UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

vs.

DANIEL CASTRO, M.D.,

Defendant.
_____/

INDICTMENT

The Grand Jury charges:

INTRODUCTION

1. Defendant is a medical doctor with board-certification in otolaryngology. An otolaryngologist specializes in the care and treatment of the head and neck, including the ears, nose and throat. Otolaryngologists are commonly called ear, nose and throat (or "ENT") physicians.

2. From February 2015 until May 2017, Bronson Hospital employed Defendant to provide care for patients at its newly formed ENT clinic at its hospital location in Battle Creek. In that role, Defendant conducted office consultations and performed surgical procedures. His surgical procedures included Functional Endoscopic Sinus Surgeries (FESS) and surgeries of the neck.

3. Defendant caused Bronson to submit claims for his services to health care benefit programs, as defined in 18 U.S.C. § 24(b), in that each program was a public or private plan or contract, affecting interstate commerce, under which medical benefits, items, and services were provided to individuals. When Defendant performed surgical procedures, the submitted claims included requests for payment for services provided by Defendant, as well as claims for facility

and related expenses incurred by Bronson Hospital. The health care benefit programs included but were not limited to Medicaid of Michigan, private managed health care plans who contracted with Medicaid of Michigan, Medicare, and Blue Cross-Blue Shield, among others.

MEDICAID AND MEDICARE

4. Defendant was a participating provider with the Michigan Medicaid Program ("Medicaid"). Medicaid required physicians to provide a diagnostic code and a procedure code on claims in order to be paid for professional services rendered to Medicaid beneficiaries. Payment for services depended upon the specific diagnostic and procedure codes indicated on the claim form. Medicaid, and its associated managed care plans, distributed payments to participating providers by sending checks through the United States mail or through electronic funds transferred to the provider's financial institution.

5. Defendant was also a participating provider with Medicare. The Centers for Medicare and Medicaid Services (CMS) was an agency of the United States responsible for administering the provisions of the federal Medicare Program, which provided health insurance to the aged and disabled under the provisions of the Social Security Act. Medicare benefits were provided by law to most persons who had attained the age of 65 and to certain disabled persons. Medicare coverage included "Part B" benefits, which authorized payments for professional services rendered by physicians. Medicare Part B covered a percentage of the fee schedule for physician services as well as a variety of other medical services. Medicare coverage also included "Part A" benefits, which authorized payment to the facilities or hospitals where professional services were provided.

6. Wisconsin Physicians Services (WPS) contracted with CMS to process Part B claims in the State of Michigan. Pursuant to that agreement, WPS distributed federal Medicare funds for the professional services provided by physicians.

CLAIMS FOR COVERED SERVICES

7. A claim for payment is submitted to a health care benefit program on CMS Form 1500. For a claim to be paid by the health care benefit program, the Form 1500 had to document each service rendered to the plan member by the healthcare provider. The services are identified through a corresponding procedure code listed in the American Medical Association (AMA) publication called the Current Procedural Terminology ("CPT") Manual. The CPT Manual contains a systematic list of codes for procedures and services performed by or at the direction of a physician or other health care providers.

8. The AMA also published the International Classification of Diseases ("ICD-10") Manual, which assigns a unique numeric identifier to numerous diseases and medical conditions. In order to be properly payable by health care benefit programs, a claim on Form 1500 must include the proper ICD-10 code specifying the underlying medical condition or disease necessitating the medical procedure, treatment, or durable medical equipment. Payment for services by the health care benefit programs depends upon the CPT and ICD-10 codes listed on the claim form.

9. Additionally, even if a health insurance claim for payment specifies the appropriate codes, health care benefit programs only pay health care practitioners for "covered services." Covered services include only those health care services which are, among other things, "medically necessary" or performed or provided out of "medical necessity."

10. At all times relevant to this indictment, the health care benefit programs utilized participation agreements, manuals, or other policies that required health care providers to comply

with certain terms and conditions. Each health care benefit program maintained terms and conditions that essentially defined the terms "medically necessary" and "medical necessity" as health care services that a practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are in accordance with generally accepted standards of medical practice.

