DJG/2011R00381

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA	:	Hon.
	:	
v.	:	Criminal No. 13-
	:	
LORI REAVES	:	18 U.S.C. § 1347
	:	

INFORMATION

The defendant having waived in open court prosecution by Indictment, the United States Attorney for the District of New Jersey charges:

1. At all times relevant to this Information, defendant LORI REAVES was a geriatric physician, and she was the founder and owner of Visiting Physicians of South Jersey ("VPA"), a Medicare-approved provider of home-based physician services for seniors, with an office located in Hammonton, New Jersey. VPA provided physician, home-based, health care visits for elderly and homebound patients as far north as Ocean County, New Jersey, as far east as Burlington County, New Jersey, as far south as Cape May County, New Jersey, and as far west as Salem County, New Jersey. As part of her responsibilities at VPA, defendant LORI REAVES was responsible for VPA's Medicare billings.

The Medicare Program and Billing Procedures

2. The Medicare Program ("Medicare") is a federal program that provides free or below-cost health care benefits to certain individuals, primarily the elderly, blind, and disabled. Medicare is a "health care benefit program" as defined by Title 18, United States Code, Section 24(b). Individuals who receive Medicare benefits are commonly referred to as "beneficiaries."

3. The Medicare Part B Program is a federally funded supplemental insurance program that provides supplementary Medicare insurance benefits for individuals aged sixty-five or older and certain individuals who are disabled. Under this program, Medicare will pay a large percentage of the cost for medical services provided to beneficiaries (usually about 80%), for which the health care provider has submitted a claim.

4. The remaining cost of the medical services that is not covered by Medicare (usually about 20%) is sometimes paid for by the beneficiaries' secondary insurance provider, if the beneficiary has such insurance. In such cases in which a beneficiary has secondary insurance, the health care provider submits a claim to both Medicare and the secondary insurance provider. For cases in which a beneficiary has no

secondary insurance coverage, the health care provider must bill the beneficiary directly for the remaining cost of the services.

5. In order to bill the Medicare Program, a health care provider must complete an enrollment application and be approved to participate in the Program. Once approved, the provider is assigned a unique Medicare Provider Number. Each claim for reimbursement submitted on behalf of a health care provider - whether the claim was made in paper form or electronically - must identify the claimant's Medicare Provider Number. Upon enrollment and periodically thereafter, each Medicare provider is furnished with information relevant to participating in the Medicare Program and regarding how to bill for services rendered.

6. The claim submitted by the health care provider is known as a Form CMS-1500. This form requires the health care provider to state a diagnosis of the patient's condition and to provide a procedure code identifying the service or services rendered. Such codes, known as Current Procedural Terminology (hereinafter "CPT") codes, are established and published by the American Medical Association. In the absence of a CPT code, the Medicare Program itself creates a set of procedure codes, which a Medicare Provider would use in seeking reimbursement from the

Medicare Program. Medicare's self-created procedure codes are known as the Healthcare Common Procedure Coding System, more commonly known in the health care industry as HCPCS.

7. The Medicare Program requires that each provider of medical services certify that the services rendered were medically necessary and were furnished by the health care provider. The provider must also certify as to the location where the services were rendered, as well as the date on which the services were rendered. Providers participating in the Medicare Program must certify in writing that they will be responsible for the accuracy of all claims submitted by themselves, their employees or their agents, and that all claims submitted under their Medicare Provider Numbers will be accurate, complete, and truthful. Finally, a warning is provided at the bottom of the Form CMS-1500, which specifically states that any false claims or statements, or the concealment of material facts, in relation to the submission of a claim for reimbursement, is a prosecutable offense under federal or state law.

8. Medicare providers forward claims for services that are covered by the Medicare Part B Program to designated private insurance organizations, known as Medicare Administrative

Contractors (hereinafter "MAC"). MAC's are contracted by the federal government to administer the Medicare Part B Program in the particular region where the services are provided. The Medicare Part B MAC for the State of New Jersey was Highmark Medicare Services, Inc. (hereinafter "Highmark"), which processes and handles the payment of Medicare Part B claims submitted by Medicare providers of services within New Jersey. Providers are not to receive reimbursement if the claimed services were not actually rendered, were not deemed medically necessary under Medicare regulations and policies, or were not properly documented.

9. The Centers for Medicare and Medicaid Services (hereinafter "CMS") is the federal agency responsible for administering the Medicare Program. In addition, organizations known as Medicare Program Safeguard Contractors (hereinafter "PSC") are contracted by CMS to identify and deter Medicare fraud and abuse, in the particular region where the services are provided. At all times relevant, the PSC for the State of New Jersey during the time period relevant to this affidavit was Safeguard Services Eastern Benefit Integrity Support Center (hereinafter "SGS"). Among other things, SGS is authorized to request patient records and other documents from Medicare providers, and to conduct on-site audits and other reviews to

determine if the providers are making accurate and truthful claims for Medicare reimbursement, or if fraud and malfeasance may exist in connection with Medicare claims. If SGS discovers evidence or indicia of fraud, it is authorized to refer such matters to HHS-OIG or other federal investigative agencies for further investigation and possible prosecution.

10. Since at least as early as on or about January 1, 2008, defendant LORI REAVES has had access to policy, rules and regulations promulgated by CMS regarding, among other things, coding and billing issues.

11. As a Medicare-approved provider of physician, home-based, health care visits, defendant LORI REAVES was allowed to seek reimbursement for patient visits from Medicare. Specifically, defendant LORI REAVES was allowed to seek reimbursement from Medicare for face-to-face time spent in patients' home while defendant LORI REAVES was performing the physician, home-based, health care visits. Defendant LORI REAVES was not allowed to bill Medicare for any services that were not provided to beneficiaries.

