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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

UNITED STATES OF AMERICA

v.

LOUIS BITOFF, D.P.M.,

Defendant.

_____/

Case:2:20-cr-20445
Judge: Edmunds, Nancy G.
MJ: Whalen, R. Steven
Filed: 09-23-2020 At 09:38 AM
INDI USA V. BITOFF (DA)

VIO: 18 U.S.C. § 1347
18 U.S.C. § 2
18 U.S.C. § 981
18 U.S.C. § 982

INDICTMENT

THE GRAND JURY CHARGES:

GENERAL ALLEGATIONS

At all times relevant to this Indictment:

The Medicare Program

1. The Medicare program was a federal health care program providing benefits to persons who were 65 years of age or older or 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. Individuals who received benefits under Medicare were referred to as Medicare "beneficiaries."

2. Medicare was a "health care benefit program," as defined by 18 U.S.C. § 24(b).

3. The Medicare program included coverage under two primary components—hospital insurance (Part A) and medical insurance (Part B). Part A covered physical therapy, occupational therapy, and skilled nursing services if a facility was certified by CMS as meeting certain requirements. Part B covered the cost of physicians' services and other ancillary services not covered by Part A.

4. Wisconsin Physicians Service ("WPS") was the CMS contracted carrier for Medicare Part B, which included podiatry services, in the state of Michigan. TrustSolutions LLC was the Program Safeguard Contractor for Medicare Part A and Part B in the state of Michigan until April 24, 2012, when it was replaced by Cahaba Safeguard Administrators LLC as the Zone Program Integrity Contractor (ZPIC). The ZPIC was the contractor charged with investigating fraud, waste and abuse. Cahaba was replaced by AdvanceMed in May 2015.

5. Physicians, clinics, and other health care providers that provided services to Medicare beneficiaries were able to apply for and obtain a Medicare "provider number." A health care provider who was issued a Medicare provider number was able to file claims with Medicare to provide reimbursement for services provided to beneficiaries. A Medicare claim was required to set forth,

among other things, the beneficiary's name, the date the services were provided, the cost of the services, and the name and identification number of the physician or other health care provider who had ordered the services.

6. By becoming a participating provider in Medicare, enrolled providers agreed to abide by the policies and procedures, rules, and regulations governing reimbursement. In order 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 the Act, and applicable policies, procedures, rules, and regulations issued by CMS and its authorized agents and contractors. Health care providers were given and provided with online access to Medicare manuals and services bulletins describing proper billing procedures and billing rules and regulations.

7. Medicare Part B regulations required health care providers enrolled with Medicare to maintain complete and accurate medical records reflecting the medical assessment and diagnoses of their patients, as well as records documenting actual treatment of the patients to whom services were provided and for whom claims for payment were submitted by the physician. These records were required to be sufficient to permit Medicare, through WPS and other contractors, to review the appropriateness of Medicare payments made to the health care provider under the Part B program.

8. In order to receive reimbursement for a covered service from Medicare, a provider was required to submit a claim, either electronically or using a form (e.g., a CMS-1500 form or UB-92), containing the required information appropriately identifying the provider, patient, and services rendered.

9. When an individual medical provider was associated with a clinic, Medicare Part B required that the individual provider number associated with the clinic be placed on the claim submitted to the Medicare contractor.

10. Providers could only submit claims to Medicare for services they rendered and that were medically necessary, and providers were required to maintain patient records to verify that the services were provided as described on the claim form.

Medical Coding

11. The American Medical Association assigned and published numeric codes, known as the Current Procedural Terminology ("CPT") and Health Care Procedure Common Coding System ("HCPCS") codes. The codes were a systematic listing, or universal language, used to describe the procedures and services performed by health care providers.

12. The procedures and services represented by the CPT and HCPCS codes were health care benefits, items, and services within the meaning of 18 U.S.C. § 24(b). They included codes for office visits, diagnostic testing and

evaluation, and other services. Health care providers used CPT and HCPCS codes to describe the services rendered in their claims for reimbursement to health care benefit programs.

13. Health care benefit programs, including Medicare, used these codes to understand and evaluate the claims submitted by providers and to decide whether to issue or deny payment. Each health care benefit program established a fee or reimbursement level for each service described by a CPT or HCPCS code.

