UNITED STATES DISTRICT COURT

for the

District of New Jersey

United States of America
v.
MORRIS ANTEBI

Case No. 20-MJ-4020

Defendant(s)

CRIMINAL COMPLAINT

I, the complainant in this case, state that the following is true to the best of my knowledge and belief.

On or about the date(s) of Nov. 2015 - at least Feb. 2020 in the county of Atlantic and elsewhere in the _____ District of New Jersey, the defendant(s) violated:

Code Section	*Description of Offenses*
Title 18, United States Code, Sections 1347, 1343, 1341, and 2	Health care fraud; wire fraud; mail fraud; aiding and abetting, as more fully described in Attachment A.

This criminal complaint is based on these facts:

See Attachment B

☑ Continued on the attached sheet.

Complainant's signature

Special Agent James A. Smith, FBI
Printed name and title

Attested to by the applicant in accordance with the requirements of Fed. R. Crim. P. 4.1 by telephone *(specify reliable electronic means)*.

Date: 11/06/2020

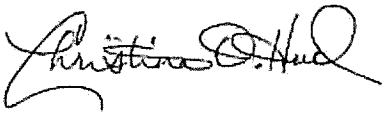
Judge's signature

City and state: District of New Jersey

Hon. Joel Schneider, U.S. Magistrate Judge
Printed name and title

CONTENTS APPROVED

UNITED STATES ATTORNEY



By:_____

CHRISTINA O. HUD, Assistant U.S. Attorney

DANIEL A. FRIEDMAN, Assistant U.S. Attorney

Date: November 6, 2020

ATTACHMENT A

COUNT 1
(Health Care Fraud)

From in or about November 2015 through at least as late as February 2020, in the District of New Jersey and elsewhere, defendant

MORRIS ANTEBI

knowingly and willfully executed and attempted to execute a scheme and artifice to defraud health care benefit programs and to obtain by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody or control of, such 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, Sections 1347 and 2.

COUNT TWO
(Wire Fraud)

From in or about November 2015 through at least as late as February 2020, in the District of New Jersey, and elsewhere, having devised and intending to devise a scheme and artifice to defraud and for obtaining money and property by means of materially false and fraudulent pretenses, representations, and promises, defendant

MORRIS ANTEBI

did knowingly and with fraudulent intent transmit and cause to be transmitted by means of wire communications in interstate commerce writings, signs, signals, pictures, and sounds for the purpose of executing such scheme and artifice.

In violation of Title 18, United States Code, Sections 1343 and 2.

COUNT THREE
(Mail Fraud)

From in or about November 2015 through at least as late as February 2020, in the District of New Jersey, and elsewhere, having devised and intending to devise a scheme and artifice to defraud and for obtaining money and property by means of materially false and fraudulent pretenses, representations, and promises, defendant

MORRIS ANTEBI

did knowingly and with fraudulent intent transmit and cause to be placed in a post office or authorized depository for mail, and caused to be delivered in accordance with directions thereon, certain mail matter to be sent and delivered by the United States Postal Service or any other private or commercial interstate carrier, and took and received therefrom any such matter or thing, for the purpose of executing such scheme and artifice.

In violation of Title 18, United States Code, Sections 1341 and 2.

ATTACHMENT B

INTRODUCTION:

1. I, James A. Smith, am a Special Agent with the United States Department of Justice, Federal Bureau of Investigation ("FBI") and have been so employed for over four years. I am currently assigned to the white collar crime squad, which investigates health care fraud, economic crimes, and other fraud offenses. As a Special Agent with the FBI, I have received extensive training in the investigation of violations of federal law, including specialized training in the investigation of health care fraud and narcotics cases. During my tenure as an FBI Special Agent, I have conducted and participated in numerous health care fraud and narcotics investigations. Additionally, I have participated in other aspects of investigations, such as conducting surveillance, analyzing information received from subpoena responses, interviewing witnesses, evaluating health care data and records, and testifying before the grand jury.

