IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITED STATES OF AMERICA	**:**	**CRIMINAL NO: 16-_____**
v.	**:**	**DATE FILED: _____**
STEPHEN A. MONACO	**:**	**VIOLATION:** **18 U.S.C. § 1347 (healthcare fraud – 1 count)** **Notice of forfeiture**

INFORMATION

COUNT ONE

(Health Care Fraud)

THE UNITED STATES ATTORNEY CHARGES THAT:

At all times material to this Information:

INTRODUCTION

The Defendant and A Foot Above

1. The defendant, STEPHEN A. MONACO, was a doctor of podiatric medicine licensed by the Commonwealth of Pennsylvania, who operated his medical practice through A Foot Above Podiatry, Inc. ("A Foot Above"), located at 1120 Township Line Road, Suite 300, Havertown PA 19083. Defendant MONACO was enrolled as a provider in the Medicare Program beginning in or about August 1985.

2. The defendant, STEPHEN A. MONACO, was President and the sole owner of A Foot Above.

3. In or about April 2003, A Foot Above applied to participate as a provider in the Medicare Program ("Medicare"). Defendant STEPHEN A. MONACO signed A Foot

Above's application to enroll as a Medicare provider, was the only Delegated Official identified in that application, and was the primary signatory on A Foot Above's checking accounts.

4. In signing the application on behalf of A Foot Above, defendant STEPHEN A. MONACO acknowledged that to be allowed to participate in the Medicare Program, he was required to comply with all Medicare-related laws and regulations, including the requirements that he maintain complete and accurate patient treatment records and submit only truthful claims for medically necessary services and procedures.

5. Defendant STEPHEN A. MONACO was the primary provider of podiatric services at A Foot Above. From January 1, 2008 through December 31, 2013, approximately 75% of all claims submitted to Medicare and Independence Blue Cross, or approximately $47.1 million of charges for podiatry services, were for services that defendant MONACO claimed that he had rendered. For that same period, defendant MONACO was identified as the podiatrist who rendered the service for approximately 99% of all claims to Highmark Blue Cross, or approximately $12.9 million worth of claims for podiatry services.

6. Defendant STEPHEN A. MONACO and A Foot Above submitted claims to insurers, each of which was a health care benefit program as defined by Title 18, United States Code, Section 24(c), in that each was a public or private plan or contract, affecting commerce, under which medical benefits and services were provided to individuals. The insurers included but were not limited to Medicare, Medicaid, Independence Blue Cross, Highmark Blue Cross, AETNA and Amerihealth (collectively, "the insurers" or "the insurance carriers"). Claims were submitted electronically or by mail to the insurers, approved by the insurers, and paid by wire

transferring funds to one of A Foot Above's checking accounts or mailing a check to defendant MONACO's practice, A Foot Above.

7. Defendant STEPHEN A. MONACO, through A Foot Above, billed the insurers for services not rendered and billed excessively for procedures such as debridement, avulsions, and injections, and was paid approximately $5,000,000 for such fraudulent claims.

The Medicare Program

8. Medicare was a federal health insurance program administered by the Centers for Medicare and Medicaid Services ("CMS"), an agency of the United States Department of Health and Human Services. Medicare helped to pay for reasonable and necessary medical services for people aged 65 and over and some persons under 65 who were blind or disabled.

9. Medicare was divided into several parts, including Part B. Medicare Part B authorized payment for, among other things, certain podiatric services that were medically necessary and were provided by a licensed doctor of podiatric medicine.

10. Novitas Solutions, Inc. ("Novitas") contracted with CMS to process Part B claims in Pennsylvania. Pursuant to that agreement, Novitas distributed federal Medicare funds to Pennsylvania physicians who filed claims for payment.

11. Novitas required physicians to provide a diagnostic code and a procedure code on claims in order to be paid for professional services rendered to Medicare beneficiaries. Payment for services depended upon the specific diagnostic and procedure codes indicated on the claim form. Novitas distributed payments to participating providers electronically, by depositing money into the provider's bank account of record, or by mailing a check to the provider's address of record.

The Medicaid Program

12. Medicaid was a health care program that helped pay for reasonable and necessary medical procedures and services provided to individuals who were deemed eligible under state low-income programs. Medicaid was funded primarily by the federal government and operated at the state level. Federal oversight of the Medicaid program was the responsibility of CMS. In the Commonwealth of Pennsylvania, Medicaid was administered by the Department of Human Services ("DHS"); Medicaid coverage was provided to Medicaid recipients by Managed Care Organizations such as AmeriHealthCaritas ("AmeriHealth").

13. AmeriHealth, formerly known as Keystone First, distributed Medicaid funds to Pennsylvania physicians who filed claims for payment.