11. In submitting claims for payment to the health care benefit programs, providers represented that the information on the claim form presented an accurate description of the services rendered and that the services were medically necessary.

WORK RELATIVE VALUE UNITS AND DEFENDANT'S COMPENSATION

12. Each service performed by a physician and associated with a CPT code is additionally assigned a Work Relative Value Unit (wRVU). A wRVU generally reflects the relative time and intensity associated with furnishing the service reflected in the CPT code. As a general matter, more complicated and time-consuming surgical procedures are assigned higher wRVUs and receive higher compensation from health care benefit programs.

13. Defendant's contract of employment with Bronson Battle Creek Hospital included compensation provisions that utilized wRVUs to determine the amount of both his base salary and bonus compensation. Generally speaking, the more surgeries Defendant performed, the higher the total of his wRVUs. And the higher the total number of wRVUs achieved by Defendant, the greater the amount of his compensation.

FUNCTIONAL ENDOSCOPIC SINUS SURGERY

A. Generally

14. There are four separate sinus cavities on each side of the head. The maxillary sinus is below the eye, the ethmoid sinus is between the eye and the nose or nasal cavity, the

sphenoid sinus is behind the nasal cavity and the frontal sinus is above the eye in the forehead region.

15. Cilia (or very small hair-like organisms) transport mucus in defined patterns from the maxillary sinuses, ethmoid sinuses, and frontal sinuses to an area where those sinuses meet, called the ostiomeatal complex ("OMC"). The OMC is the final drainage pathway into the nose from the sinuses.

16. Environmental allergies, viral illnesses, bacterial infections, nasal polyps, irritants or other conditions can cause narrowing and/or blockage of the normal anatomic sinus pathways and/or blockage of the OMC resulting in symptoms. The most common cause of symptoms is rhinosinusitis, which is inflammation of the nose and all or some of the sinuses. Generally, rhinosinusitis is categorized as "chronic" when symptoms last for 12 weeks or more.

17. FESS is a surgical procedure involving the sinuses that is performed with an endoscope (a thin lighted fiber-optic glass rod inserted through the nose, which is typically attached to a camera and television monitor for viewing). The purpose of FESS is to restore sinus function by reestablishing the normal anatomical pathways and drainage of the sinuses.

18. In almost all cases, an otolaryngologist treating chronic rhinosinusitis begins with conservative medical therapies. These can include saline rinses, antibiotics, decongestants and cordicosteroidal nasal spray, among others.

19. If conservative medical therapies do not resolve the problem, a computed tomography scan ("CT scan") of the sinuses is typically performed to determine if and where disease or blockage is present in the nose, sinuses and OMC. The CT scan additionally provides anatomical landmarks in and around each particular patient's sinus cavities should surgery be required.

20. If FESS is appropriate, the operation is limited to only those sinuses that are blocked or irreversibly diseased, which is, for the most part, determined by the presence of disease on a CT scan that failed to respond to conservative medical treatment. Uninvolved sinuses should be left alone.

21. During FESS, the otolaryngologist removes irreversibly diseased mucosa, abnormal tissue, and underlying thin bony walls, preserving all normal tissue, and widening the opening of the sinuses.

22. The CPT Manual contains separate CPT codes for surgical procedures performed on each of the maxillary, ethmoid, frontal and sphenoid sinuses. These include, among others: CPT code 31255 (ethmoidectomy); CPT code 31256 (maxillary antrostomy); CPT code 31267 (maxillary antrostomy with tissue removal); CPT code 31276 (frontal sinus endoscopy); CPT code 31287 (sphenoidotomy); and CPT code 31288 (sphenoidotomy with tissue removal). A physician performing surgery on a particular sinus cavity on both sides of the patient's head would use the code assigned to that sinus cavity and modifier 50 (from the CPT Manual), which reflects that the surgery was bilateral or done on both sides of the body.

B. Coding for Tissue Removal

23. FESS most commonly involves restoring the normal anatomical pathways leading to some or all of the various sinus cavities through one or more procedures called a maxillary antrostomy, an ethmoidectomy, a frontal sinusotomy, or a sphenoidotomy. These procedures open up the pathways and entrances to the sinuses.

