance Plan	Listed Date of Service	Claim On or About Date
2	M.V.	Medicare	November 24, 2022	January 7, 2023
3	R.H.	Medicare	February 10, 2023	March 15, 2023
4	W.P.	Medicare	March 27, 2023	April 11, 2023
5	D.W.	Medicare	October 11, 2023	November 9, 2023
6	S.C.	Medicare	January 5, 2024	January 17, 2024
7	S.C.	BCBS	January 5, 2024	January 17, 2024

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

#### **COUNT EIGHT**

THE GRAND JURY FURTHER CHARGES:

38. The allegations contained in Paragraphs 1 through 37 are re-alleged and incorporated by reference as though fully set forth herein.

39. On or about April 3, 2024, in the Middle District of Tennessee, the defendant, [2] **MEI**, knowingly and willfully made materially false, fictitious, and fraudulent statements and representations, namely, representing to BCBS that [1] **ZHANG** was seeing patients at Hospital #1, when she had not because Hospital #1 was closed, in connection with the delivery of or payment for health care benefits, items, and services involving BCBS, a health care benefit program, as defined by Title 18, United States Code, Section 24(b).

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

**COUNTS NINE THROUGH ELEVEN**

THE GRAND JURY FURTHER CHARGES:

40. The allegations contained in Paragraphs 1 through 39 are re-alleged and incorporated by reference as though fully set forth herein.

41. On or about each date listed below, in the Middle District of Tennessee, and elsewhere, the defendants, [1] ZHANG and [2] MEI, did knowingly use, without lawful authority, a means of identification of another person, outlined in each separate count below, during and in relation to a felony violation enumerated in Title 18, United States Code, Section 1028A(c), to wit, health care fraud in violation of Title 18, United States Code, Section 1347, knowing that the means of identification belonged to another actual person:

Count	Person	Means of Identification Used	On or About Date of Offense
9	M.V.	Name Medicare Identification Number Date of Birth Address	January 7, 2023
10	D.W.	Name Medicare Identification Number Date of Birth Address	November 9, 2023
11	S.C.	Name Medicare Identification Number Date of Birth Address	January 17, 2024

In violation of Title 18, United States Code, Sections 1028A(a)(1) and 2.

## COUNT TWELVE

THE GRAND JURY FURTHER CHARGES:

42. The allegations contained in Paragraphs 1 through 41 are re-alleged and incorporated by reference as though fully set forth herein.

43. From at least February 2017 and continuing through in or around May 2025, in the Middle District of Tennessee and elsewhere, the defendants, [1] **ZHANG** and [2] **MEI**, did knowingly combine, conspire, confederate, and agree with each other, and with others known and unknown to the Grand Jury, to commit certain offenses against the United States, that is, to knowingly engage and attempt to engage, in monetary transactions by, through, or to a financial institution, affecting interstate and foreign commerce, in criminally derived property of a value greater than \$10,000, that is, such property having been derived from a specified unlawful activity, that is, health care fraud, as alleged in Counts One through Seven, in violation of Title 18, United States Code, Section 1957.

### Manner and Means

44. The manner and means by which [1] **ZHANG** and [2] **MEI** sought to accomplish the purpose of the conspiracy included, among others, the following:

45. [1] **ZHANG** and [2] **MEI** knew that they obtained funds from Medicare and BCBS through the fraud scheme described above.

46. [1] **ZHANG** and [2] **MEI** knew that the only other income they received was from rental income and a small amount of supervision fees by [1] **ZHANG**, that [2] **MEI** was unemployed, and that the amounts of legitimate income were far less in the amount received through Xuhan PC from Medicare and BCBS.

47. After [1] ZHANG and [2] MEI received funds from the health care fraud scheme described above, [1] ZHANG and [2] MEI made multiple transfers of the criminally-derived proceeds in amounts greater than \$10,000, knowing that the funds used to make the transfers were criminally derived property.

All in violation of Title 18, United States Code, Section 1956(h).

**COUNTS THIRTEEN THROUGH FOURTEEN**

THE GRAND JURY FURTHER CHARGES:

48. The allegations contained in Paragraphs 1 through 47 are re-alleged and incorporated by reference as though fully set forth herein.

49. On or about each date listed below, in the Middle District of Tennessee and elsewhere, the defendants, [1] ZHANG and [2] MEI, did knowingly engage and attempt to engage in the following monetary transactions by, through, and to a financial institution, and affecting interstate commerce, in criminally derived property of a value greater than \$10,000, that is, the deposit and transfer of funds from bank account with an account number listed below, to the accounts listed, in the amounts listed, such funds having been derived from specified unlawful activity, that is, conspiracy to commit health care fraud, in violation of Title 18, United States Code, Section 1349, health care fraud, in violation of Title 18, United States Code, Section 1347, with each transaction forming a separate count as outlined in the table below:

Count	Account	On or About Date of Monetary Transaction	Description of Monetary Transaction
13	Regions Bank x8781	July 24, 2023	Transfer of \$30,000 to American Express Investment Account x0673.
14	American Express Account x5774	June 13, 2024	ACH payment in the amount of \$108,524.45 to Tesla Motors for a Tesla Cyber Truck.



Each in violation of Title 18, United States Code, Sections 1957 and 2.

**FORFEITURE ALLEGATION**

50. The allegations of this Indictment are re-alleged and incorporated by reference as though fully set forth herein for purposes of alleging forfeiture to the United States of certain property in which the defendants have an interest.

51. Upon conviction of any of Counts One through Eight, the defendants, [1] **ZHANG** and [2] **MEI**, shall forfeit to the United States, pursuant to Title 18, United States Code, Section 982(a)(7), any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense(s), including, but not limited to including but not limited to the property identified below.

52. Upon conviction of any one of Counts Twelve through Fourteen (money laundering) of this Indictment, [1] **ZHANG** and [2] **MEI**, shall forfeit to the United States, pursuant to Title 18, United States Code, Section 982(a)(1), any property, real or personal, involved in such offense, or any property traceable to such property, including but not limited the property identified below.

53. The property to be forfeited includes, but is not limited to, the following:

- a. The contents of the following bank and financial accounts:
  - i. Santander Bank (Openbank) account number ending in \*4301 held in the name of [2] **MEI**;
  - ii. Cit Bank (First Citizens Bank) account number ending in \*9294 held in the name of [1] **ZHANG** and [2] **MEI**;
  - iii. Axos Bank (UFB) and account number ending in \*4297 held in the name of [1] **ZHANG** and [2] **MEI**; and
- b. 2024 Tesla Cybertruck, VIN number 7G2CEHED5RA017300, including related accessories (charging cord, keys, key FOB), registered to [2] **MEI**.

54. If any of the property described above, as a result of any act or omission of [1] **ZHANG** and [2] **MEI**:

- a. cannot be located upon the exercise of due diligence;
- b. has been transferred or sold to, or deposited with, a third party;
- 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 that cannot be divided without difficulty,

the United States shall be entitled to forfeiture of substitute property, and it is the intent of the United States, pursuant to Title 21, United States Code, Section 853(p), to seek forfeiture of any other property of [1] **ZHANG** and [2] **MEI**, up to the value of said property listed above as subject to forfeiture.

A TRUE BILL

[REDACTED]

FOREPERSON

ROBERT E. McGUIRE  
ACTING UNITED STATES ATTORNEY



ROBERT S. LEVINE  
SARAH K. BOGNI  
ASSISTANT UNITED STATES ATTORNEYS