14. CPT Codes 11730 and 11732 corresponded to a nail avulsion procedure. This procedure involved the surgical removal of an offending nail from the nail bed, extending from the tip of the nail back to the nail matrix. CPT code 11730 was supposed to be used to bill the first nail avulsion of a visit, and CPT code 11732 was supposed to be used to bill subsequent nail avulsions performed during the same visit. As a result, CPT code 11732 had a slightly lower reimbursement rate than CPT code 11730. Neither code permitted a provider to be reimbursed for merely clipping a patient's toenails.

The Physician Business

15. Mary E. Barna D.P.M. & Associates, P.C. ("MBA") was a Michigan corporation, organized in or around May 1988, doing business at 7445 Allen Road, Suite 280, Allen Park, Michigan 48101. MBA was enrolled as a participating

provider with Medicare and authorized the submission of claims to Medicare since on or about July 11, 1992.

The Defendant

16. Defendant LOUIS BITOFF, D.P.M., a resident of Oakland County, Michigan, was a licensed podiatrist, who was enrolled as a participating provider with Medicare. LOUIS BITOFF, D.P.M., was employed by MBA since 2006 and purportedly provided podiatric services to patients of that company.

COUNTS 1-5
(18 U.S.C. § 1347 and § 2—Health Care Fraud)

17. Paragraphs 1 through 16 of the General Allegations section of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

18. From in or around January 2010 and continuing to in or around August 2020, in Oakland County, in the Eastern District of Michigan, and elsewhere, the defendant, LOUIS BITOFF, D.P.M., did knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud Medicare, a health care benefit program as defined in 18 U.S.C. § 24(b), 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 program, in connection with the delivery of, and payment for, health care benefits, items, and services.

Purpose of the Scheme to Defraud

19. It was the purpose of the scheme to defraud for LOUIS BITOFF, D.P.M., to unlawfully enrich himself, by, among other things: (a) submitting and causing the submission of false and fraudulent claims to Medicare for services that were not rendered, not medically necessary, and not eligible for reimbursement from Medicare; (b) concealing the submission of false and fraudulent claims to Medicare and receipt and transfer of fraud proceeds; and (c) diverting fraud proceeds for his personal use and benefit.

The Scheme to Defraud

20. The manner and means by which the defendant sought to accomplish the scheme to defraud included, among others:

21. LOUIS BITOFF, D.P.M., was a Medicare provider and, as such, was required to abide by all Medicare rules and regulations and federal laws, including that he would not knowingly present or cause to be presented a false and fraudulent claim for payment by Medicare. BITOFF had been enrolled as a Medicare provider since in or around 1976, and was required to, and did, certify and re-certify that he would comply with all Medicare rules and regulations.

22. LOUIS BITOFF, D.P.M., devised and engaged in a scheme to submit claims to Medicare for nail avulsion procedures under CPT Code 11730 and CPT

Code 11732 that were not medically necessary, not rendered, and not eligible for Medicare reimbursement.

23. LOUIS BITOFF, D.P.M., would routinely trim his patients' toenails, and then submit, and cause the submission of, claims to Medicare that falsely claimed that he performed a nail avulsion procedure under CPT Code 11730, CPT Code 11732, and/or both codes.

24. From in or around January 2010 through in or around August 2020, LOUIS BITOFF, D.P.M., submitted and caused the submission of more than $2.2 million in false and fraudulent claims to Medicare for nail avulsion procedures under CPT Code 11730, and more than $1.2 million in false and fraudulent claims to Medicare for nail avulsion procedures under CPT Code 11732, for services that were not rendered, not medically necessary, and not eligible for reimbursement from Medicare.

Executions of the Scheme to Defraud

25. On or about the dates specified as to each count below, in Oakland County, in the Eastern District of Michigan, and elsewhere, LOUIS BITOFF, D.P.M., in connection with the delivery of and payment for health care benefits, items, and services, did knowingly and willfully execute, and attempt to execute, the above-described scheme and artifice to defraud Medicare, a health care benefit program, 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 program, with each claim submission forming a separate execution of the scheme and artifice to defraud:

Count	Medicare Bene-ficiary	Approx. Date of Service	Approx. Date of Claim	Description of Items Billed	Approx. Amount Billed to Medicare
1	B.W.	6/22/2016	12/22/2016	Separation of nail plate from nail bed (11730); Separation of nail plate from nail bed (11732)	$195
2	M.E.	8/24/17	2/20/18	Separation of nail plate from nail bed (11732)	$40
3	M.M.	9/9/19	12/3/19	Separation of nail plate from nail bed (11730); Separation of nail plate from nail bed (11732); Separation of nail plate from nail bed (11732)	$230