24. Occasionally, a surgeon must also remove diseased tissue from *inside* the sinuses to avoid additional blockage of the entrance to the sinuses and to restore normal function.

25. The CPT Manual distinguishes between simply opening the entrance to the maxillary sinuses (maxillary antrostomy) or sphenoid sinuses (sphenoidotomy) and removing abnormal or diseased tissue from *inside* the maxillary or sphenoid sinuses.

26. Specifically, CPT code 31256 is properly billed when a surgeon performs a maxillary antrostomy and opens the normal pathways to the maxillary sinuses. CPT code 31267 is properly billed when a surgeon performs the maxillary antrostomy and removes irreversibly abnormal or diseased tissue from *inside* the maxillary sinuses.

27. Similarly, CPT code 31287 is properly billed when a surgeon performs a sphenoidotomy and opens the normal pathways to the sphenoid sinuses. CPT code 31288 is properly billed when a surgeon performs the sphenoidotomy and removes irreversibly abnormal or diseased tissue from *inside* the sphenoid sinuses.

28. The removal of irreversibly abnormal or diseased tissue from *inside* the sinuses requires more skill and more work than merely performing a simple maxillary antrostomy or sphenoidotomy to open the pathway to the sinuses. As a result, CPT codes 31267 and 31288 are assigned higher wRVUs than the CPT codes associated with performing a maxillary antrostomy or sphenoidotomy alone. Additionally, health care benefit programs pay more for CPT codes 31267 and 31288 than the CPT codes associated with a maxillary antrostomy or sphenoidotomy.

RADICAL, MODIFIED RADICAL, AND SELECTIVE NECK DISSECTIONS AND CPT CODES 38720 AND 38724

29. The neck is divided into levels or regions that contain systems of lymph nodes (the "lymphatic systems") and corresponding important non-lymphatic anatomical structures: the sternocleidomastoid muscle; jugular vein; spinal accessory nerve, and other nerves or major salivary glands ("non-lymphatic anatomical structures").

30. The lymph nodes are part of the body's immune system and help protect the body from illness. The lymphatic system is also an avenue for cancers to spread. Cancers of the head and neck often spread (metastasize) to the lymph nodes of the neck. Depending on the location of the cancer, particular neck levels are at risk for spread to the lymph nodes.

31. A neck dissection is a serious and complicated neck surgery for cancer. A neck dissection is a component of head and neck cancer therapy. This surgery removes the lymph nodes involved with cancer or those lymph nodes at high risk for cancer spread in patients with head and neck cancer as a part of a comprehensive cancer treatment plan.

32. There are generally three types of neck dissections: 1) a radical neck dissection; 2) a modified radical neck dissection; and 3) a selective neck dissection.

33. In a radical neck dissection, the lymphatic systems of all 5 levels of the lateral neck (levels 1-5) are removed, along with removal of the sternocleidomastoid muscle, internal jugular vein and spinal accessory nerve.

34. A modified radical neck dissection also removes the lymphatic systems of all 5 levels of the lateral neck (levels 1-5); however, one or more of the following structures is preserved: the sternocleidomastoid muscle, internal jugular vein and spinal accessory nerve.

35. In a selective neck dissection, the lymphatic systems from only those levels that are known to be at high risk of cancer spread are removed. These levels are determined by the location of the primary cancer. At least 2 levels of the neck are removed during a selective neck dissection, though typically 3 or 4 levels are removed.

36. A radical neck dissection is billed using CPT code 38720. A modified radical neck dissection or a selective neck dissection is billed using CPT code 38724.

37. The contents of a neck dissection must be submitted to the pathology department of the hospital at the conclusion of the surgical procedure. This is critical for, among other things, quantifying the number of lymph nodes involved with cancer and identifying pathological features of the lymph nodes that would require further treatment with radiation therapy or chemotherapy.

38. Because the goal of a neck dissection is the removal of lymph nodes from multiple levels of the neck, the contents of the neck removed during a neck dissection will contain the presence of numerous lymph nodes.

39. Additionally, because a neck dissection results in the removal of lymph nodes from multiple levels of the neck, and because important anatomical structures must be dissected and protected, the surgical procedure is performed by using a sizeable incision in the patient's neck.