14. AmeriHealth required physicians to provide a diagnostic code and a procedure code on claims in order to be paid for professional services rendered to Medicaid recipients. Payment for services depended upon the specific diagnostic and procedure codes indicated on the claim form. AmeriHealth distributed payments to participating providers electronically, by depositing money into the provider's bank account of record, or by mailing a check to the provider's address of record.

Independence Blue Cross

15. Independence Blue Cross, LLC ("IBC") offered health insurance and other health care products and services in southeastern Pennsylvania through its subsidiaries, QCC Insurance Company, Keystone Health Plan East, and Independence Administrators.

16. IBC required physicians to provide a diagnostic code and a procedure code on claims in order to be paid for professional services rendered to IBC beneficiaries. Payment for

services depended upon the specific diagnostic and procedure codes indicated on the claim form. IBC distributed payments to participating providers electronically, by depositing money into the provider's bank account of record, or by mailing a check to the provider's address of record.

Federal Employee Health Benefits Program/AETNA/Highmark Blue Cross

17. The Federal Employees Health Benefits Program ("FEHBP") was a federally funded medical insurance program created to provide health insurance for federal employees, annuitants, and their spouses and dependent unmarried children under the age of twenty-six. Health insurance coverage was made available through contracts with various health insurance carriers, and federal employees and annuitants could choose from a variety of insurance plans.

18. AETNA and Highmark Blue Cross were two insurance carriers that provided health insurance through FEHBP. AETNA and Highmark Blue Cross required physicians to provide a diagnostic code and a procedure code on claims in order to be paid for professional services rendered to FEHBP beneficiaries. Payment for services depended upon the specific diagnostic and procedure codes indicated on the claim form. AETNA and Highmark Blue Cross distributed payments to participating providers electronically, by depositing money into the providers' bank account of record, or by mailing a check to the provider's address of record.

Billing Codes and Procedures

19. In order to bill Medicare or the insurance carriers for services rendered, physicians submitted a claims form, Form 1500. When Form 1500 was submitted, usually in electronic form, the physician certified that the contents of the form were true, correct, complete,

and that the form was prepared in compliance with the laws and regulations governing the Medicare Program.

20. Because of the large number of claims received by Medicare and the insurance carriers, carriers generally relied upon and paid claims based on the information on the Form 1500s and the providers' certifications.

21. However, Medicare and the insurance carriers required that the provider document in the beneficiary's medical record the services that were provided and that the services were reasonable and necessary. If requested, the provider was required to produce the documents reflecting the beneficiaries' conditions, diagnoses, and treatments.

22. For Medicare beneficiaries, a Medicare claim was required to set forth, among other things, the beneficiary's name and Medicare Beneficiary Number, the services provided for the beneficiary, the date the services were provided, the cost of the services, and the name and rendering National Provider Identifier ("NPI") number of the health care provider who rendered the services. The Medicare Beneficiary Number was the patient's unique identification code on the patient's Medicare card and was comprised of the patient's nine-digit social security number plus a one or two-position suffix identifier.

23. In submitting Medicare and other insurance claims, a physician identified the services provided by using standard Current Procedural Terminology ("CPT") codes. CPT codes provided a uniform language that accurately described medical, surgical and diagnostic services billed to government and private health insurance programs. The American Medical Association annually published and made available to all providers entitled to submit claims to

Medicare a CPT Manual, which set forth the criteria to be considered in selecting the proper codes to represent the services rendered.

24. When submitting claims for reimbursement for services provided, physicians were required to use correct CPT codes to identify each procedure and service. Medicare required providers to accurately list the CPT code that most completely identified the procedures or services provided.

25. CPT codes that podiatrists commonly used in submitting claims to Medicare and the insurers included injections (CPT Code 64640); nail avulsions (the separation and removal of an entire nail plate or portion of a nail plate; a procedure generally requiring injected local anesthesia) (CPT Codes 11730 and 11732); and nail excisions (the separation and removal of an entire nail plate or portion of a plate, followed by removal of the associated nail matrix; performed under local anesthesia) (CPT Code 11750).

THE HEALTH CARE FRAUD SCHEME

Manner and Means

It was part of the scheme to defraud that:

26. Defendant STEPHEN A. MONACO fraudulently represented on claims to Medicare and the insurance carriers that he had provided podiatric services to, and performed podiatric procedures upon, patients when he had not done so. Defendant MONACO also fraudulently submitted claims for medically unnecessary procedures and services that were not reimbursable by Medicare or other insurers.

27. Defendant STEPHEN A. MONACO fraudulently represented on claims to Medicare and other insurers that he had performed procedures and provided services, including

debridement, injections and nail avulsions, on patients for whom he did not provide the services claimed and did not perform the procedures claimed.