2. I am familiar with the facts set forth below based on my own knowledge and investigation, conversations with other law enforcement officials, and my review of reports, documents, data, memoranda, and other evidence. Where statements of others are related herein, they are related in substance and part. Since this Complaint is being submitted for the sole purpose of establishing probable cause, I have not set forth each and every fact known to me concerning this investigation. Where I assert that an event took place on a particular date, I am asserting that it took place on or about the date alleged.

3. The FBI, Department of Health and Human Services—Office of the Inspector General ("HHS-OIG"), the United States Department of Labor—Office of Inspector General ("US-DOL"), the Drug Enforcement Administration ("DEA"), and the Internal Revenue Service—Criminal Investigations ("IRS-CI") have been investigating fraudulent conduct regarding the below described medical provider and associated medical practices ("the Investigation"). During the Investigation, law enforcement has collected and reviewed many documents, patient records, billing and financial records, insurance data, and other relevant materials. Law enforcement also conducted surveillance on numerous occasions and interviewed numerous individuals.

BACKGROUND:

At all times relevant to this Criminal Complaint:

4. MORRIS ANTEBI ("ANTEBI") was a resident of Long Branch, New Jersey. ANTEBI was a physician specializing in anesthesia and pain management licensed to practice medicine in New Jersey since approximately 1980.

5. ANTEBI owns and operates a pain management clinic chain with locations in Northfield, Vineland, Cape May Courthouse, and Toms River, New Jersey ("the Clinics").[1]

The Health Care Benefit Programs:

6. ANTEBI has been enrolled as a provider in the Medicaid and Medicare programs since approximately 1989. In addition to Medicaid and Medicare, ANTEBI and other health care professionals at the Clinics bill private health insurance and employee benefit plans, including but not limited to, "Private Insurance Company 1," "Private Insurance Company 2," "Private Insurance Company 3," and "Private Insurance Company 4" (collectively "the Private Insurance Plans"). Medicaid, Medicare, and the Private Insurance Plans billed by ANTEBI and others at the Clinics are each "health care benefit programs" affecting commerce as defined 18 U.S.C. § 24(b).

7. Medicaid is a program jointly funded by the federal government and individual states to assist low-income, disabled, and other qualified individuals to pay for health care. Medicaid reimburses hospitals, health care providers, and health care suppliers for qualifying services and products. The State of New Jersey participates in the Medicaid program. At all times relevant to this Complaint, the federal government provided funds to New Jersey through the Medicaid program, pursuant to Title XIX of the Social Security Act of 1965, 42 U.S.C. §§ 1396 *et seq.*, which were and are used for reimbursement of health care services and products.

8. Medicare is a federal program established by the Social Security Act to assist aged and other qualified individuals in paying for health care. Medicare reimburses health care providers and suppliers for health care services and products that are medically necessary and actually provided.

9. As the owner of the Clinics and in order to enroll and participate as a provider in Medicaid and Medicare, ANTEBI signed certifications in which he agreed to abide by applicable federal and state laws, rules, and regulations pertaining to the health care benefit programs. In so doing, ANTEBI acknowledged that making or causing the making of false claims and representations in connection with the health care benefits programs is a violation of law, and acknowledged potential criminal charges that could result from such conduct.

Claims Submission and Billing:

10. Providers submit claims for reimbursement for medical services and products to Medicaid, Medicare, and the Private Insurance Plans. Claims are required to reflect, among other things: (a) the procedure performed or service rendered; (b) the date of the provided service or item; (c) the patient's name; and (d) the name of the rendering physician

[1] ANTEBI opened the location in Toms River in approximately the fall of 2019. ANTEBI also previously operated Clinic locations in Sicklerville and Manahawkin, New Jersey during the relevant time period.

or health care professional. The service or procedure must be sufficiently documented in the medical record to support claims submitted to Medicaid, Medicare, or other insurance plans for payment.

