UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

UNITED STATES OF AMERICA

vs.

SYED ATHER, MD

Case No. 18CR 365

Violations: Title 18, United States Code, Sections 2, 1347

JUDGE KENNELLY
MAGISTRATE JUDGE COLE

COUNTS ONE through FOURTEEN

The SPECIAL AUGUST 2017 GRAND JURY charges:

1. At times material to this Indictment:

a. Dr. Syed Ather ("ATHER") was a physician licensed in the State of Illinois who owned and operated medical practices under the names of Mobile Physicians, S.C. and M&F Medical Services, Ltd.

b. Mobile Physicians, S.C. ("Mobile Physicians") was a medical provider located at 7358 North Lincoln Avenue, Lincolnwood, Illinois.

c. M&F Medical Services, Ltd. ("M&F") was a medical provider located at 3849 West Chase Avenue, Lincolnwood, Illinois.

The Medicare Program

d. Medicare was a federal health care program providing benefits to persons who were 65 years of age or older, or were 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 ("HHS"). Individuals who received benefits under Medicare were referred to as Medicare "beneficiaries."

e. Medicare was a "health care benefit program," as defined by Title 18, United States Code, Section 24(b).

f. The Medicare program had three primary components: hospital insurance ("Part A"), medical insurance ("Part B"), and prescription drug benefits ("Part D"). Part B of Medicare covered the cost of physicians' services and other ancillary services not covered by Part A. Home visits and associated laboratory and diagnostic testing were paid for by Part B.

g. Physicians, clinics, and other health care providers who provided services to Medicare beneficiaries were able to apply to enroll with Medicare and obtain a Medicare provider number. A health care provider who was issued a Medicare provider number was able to file claims with Medicare and receive reimbursement for those services.

h. By becoming a participating provider in Medicare, enrolled providers agreed to abide by the policies, 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 the provisions of the Social Security Act, the regulations promulgated under that

Act, and applicable policies and procedures, rules, and regulations issued by CMS and its authorized agents and contractors. This included agreeing that providers could submit claims to Medicare only for medically necessary services they actually rendered.

i. Medicare required complete and accurate patient medical records so that Medicare could verify that the services were provided as described on the claim form. These records were required to be sufficient to permit Medicare to review the appropriateness of payments made to the health care provider.

j. For a physician to bill Medicare for a home visit, Medicare required the home visiting physician to document the reason a home visit was necessary, for example, because an in-office visit would require ambulance transport or excessive physician effort or because it would cause pain, or because the patient was home-bound.

k. To receive reimbursement for a covered service from Medicare, a provider must submit a claim, either electronically or using a form (*e.g.*, a CMS-1500 form or UB-92). All Medicare claims were required to set forth, among other things, the beneficiary's name, the date the services, the type of services provided (using a Current Procedural Terminology or "CPT" code), the billed amount of the services provided, and the name and identification number of the physician or other health care provider who had ordered the services or prescription. CPT codes and

descriptions were promulgated and maintained by the American Medical Association.

l. CPT codes 99341 through 99345 were used to bill physician visits to a new patient's home. CPT codes 99347 through 99350 were used to bill physician visits to an established patient's home.

m. For each of these series of CPT codes, the higher code number corresponded to a more in-depth and time consuming level of service, with a correspondingly higher reimbursement amount. Specifically, according to the CPT manuals, complexity of a visit was determined by: (1) the extent of the patient history that the physician takes during the visit, (2) the extent of the examination performed by the physician during the visit, and (3) the medical decision making done by the physician, which referred to the "complexity of establishing a diagnosis and/or selecting a management option."

n. For example, the American Medical Association stated that CPT code 99349 should be used for a visit that "usually" involved a problem or problems of "moderate to high severity," medical decision making of "moderate complexity," and the typical face time with a patient or family of 40 minutes.

o. Medicare-enrolled providers could only submit claims to Medicare for services that fit under the description of the specific billing code used.

p. In the medical field, the fraudulent practice of billing for a higher code than corresponded to the actual level or type of services provided was commonly known as "up-coding."

q. Medicare reimbursed providers differently depending on their credentials. For example, Medicare reimbursed more for services performed by a medical doctor compared to a nurse practitioner.

2. From in or around January 2010 and continuing through in or around May 2018, at Cook County, in the Northern District of Illinois, and elsewhere,

SYED ATHER,

defendant herein, and others, known and unknown to the Grand Jury, participated in a scheme to defraud a health care benefit program, namely, Medicare, 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 a health care benefit program, in connection with the delivery of and payment for health care benefits and services, which scheme is further described below.