The Scheme to Defraud

12. From on or about January 1, 2008 through on or about October 14, 2011, in Atlantic County, in the District of New Jersey, and elsewhere, defendant

LORI REAVES,

in connection with the delivery of and payment for health care benefits, items, and services, did knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud a health care benefit program affecting commerce, that is, 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 that health care benefit program.

The Object of the Scheme to Defraud

13. The object of the scheme and artifice to defraud was for defendant LORI REAVES to cause the submission of Form CMS-1500s that falsely claimed, based on the CPT codes utilized, that defendant LORI REAVES had provided prolonged service visits to her patients, when in fact the services provided did not qualify as prolonged service visits, in order to induce Medicare to make payments to defendant LORI REAVES that were significantly higher than the payments defendant LORI REAVES was permitted to and should have received.

The Manner and Means of the Scheme to Defraud

14. From at least as early as on or about January 1, 2008 through on or about October 14, 2011, defendant LORI REAVES caused the submission of fraudulent Form CMS-1500s to Medicare which inflated the amount of time defendant LORI REAVES actually spent providing physician, home-based, health care visits to many of her elderly patients.

15. Based on Medicare billing data, for the period from on or about January 1, 2008 through on or about October 14, 2011 (hereinafter the "relevant time period"), defendant LORI REAVES Medicare billings caused her to be ranked as the highest billing physician of home-based, health care providers out of the over 24,000 doctors in New Jersey.

16. In most instances, defendant LORI REAVES billed CPT code "99345" (home visit for a new patient with an unstable or significant new problem) or "99350" (home visit for an established patient with an unstable or significant new problem). Medicare regulations require that a doctor provide approximately 75 minutes of face-to-face care for procedure code 99345 and approximately 60 minutes for CPT code 99350.

17. In addition to the use of the procedure codes 99345 or 99350 (hereinafter the "base codes") during the relevant time period, defendant LORI REAVES typically billed "prolonged

visit codes," specifically CPT codes "99354" (prolonged physician service in the office or other outpatient setting requiring direct face-to-face contact beyond the usual service, for the first hour) and "99355" (prolonged physician service in the office or other outpatient setting requiring direct face-to-face contact beyond the usual service, for each additional 30 minutes). Medicare regulations require the use of one base code in conjunction with CPT code 99354, and the regulations note that the threshold time to bill CPT code 99354 is actually 30 minutes of treatment beyond the base code. For the use of CPT code 99355, Medicare regulations require the use of one base code and CPT code 99354. The regulations also note that the threshold time for CPT code 99355 is actually 15 minutes beyond the first full hour of prolonged service, subsequent to the base code service.

18. Based upon the Medicare regulations described in the preceding paragraph, a Medicare claim for a single patient that included CPT codes 99350 and 99354 would require a minimum of 90 minutes of face-to face contact; CPT codes 99350, 99354, and 99355 would require a minimum of 135 minutes of face-to-face contact; CPT codes 99345 and 99354 would require a minimum of 105 minutes of face-to-face contact; and CPT codes 99345, 99354, and 99355 would require a minimum of 150 minutes of face-to-face contact.

19. During the relevant time period, in most instances, despite billing Medicare for numerous prolonged visit codes, defendant LORI REAVES failed to spend the total amount of time that corresponded with the CPT codes that were claimed on the Form CMS-1500s submitted to Medicare.

20. During the relevant time period, defendant LORI REAVES billed Medicare for numerous prolonged visit codes for patient visits that she purportedly made and which she claimed lasted approximately 2.5 hours. However, while defendant LORI REAVES typically did provide physician, home-based health care services to her various patients on the dates corresponding to the bills she submitted to Medicare, defendant LORI REAVES typically only spent approximately 30 minutes to 45 minutes with each patient, and not the approximately 2.5 hours of face-to-face time for which defendant LORI REAVES billed Medicare. Accordingly, defendant LORI REAVES billings for prolonged visit codes during the relevant time period were false and fraudulent.

21. During the relevant time period, Medicare paid defendant LORI REAVES approximately $511,068.19 for prolonged service visits that defendant LORI REAVES fraudulently claimed to have performed when, in fact, she had only performed routine non-prolonged service visits.

In violation of Title 18, United States Code, Section 1347.

FORFEITURE ALLEGATION

1. The allegations contained in this Information are hereby realleged and incorporated by reference for the purpose of noticing forfeiture pursuant to Title 18, United States Code, Section 982(a)(7).

2. Upon conviction of the offense in violation of Title 18, United States Code, Section 1347, defendant, LORI REAVES, shall forfeit to the United States, pursuant to Title 18, United States Code, Section 982(a)(7), any property, real and personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the offense, including but not limited to at least approximately $511,068.19, a sum of money representing the gross proceeds of the offense.

3. If any of the property described above, as a result of any act or omission of the defendant:

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 which cannot be divided without difficulty,

the United States shall be entitled, pursuant to Title 21, United States Code, Section 853(p), as incorporated by Title 18, United States Code, Section 982(b)(1) and Title 28, United States Code, Section 2461 (c), to forfeiture of any other property of defendant LORI REAVES, up to the value of the property described in the preceding paragraph.

All pursuant to 18 U.S.C. §§ 982(a)(7) and 982(b)(1), and 28 U.S.C. § 2461(c).

PAUL J. FISHMAN
United States Attorney

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INFORMATION FOR

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