11. Claims typically contain Current Procedural Terminology ("CPT") and/or Healthcare Common Procedure Coding Systems ("HCPCS") codes, which are standardized codes maintained by the American Medical Association to report medical, surgical, and diagnostic procedures and services. Each procedure or service receives an assigned CPT or HCPCS code, and each code receives a certain level of reimbursement.

12. Health insurance plans typically require that health care professionals who provide treatment to patients be identified in claims using a National Provider Identifier ("NPI") number unique to each provider. For certain types of services and procedures, health insurance plans will only reimburse for claims if the health care professional whose NPI number was used performed an in-person examination or face-to-face consultation with the patient.

13. ANTEBI has his own unique NPI number which is utilized for services and procedures purportedly provided by him at the Clinics. Other health care providers at the Clinics maintain their own NPI numbers for billing purposes.

14. According to former and current employees interviewed during the Investigation, Clinic staff use a pre-printed form known in the industry as a "superbill" to document the medical services rendered to a patient. The superbill contains a listing of CPT codes commonly used by the Clinics. The information from the superbill is input into a billing software package, which in turn generates an insurance claim form, known in the industry as a Centers for Medicare & Medicaid Services ("CMS") Claim Form 1500 ("Form 1500"). By signing Form 1500s, providers certify that their billings are "true, accurate and complete" and that "any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable Federal or State laws." Providers also certify that the services listed "were medically necessary to the health of th[e] patient and were personally furnished by me or my employee under my personal direction." The claims forms are then transmitted by mail or electronically to Medicaid, Medicare, or the Private Insurance Plans for reimbursement.

15. According to interviewed employees, ANTEBI is heavily involved in the billing process at the Clinics and reviews bills. Interviewed employees also advised law enforcement that ANTEBI is driven by profit.

16. To make a claim for reimbursement and receive payment from Medicaid:

a. Participating providers can submit claims in hard copy or electronically for processing. During the relevant time period, ANTEBI submitted claims to Medicaid in both hard copy and electronically;

b. If submitted in hard copy, the claims are submitted on Form 1500s. The paper Form 1500s are mailed to a Managed Care Organization ("MCO") in New Jersey that administers Medicaid for the patient. ANTEBI signed and submitted Form 1500s for Medicaid MCOs. The MCO scans and converts the paper Form 1500s to electronic claims, which are then uploaded into a claims processing system associated with Medicaid;

c. Providers may also submit claims electronically to an electronic clearinghouse and billing service affiliated with Medicaid. The MCO responsible for the administration of the majority of ANTEBI's Medicaid patients' coverage operates its clearinghouse and billing service in Arizona.

d. In order to submit Medicaid claims electronically, a representative of the Clinics—ANTEBI's family member, "Individual 1"—signed and submitted a form, which included certifications and acknowledgments on behalf of the Clinics, including: (i) payments and satisfaction of all claims will be from federal and state funds; (ii) any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal or state laws; and (iii) anyone who misrepresents or falsifies essential claims information or electronically produced data may be subject to fine and imprisonment;[2]

e. After the claims are processed through the claims processing system and finally adjudicated, they are submitted to the MCO's accounting system for payment. The MCO thereafter initiates an electronic funds transfer ("EFT") with funds to be deposited into the provider's bank account. Individual 1 signed an EFT authorization agreement on behalf of the Clinics authorizing the electronic transfer of Medicaid funds to the Clinics' bank account in New Jersey;

f. Medicaid providers—such as the Clinics operated by ANTEBI—are paid weekly by the Medicaid MCO. The State of New Jersey pays the Medicaid MCO once per month. The State receives federal funds from the federal government for its administration of the Medicaid program.

17. To make a claim for reimbursement and receive payment from Medicare:

a. As with Medicaid, participating providers submit claims electronically for processing to a Medicare system.