Purpose of the Scheme and Artifice

3. It was the purpose of the scheme and artifice for ATHER to unlawfully enrich himself through the submission of false and fraudulent Medicare claims for medically unnecessary services and services which were up-coded to reflect a level of service not actually provided.

The Scheme and Artifice

4. It was part of the scheme that ATHER instructed employees to

schedule patients for visits every month, even though ATHER knew that the visits were medically unnecessary and that the patients could visit a doctor in an office.

5. It was further part of the scheme that ATHER submitted and caused the submission of claims to Medicare for perfunctory home visits up-coded to CPT code 99349, knowing that level of service was not provided.

6. It was further part of the scheme that at Mobile Physicians, ATHER caused claims to be submitted to Medicare for nurse practitioners' visits to patients in their homes, falsely representing to Medicare that ATHER was himself providing the services while knowing that he did not provide the services.

7. It was further part of the scheme that even after others told ATHER he was up-coding, ATHER continued the practice, and continued to make unnecessary visits to patients in their homes, knowing that the claims submitted for these visits were false and fraudulent.

8. It was further part of the scheme that on or about December 2012, ATHER created a blood testing laboratory at Mobile Physicians' location, and that ATHER caused medically unnecessary blood draws from patients, knowing that the claims submitted for these blood draws and the claims for associated travel costs were false and fraudulent.

9. It was further part of the scheme that ATHER misrepresented, concealed, hid, and caused to be misrepresented, concealed, and hidden, the purpose of the scheme and acts done in furtherance of the scheme.

10. It was further part of the scheme that ATHER submitted and caused to be submitted claims to Medicare for services he, and nurse practitioners acting at his direction, performed, causing Medicare to pay ATHER, through Mobile Physicians, at least approximately $2,800,000, while ATHER knew that the services were not medically necessary and were billed for a level of service not actually provided.

Acts in Execution of the Scheme and Artifice

11. On or about the dates set forth as to each count below, in the Northern District of Illinois, and elsewhere,

SYED ATHER,

defendant herein, did knowingly and wilfully execute, and attempt to execute, the above described scheme by submitting and causing to be submitted claims to a health care benefit program, namely, Medicare, for health care services that were not medically necessary and were billed for a level of service not actually provided:

Count	Medicare Beneficiary Name	Approx. Purported Dates of Service	Approx. Claim Submission Date	CPT Code	Amount Billed to Medicare
1	R.S.	1/4/14	4/21/14	99349	$150
2	R.S.	2/8/14	4/21/14	99349	$150
3	R.S.	5/11/15	6/22/15	99349	$250
4	I.H.	2/8/14	4/21/14	99349	$150
5	M.R.	1/31/14	3/28/14	99349	$150
6	M.R.	3/13/14	3/26/14	99349	$150
7	J.B.	3/13/14	5/13/14	99349	$150
8	B.B.	8/29/13	9/16/13	99349	$150
9	B.B.	11/13/14	12/8/14	99349	$250
10	B.B.	9/9/2015	10/12/15	99349	$250
11	A.W.	6/20/13	7/10/13	99349	$150
12	A.W.	7/23/13	7/25/13	99349	$150
13	R.W.	6/20/13	7/10/13	99349	$150
14	R.W.	7/23/13	7/25/13	99349	$150

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

FORFEITURE ALLEGATIONS

The SPECIAL AUGUST 2017 GRAND JURY further alleges:

1. The allegations contained in Counts One through Fourteen of this Indictment are incorporated here for the purpose of alleging forfeiture pursuant to the provisions of Title 18, United States Code, Section 982.

2. Upon conviction of a violation of Title 18, United States Code, Section 1347 or Title 21, or United States Code, Sections 841 or 856, as alleged in Counts One through Eleven of this Indictment, the defendant shall forfeit to the United States of America, 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.

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

a. A forfeiture judgment of at least $2,800,000.

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

i. cannot be located upon the exercise of due diligence;

ii. has been transferred or sold to, or deposited with, a third party;

iii. has been placed beyond the jurisdiction of the Court;

iv. has been substantially diminished in value; or

v. has been commingled with other property that cannot be subdivided without difficulty;

it is the intent of the United States, pursuant to Title 21, United States Code, Section 853(p), to seek to forfeit any other property of the defendants up to the value of the forfeitable property described above.

A TRUE BILL:

_____
FOREPERSON

_____
UNITED STATES DEPARTMENT OF JUSTICE
CRIMINAL DIVISION, FRAUD SECTION
ACTING CHIEF

_____
UNITED STATES DEPARTMENT OF JUSTICE
CRIMINAL DIVISION, FRAUD SECTION
CHIEF – HEALTH CARE UNIT