28. The codes that defendant STEPHEN A. MONACO had billed excessively were reimbursed at higher rates than codes for routine procedures performed by podiatrists. For example, nail trimming under CPT code 11719 was reimbursed by Medicare at approximately $20. In contrast, CPT codes 11041, 11721, 11730, 20550, and 64640 were reimbursed by Medicare at approximately $49; $40; $54; $89; and $212, respectively. Defendant MONACO's claims under CPT codes 11041, 11721, 11730, 20550, and 64640 were significantly higher than those of his peer group. The CPT codes in question were:

a. 11041 – Removal of dead, infected, or foreign material to promote wound healing. Also known as debridement.

b. 11721 – Removal of infected portion of toenails, by any method, for six to ten toenails.

c. 11730 – Removal of the entire or partial nail plate. Also known as a nail avulsion.

d. 20550 – Injection of anesthesia or corticosteroids into the foot tendon for short-term pain relief.

e. 64640 – Injection of a chemical agent into a nerve to destroy it and stop the transmission of pain signals.

29. Defendant STEPHEN A. MONACO also billed an excessive amount for certain costly procedures, specifically destruction of a nerve with a neurolytic agent (CPT 64640); avulsion, or permanent removal, of a nail plate (CPT 11750); injection of tendon sheath/ligament

(CPT 20550); and shave biopsy of lesions over 2.0 cm (CPT 11308) that were not medically necessary and therefore not reimbursable by Medicare or other insurers.

a. CPT code 64640 was indicated for the treatment of chronic pain. The modality involved injecting a chemical agent into the nerve to destroy it and stop the transmission of pain signals through the nerve. The procedure was performed with anesthesia.

b. CPT code 11750 was indicated for chronic pain from ingrown toe nail, or serious infection. The procedure involved the partial or entire removal of the nail plate usually under local anesthesia, commonly referred to as a nail avulsion. The procedure was surgical in nature and could require chemical and/or electrocoagulation to stop any excessive bleeding resulting from the procedure.

c. CPT code 20550 was indicated for *plantar fasciitis*, which was a common cause of heel pain. The procedure involved injecting anesthesia or corticosteroids into the foot tendon for short-term pain relief. Routine injections were generally not medically necessary.

d. CPT code 11308 was indicated for the removal of a skin lesion over 2 cm, such as cysts, warts or a suspected malignant growth, for biopsy and/or to relieve pain or intense itching. The procedure involved cutting away the lesion by scalpel using local anesthesia.

e. CPT code 11721 was indicated for the debridement of infected toenails. The procedure was considered routine foot care and not usually covered by Medicare unless the patient had a systemic disease, or met other coverage criteria.

30. In all, by the above means, defendant STEPHEN A. MONACO, through A Foot Above, obtained more than $5,000,000 from insurers including Medicare, Medicaid, Independence Blue Cross, Highmark Blue Cross, AETNA and Amerihealth, in payment on the fraudulent claims.

31. From in or about January 1, 2008 through October 31, 2014, in the Eastern District of Pennsylvania, defendant

STEPHAN A. MONACO

in connection with the delivery of and payment for health care benefits, items and services, knowingly and willfully executed a scheme and artifice to defraud Medicare, Medicaid, Independence Blue Cross, Highmark Blue Cross, AETNA and Amerihealth, each of which is a health care benefit program affecting commerce, as defined in Title 18, United States Code, Section 24(b), and to obtain, by means of false and fraudulent pretenses, representations, and promises, money and property owned by and under the custody and control of those health care benefit programs, that is: the defendant caused the submission of claims to Medicare, Medicaid, Independence Blue Cross, Highmark Blue Cross, AETNA and Amerihealth, that falsely and fraudulently sought reimbursement for health care services and procedures, and that falsely and fraudulently failed to disclose the fact that the submitted health care services and procedures were not actually provided to the insurance beneficiaries, and by submitting and causing to be submitted fraudulent health care insurance claims for services that were not medically necessary, and for services that the defendant knew were not reimbursable.

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

NOTICE OF FORFEITURE

THE UNITED STATES ATTORNEY FURTHER CHARGES THAT:

1. As a result of the violation of Title 18, United States Code, Section 1347, set forth in this information, defendant

STEPHAN A. MONACO

shall forfeit to the United States of America any property that constitutes or is derived from gross proceeds traceable to the commission of such offense, as charged in this information, including, but not limited to, the sum of $5,000,000, which includes approximately $975,000 in United States currency seized and restrained by the United States pursuant to Civil Action 14-5592.

2. If any of the property subject to forfeiture, 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;

it is the intent of the United States, pursuant to Title 18, United States Code, Section 982(b), incorporating Title 21, United States Code, Section 853(p), to seek forfeiture of any other

property of the defendant up to the value of the property subject to forfeiture.

All pursuant to Title 18, United States Code, Section 982(a)(7).

ZANE DAVID MEMEGER
UNITED STATES ATTORNEY