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[2] The Investigation has revealed that Individual 1 was involved in and worked directly with ANTEBI in the operation and management of the Clinics.

b. To submit the claims electronically to Medicare, ANTEBI filled out and signed an enrollment form in which he certified and acknowledged, among other things, that: (i) all submitted claims shall be "accurate, complete, and truthful," (ii) use of a provider's NPI number is equivalent to the provider's legal electronic signature and constitutes an assurance by the provider that services were performed as billed, (iii) he accepts responsibility for all Medicare claims submitted to CMS or designated contractors made by himself, his employees, or his agents, (iv) all claims will be paid from federal funds, and (v) misrepresentation or falsity in connection with the submission of claims is grounds for criminal penalties;

c. After a claim has been processed and finally adjudicated, it is submitted to Medicare's accounting system for payment. A Medicare contractor then initiates an EFT with Medicare funds to the provider's bank account;

d. ANTEBI signed an EFT authorization agreement with Medicare in which he certified, among other things, that he maintained sole control of the Clinics' bank account into which Medicare funds were transferred and that his conduct complied with Medicare regulations.

18. To make a claim for reimbursement and receive payment from Private Insurance Company 1:

a. As with Medicaid, providers can submit claims in hard copy or electronically for processing. During the relevant time period, ANTEBI submitted claims to Private Insurance Company 1 in both hard copy and electronically;

b. If submitted in hard copy, Form 1500s—which contain the same certifications and acknowledgements described above—are mailed to an entity affiliated with Private Insurance Company 1 in New Jersey. ANTEBI electronically signed Form 1500s for Private Insurance Company 1 patients. The Form 1500s are scanned and converted to electronic claims, which are then uploaded to a claims processing system;

c. If submitted electronically, providers submit electronic claims forms through the 837P process, which are passed through a claims processing system, and are thereafter absorbed into Private Insurance Company 1's claims processing system in New Jersey;

d. After the claims are processed through the claims processing system and finally adjudicated, they are remitted for payment;

e. During the relevant time period, Private Insurance Company 1 remitted payment to the Clinics both through EFT and by mailed check. For EFT transactions, the transfer was initiated from Private Insurance Company 1's account in Delaware to the Clinics' bank account in New Jersey. For mailed payments, the checks—which draw on Private Insurance Company 1's bank account in Delaware—were mailed from Private Insurance Company 1's office in New Jersey via the United States Postal Service to the Clinics in New Jersey.

19. To make a claim for reimbursement and receive payment from Private Insurance Company 2:

a. As with Medicaid, providers can submit claims hard copy or electronically. During the relevant time period, ANTEBI submitted claims to Private Insurance Company 2 in both hard copy and electronically;

b. When submitted in hard copy, a provider mails Form 1500s to Private Insurance Company 2's offices. The Form 1500s contain the same certifications and acknowledgements as those discussed above. ANTEBI signed Forms 1500s for Private Insurance Company 2. Private Insurance Company 2 scans and converts the paper claims to electronic form, which are then uploaded into a claims processing system;

c. When submitted electronically, the provider submits claims to an electronic gateway system. Thereafter, the claims are accepted into Private Insurance Company 2's internal claims processing system;

d. Once the claims are processed and finally adjudicated, they are submitted for payment. During the relevant time period, Private Insurance Company 2 remitted payment to the Clinics by mailed check. Over time, the checks were mailed from Private Insurance Company 2's various offices in the United States to the Clinics in New Jersey.

20. To make a claim for reimbursement and receive payment from Private Insurance Company 3:

a. ANTEBI signed and submitted Form 1500s in hard copy to an entity owned by Private Insurance Company 3 ("the Entity"). In so doing, ANTEBI made the same certifications and acknowledgments as

described above. The claims were mailed from the Clinics in New Jersey to the Entity's claims receipt center in Minnesota;

b. Upon receipt, the Entity then scans and converts the Form 1500s to electronic form. The Entity then electronically transmits the claims to another affiliate of Private Insurance Company 3 in Pennsylvania for processing and adjudication. Once claims are finally adjudicated, the Entity sends a paper check through the mail to the Clinics in New Jersey;

c. Private Insurance Company 3 also covers other patients separate and apart from those under the Entity. With respect to ANTEBI's practice, this second set of patients is largely based out of state in Pennsylvania. With respect to these claims, the Clinics submit the claims electronically to Private Insurance Company 3's portal, and Private Insurance Company 3 thereafter causes payment to be made to the Clinics through EFT to the Clinics' bank account in New Jersey.