Count	Medicare Bene-ficiary	Approx. Date of Service	Approx. Date of Claim	Description of Items Billed	Approx. Amount Billed to Medicare
4	C.B.	11/14/19	1/24/20	Separation of nail plate from nail bed (11730); Separation of nail plate from nail bed (11732); Separation of nail plate from nail bed (11732)	$230
5	L.J.	12/2/2019	2/24/20	Separation of nail plate from nail bed (11730); Separation of nail plate from nail bed (11732); Separation of nail plate from nail bed (11732)	$230

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

FORFEITURE ALLEGATIONS
(18 U.S.C. § 981(a)(1)(C) and 28 U.S.C. § 2461(c);
18 U.S.C. § 982(a)(7)—Criminal Forfeiture)

26. The above allegations contained in this Indictment are incorporated by reference as if set forth fully herein for the purpose of alleging forfeiture pursuant to the provisions of Title 18, United States Code, Sections 981(a)(1)(C) and 982(a)(7), and Title 28, United States Code, Section 2461(c).

27. As a result of the violations of Title 18, United States Code, Sections 1347, as set forth in this Indictment in Counts 1-5, LOUIS BITOFF, D.P.M., shall forfeit to the United States any property, real or personal, that constitutes or is derived from any proceeds obtained, directly or indirectly, as a result of such violation(s), pursuant to 18 U.S.C. § 982(a)(7) and 18 U.S.C. § 981(a)(1)(C), as incorporated by 28 U.S.C. § 2461(c). The property to be forfeited includes, but is not limited to, the following:

a) Funds in the amount of $194,546.74 seized from JPMorgan Chase bank account ending in 7068;

b) Funds in the amount of $132,713.07 seized from Capital One bank account ending in 9186;

c) The real property located at 29560 Bradmoor Court, Farmington Hills, Oakland County, Michigan.

The United States also intends to seek a forfeiture money judgment equivalent to the total amount of property subject to forfeiture in this action.

28. Substitute Assets: If the property described above as being subject to forfeiture, as a result of any act or omission of the Defendant:

d) cannot be located upon the exercise of due diligence;

e) has been transferred or sold to, or deposited with, a third party;

f) has been placed beyond the jurisdiction of the Court;

g) has been substantially diminished in value; or

h) has been commingled with other property that cannot be subdivided without difficulty;

it is the intent of the United States, pursuant to 21 U.S.C. § 853(p) as incorporated by 18 U.S.C. § 982(b) and/or 28 U.S.C. § 2461, to seek to forfeit any other property of the Defendant up to the value of the forfeitable property described above.

THIS IS A TRUE BILL.

s/Grand Jury Foreperson
Grand Jury Foreperson

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Dated: September 23, 2020

United States District Court Eastern District of Michigan	**Criminal Case C**

NOTE: It is the responsibility of the Assistant U.S. Attorney signing this form to

Case:2:20-cr-20445
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Companion Case Information	**Companion Case Number:**
This may be a companion case based upon **LCrR 57.10 (b)(4)**[1]**:**	**Judge Assigned:**
☐ **Yes** ☒ **No**	**AUSA's Initials:** MLD

Case Title: USA v. LOUIS BITOFF, D.P.M.

County where offense occurred : Oakland County

Check One: ☒**Felony** ☐**Misdemeanor** ☐**Petty**

✓ Indictment/____Information --- **no** prior complaint.
____Indictment/____Information --- based upon prior complaint [**Case number:**]
____Indictment/____Information --- based upon **LCrR 57.10 (d)** ***[Complete Superseding section below]***.

Superseding Case Information

Superseding to Case No: _____ **Judge:** _____

☐ Corrects errors; no additional charges or defendants.
☐ Involves, for plea purposes, different charges or adds counts.
☐ Embraces same subject matter but adds the additional defendants or charges below:

Defendant name	**Charges**	**Prior Complaint (if applicable)**

Please take notice that the below listed Assistant United States Attorney is the attorney of record for the above captioned case.

September 23, 2020
Date

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[1] Companion cases are matters in which it appears that (1) substantially similar evidence will be offered at trial, or (2) the same or related parties are present, and the cases arise out of the same transaction or occurrence. Cases may be companion cases even though one of them may have already been terminated.