21. To make a claim for reimbursement and receive payment from Private Insurance Company 4:

a. As with Medicaid, providers can submit claims hard copy or electronically. During the relevant time period, ANTEBI submitted claims to Private Insurance Company 4 in both hard copy and electronically;

b. When submitted in hard copy, a provider mails the claims forms, Form 1500s, to Private Insurance Company 4's offices in El Paso, Texas. The forms contain the same certifications and acknowledgements as those discussed above. ANTEBI signed Forms 1500s for Private Insurance Company 4. Private Insurance Company 4 scans and converts the paper claims to electronic form at a scanning facility in Lexington, Kentucky, and uploads them to a claims processing system;

c. When submitted electronically, the provider submits claims to an electronic gateway system. Thereafter, the claims are accepted into Private Insurance Company 4's internal claims processing system based in Connecticut;

d. Once the claims are processed and finally adjudicated, they are submitted for payment. During the relevant time period, Private Insurance Company 4 remitted payment to the Clinics by mailed check and by EFT. Insurance Company 4 mailed checks and caused checks to be mailed from its facilities to the Clinics in New Jersey. With respect

to electronic payment, Insurance Company 4 initiated or caused the initiation of EFT from its accounts, including in North Carolina and New York, to the Clinics' bank account in New Jersey.

e. ANTEBI previously signed an EFT authorization agreement with Private Insurance Company 4. During the relevant time period, at least one additional EFT authorization agreement was signed. That agreement listed Individual 1 as the primary contact for the Clinics, and was signed by another health care provider on behalf of the Clinics. In signing that agreement, the provider certified to the accuracy and completeness of the information.

THE FRAUDULENT SCHEME

22. The Investigation showed the following regarding billing at the Clinics:

a. Between approximately January 2014 and approximately January 2020, ANTEBI and other providers at the Clinics billed over $33 million total for services purportedly provided.

b. Of that amount, ANTEBI himself billed over $24.6 million for services he purportedly personally rendered or supervised. Of that approximate $24.6 million, ANTEBI billed more than $15.3 million to Medicaid and more than $8 million to Medicare.

c. Based on my training and experience, I know that such high numbers of billings for one health care provider are atypical and indicative of fraud and abuse.

23. As stated above, claims for reimbursement from Medicaid, Medicare, and the Private Insurance Plans typically utilize CPT or HCPCS codes for billing purposes. Many codes have a prescribed time duration based on a uniform system of coding known as the International Classification of Diseases ("ICD"). In general, a code assigning a longer period of patient evaluation or more complex procedure has a higher level of reimbursement associated with it. In submitting a claim with an associated time duration, the biller makes the representation that the provider spent the designated amount of time with the patient.

24. The below chart summarizes the top five most common codes with specified time durations based on ICD billed at the Clinics between 2015 and 2020:

CODE	CODE DESCRIPTION	DURATION
99213	Office or other outpatient visit for the evaluation and management of an established patient	15 minutes
99214	Office or other outpatient visit for the evaluation and management of an established patient (detailed)	25 minutes
99244	Office or other outpatient visit for the evaluation and management of an established patient (comprehensive)	60 minutes
99406	Smoking and tobacco use cessation counseling visit	7 minutes
99204	Office or other outpatient visit for the evaluation and management of patient (new patient)	45 minutes

25. Based on the ICD and industry guidance, these five commonly billed codes (as well as others billed at the Clinics) require face-to-face consultation between a provider and patient in order to be properly billed. In billing these claims, the biller represents that there has been a face-to-face consultation with the patient.

26. During the course of my training and experience, I have become familiar with the concept of "incident to" billing—instances in which auxiliary health care personnel provide services in connection with (*i.e.*, incident to) a physician's services.

27. Information collected from the insurance plans during the Investigation revealed that Private Insurance Company 1, Private Insurance Company 3, Private Insurance Company 4, and the MCO associated with the largest contingent of Medicaid patients at ANTEBI's practice do not permit or reimburse for "incident to" billing. *See also* 42 C.F.R. § 455.440; N.J.A.C. § 10:66-6.1(c)(1)(vii). This was relayed to ANTEBI and the Clinics in insurance guidance, policies, regulations, and regulatory and insurance audits. The vast majority of patients at the Clinics had insurance coverage through these four health care benefit plans.

28. Information obtained during the Investigation indicated that, in certain instances, Medicare and Private Insurance Company 2 permit "incident to" billing. In such instances, in order to be legitimate billing, services and supplies must be furnished under the direct supervision of the physician. 42 C.F.R. § 410.26. "Direct supervision" requires the supervising physician to be physically present in the office and available to provide assistance. 42 C.F.R. § 410.32. Moreover, the person who furnished the service under the physician's direct supervision must have the proper education, training, credentials, and registrations to perform the services and be legally authorized to perform them. 42 C.F.R. §§ 410.74-76.

Out-of-Office Billings:

29. Travel records and other information obtained during the Investigation show that ANTEBI often traveled outside of New Jersey, both domestically and internationally, on many occasions between 2015 and 2020. Thus, ANTEBI was not physically present at the Clinics during these periods of time.

30. As described above, the most commonly billed codes at the Clinics under ANTEBI's NPI number require face-to-face consultation with patients in order to be billed properly. ANTEBI could not have consulted with patients face-to-face if he was outside the State of New Jersey at the time.

31. As also described above, several insurance plans associated with the majority of patients at the Clinics did not allow for "incident to" billing by auxiliary medical personnel. For those insurance plans that did permit "incident to" billing in certain instances, all services performed by auxiliary medical personnel and billed under ANTEBI's NPI needed to be performed under ANTEBI's direct supervision, which required him to be physically present in the office. 42 C.F.R. §§ 410.26; 410.32. ANTEBI could not directly supervise any auxiliary personnel if he was traveling and not physically present in the office.

32. A review of billing and patient records obtained during the Investigation revealed that, on dates when ANTEBI was traveling, billings under his NPI number showed that he was the rendering provider and billed for services requiring a face-to-face consultation. For example:[3]

a. Travel records show that ANTEBI traveled to Istanbul, Turkey on or about October 17, 2019 and was out of the country until on or about October 23, 2019. ANTEBI billed for seeing approximately 39 patients face-to-face on or about October 21, 2019.

b. Travel records show that ANTEBI traveled to Beijing, China on or about August 28, 2019 and was out of the country until on or about September 5, 2019. ANTEBI billed for seeing approximately 27 patients face-to-face on or about September 4, 2019.

c. Travel records show that ANTEBI traveled to Israel on or about June 6, 2019 and was out of the country until on or about June 20, 2019. ANTEBI billed for seeing approximately 33 patients face-to-face on or about June 10, 2019. ANTEBI billed for seeing approximately 38

[3] The below travels are a representative sample of dates when ANTEBI billed insurance while he was out of the country or outside the State of New Jersey. There are many other instances not directly noted herein in which ANTEBI billed insurance plans for services he purportedly rendered or supervised while away on international or domestic travel. For purposes of this Criminal Complaint, I have included these specific instances of travel and billing as examples reflective of a larger group.

patients face-to-face on or about June 12, 2019. ANTEBI billed for seeing approximately 37 patients face-to-face on or about June 13, 2019. ANTEBI billed for seeing approximately 35 patients face-to-face on or about June 14, 2019.

d. Travel records show that ANTEBI traveled to the Dominican Republic on or about February 1, 2019 and was out of the country until on or about February 4, 2019. ANTEBI billed for seeing approximately 18 patients face-to-face on or about February 3, 2019.

e. Travel records show that ANTEBI traveled Israel on or about February 27, 2018 and was out of the country until on or about March 6, 2018. ANTEBI billed for seeing approximately 35 patients face-to-face on or about March 5, 2018.

f. Travel records show that ANTEBI traveled to Italy and the Netherlands on or about October 10, 2017 and was out of the country until on or about October 17, 2017. ANTEBI billed for seeing approximately 35 patients face-to-face on or about October 13, 2017. ANTEBI billed for seeing approximately 26 patients face-to-face on or about October 16, 2017.

g. Travel records show that ANTEBI traveled to Istanbul, Turkey or about August 30, 2017 and was out of the country until on or about September 6, 2017. ANTEBI billed for seeing approximately 21 patients face-to-face on or about September 5, 2017. ANTEBI billed for seeing approximately 35 patients face-to-face on or about September 6, 2017.

h. Travel records show that ANTEBI traveled to England and Germany on or about May 25, 2017 and was out of the country until on or about June 4, 2017. ANTEBI billed for seeing approximately 40 patients face-to-face on or about May 26, 2017. ANTEBI billed for seeing approximately 45 patients face-to-face on or about May 31, 2017.

i. Travel records show that ANTEBI traveled to Spain and France on or about March 1, 2017 and was out of the country until on or about March 5, 2017. ANTEBI billed for seeing approximately 25 patients face-to-face on or about March 2, 2017.

33. ANTEBI billed approximately $230,700.00 to Medicaid, Medicare, and the Private Insurance Companies between November 2015 and January 2020 for services purportedly rendered by him or directly supervised by him while he was traveling and out of the office.

"Impossible Days" Billing:

34. The Investigation revealed that, over the course of several years, ANTEBI had numerous excessive billings for one-day periods of time, resulting in what is commonly referred to by law enforcement as "impossible day scenarios."

35. For example, when considering billings for which ANTEBI's NPI number was used as the rendering provider between 2014 and early 2020, the insurance plans at the Clinics were billed for more than 24 hours' worth of services in a one-day period of time on more than 900 occasions. Based on my training and experience, I know that purportedly providing more than 24 hours of services in a given day is impossible and a likely indicator of fraud.

36. Also between 2014 and early 2020, ANTEBI billed all insurance companies at the Clinics for providing between 12 and 23.99 hours of purported services in a one-day period of time on more than 300 occasions. Based on my training and experience, I know that it is very unlikely that billed-for services and procedures were legitimate.

37. For example, the below chart shows several instances between 2016 and 2019 in which ANTEBI billed impossible or unreasonably high amounts in given one-day periods:

NO.	DATE	HOURS
1	5-25-2016	78.182
2	4-3-2019	69.934
3	3-18-2019	56.23
4	1-18-2017	55.184
5	4-30-2018	53.735
6	11-7-2017	53.372
7	4-24-2019	53.116
8	7-3-2019	52.131
9	5-20-2019	51.436
10	12-1-2017	51.087
11	6-5-2019	50.77
12	9-17-2018	50.467
13	10-10-2017	49.919
14	10-19-2016	49.637
15	3-25-2019	49.266
16	11-13-2019	49.147

No.	Date	Hours
17	3-13-2019	49.068
18	8-26-2019	48.668
19	7-15-2019	48.149

38. During the Investigation, law enforcement surveilled ANTEBI leaving the Clinics early on days when billing records show he claimed to see several Medicaid and Medicare patients. For example:

Date	Number of Medicaid & Medicare Beneficiaries ANTEBI Billed for
1-24-2020	48
1-30-2020	100
1-31-2020	64
2-7-2020	42

Based on my training and experience, I believe it is highly unlikely that ANTEBI actually saw all these patients on these days.

39. Law enforcement interviewed patients during the Investigation. Several patients reported that their patient visits were very brief and typically lasted less than five minutes. A review of those patients' medical records showed that insurance plans were billed using codes requiring longer periods of evaluation.

40. Patients also advised law enforcement that ANTEBI often would not physically examine them, take a full medical history, or perform tests during appointments. One former employee advised that ANTEBI often billed multiple CPT codes for one brief patient visit, and billed as though he performed physical exams of patients when he did not do so. Information obtained during the Investigation also indicated that there was often no medical equipment or examination tables in the rooms at the Clinics in which patients met with providers, and that patients sometimes met with providers on folding chairs in the hallway of the Clinics.

41. The Investigation likewise revealed that, over the course of several years, ANTEBI has on many occasions claimed to see an inordinately high number of patients in a one-day period in his billing submissions to insurance companies. Based on my training and experience, I know that claiming to see such high number of patients in a one-day period is a likely indicator of fraud.

42. For example, a review of patient charts signed by ANTEBI on the following days shows a sample of days that ANTEBI claimed to see inordinately high numbers of patients:

DATE	NUMBER OF PATIENTS BILLED IN ONE-DAY PERIOD	NUMBER OF HOURS BILLED
6-22-2018	115	22.7
6-28-2018	149	30.1
7-6-2018	136	27.3
7-27-2018	118	25
8-10-2018	140	26
8-23-2018	155	34
8-24-2018	141	29.3

43. Certain Clinic staff members interviewed during the Investigation acknowledged that it would not be possible to see such high numbers of patients and spend meaningful time with them.

44. As discussed above, the vast majority of patients at the Clinics maintain insurance plans—Private Insurance Company 1, Private Insurance Company 3, Private Insurance Company 4, and the plan associated with the largest contingent of Medicaid patients at ANTEBI's practice—that do not permit or reimburse for "incident to" billing. *See also* 42 C.F.R. § 455.440; N.J.A.C. § 10:66-6.1(c)(1)(vii). Thus, in billing for services provided to a patient with one of these insurance plans, only ANTEBI could legitimately bill for those services. It would be fraudulent for ANTEBI to permit other auxiliary personnel to bill under his NPI number for services provided to patients with these insurance plans.

45. If "incident to" billing did occur at the Clinics in connection with Medicare and/or Private Insurance Company 2 patients, in causing the claims to be submitted under his NPI number, ANTEBI represented that he either rendered those services personally or that a properly credentialed and legally authorized employee rendered the services under his direct supervision.

46. Even if auxiliary personnel saw patients at the Clinics, the visit would need to occur under ANTEBI's direct supervision in order to legitimate "incident to" billing. Based on my training and experience, I know that, given the very high number of claimed patients and billings under ANTEBI's NPI number, it would not have been possible for ANTEBI to independently see patients while simultaneously directly supervising auxiliary medical personnel performing services. In fact, former employees of the Clinics advised law enforcement that ANTEBI did not physically see many patients in actuality.

47. Moreover, information obtained during the Investigation showed that personnel who could have been qualified to provide "incident to" services at the Clinics

maintained and billed under their own assigned NPI numbers, and therefore could not have likewise permissibly billed under ANTEBI's NPI number. If other auxiliary personnel at the Clinics besides these individuals performed "incident to" services under ANTEBI's NPI number, they likely would not have had the proper education, training, credentials, and registrations to perform the services or be legally authorized to do so.

48. Accordingly, based on the above, ANTEBI caused the submission of numerous false and fraudulent claims to Medicare, Medicaid, and the Private Insurance Plans, and he knowingly and with fraudulent intent caused these claims and associated payments to be transmitted by means of wire communication in interstate commerce or through the mail.

Respectfully submitted,

James A. Smith
Special Agent, FBI

Pursuant to Fed. R. Crim. P. 4.1, Special Agent James A. Smith was sworn and attested to the contents of this affidavit in support of the issuance of an arrest warrant and criminal complaint charging defendant MORRIS ANTEBI with health care fraud, wire fraud, and mail fraud, as set forth in Attachment A.

Date: November 6th, 2020

HON. JOEL SCHNEIDER
United States Magistrate Judge