40. Because of its complexity, high risk, and technical demands as part of a cancer therapy, health care benefit programs pay a much higher price for a neck dissection and the procedure is assigned higher wRVUs than most other surgical procedures of the neck, including gland excisions, cyst removals, or simple individual excisional lymph node biopsy. For example, during the relevant time period, a modified radical neck dissection was assigned 23.9 wRVUs, while a submandibular gland excision (a salivary gland in the neck) was assigned 6 wRVUs, and a single excisional lymph node biopsy between 3-7 wRVUs, depending upon the location of the lymph node.

PREPARATION AND SUBMISSION OF CLAIMS FOR PAYMENT
TO HEALTH CARE BENEFIT PROGRAMS

41. Defendant, like all physicians at Bronson Battle Creek Hospital, was responsible for selecting and entering into the hospital's electronic medical records system the appropriate procedural code from the CPT Manual for the surgical procedures that he performed.

42. Defendant, like all physicians at the hospital, was responsible for selecting and entering into the hospital's electronic medical records system the appropriate diagnosis code from the ICD-10 Manual for the surgical procedures that he performed.

43. Defendant knew that his operative report and other medical records he prepared would be used by the individuals employed in the hospital's billing and coding department to review his procedural and diagnosis codes and to make a final determination of the appropriate services that should be submitted for payment on the CMS 1500 claim form to the patient's health care benefit program.

44. Defendant also knew that the health care benefit programs would rely upon the procedural and diagnosis codes on the submitted CMS 1500 form in determining whether and how much to pay for the services he rendered.

COUNTS 1-12

(Health Care Fraud – Medically Unnecessary Functional Endoscopic Sinus Surgeries)

Paragraphs 1 to 22 and 38 to 41 above are incorporated as if fully set forth herein.

From in or about February 2015, and continuing to in or about May 2017, in the Southern Division of the Western District of Michigan,

DANIEL CASTRO, M.D.,

defendant, knowingly and willfully executed a scheme and artifice to defraud and to obtain money from various health care benefit programs, by means of false and fraudulent pretenses and representations, in connection with the delivery of and payment for health care benefits and services. Specifically, Defendant routinely performed FESS procedures that were not medically necessary.

THE PURPOSE OF THE SCHEME TO DEFRAUD

45. The purpose of the scheme to defraud was for Defendant to maximize his total wRVUs, thereby maximizing his compensation, by performing lucrative FESS procedures on a substantial percentage of his patients and on all or most of a patient's sinus cavities even when such procedures were not medically necessary.

THE SCHEME TO DEFRAUD

46. It was part of the scheme to defraud that on the first office visit Defendant routinely recorded findings as part of the patient history that were untrue and were designed primarily to justify FESS on all or most of the sinuses. Defendant often created false office notes by recording these false findings in the history and physical section of the patient's medical records.

47. Defendant also routinely diagnosed his patients with chronic pansinusitis (inflammation and infection of all the sinuses) during his office consultations. Defendant

diagnosed chronic pansinusitis even for patients that suffered fractures from trauma sustained in a fall or an assault, and those who had no recent history, or any history at all, of suffering from sinus disease or chronic sinusitis. Defendant repeatedly used this diagnosis to justify performing FESS procedures on all of the patient's sinuses.

48. On many occasions, Defendant also made the decision to schedule his patients for FESS as part of the very first consultation and even before obtaining a CT scan of the patient's sinuses to confirm the presence, extent, and location of disease or other abnormalities affecting the patient's sinuses that would benefit from FESS.

49. Defendant additionally prescribed antibiotics and a corticosteroidal nasal spray at the first visit, but on many occasions did not allow sufficient time for this conservative medical therapy to work before the scheduled FESS. In most cases, Defendant only consulted with the patient once before performing surgery and did not meet with the patient prior to surgery to determine if the conservative medical treatment was effective, should be continued, or should be changed in an effort to avoid surgery.

50. It was further part of the scheme to defraud that at the first office consultation Defendant often ordered a CT scan of the sinuses to be performed at a later date. The results of the CT scans ordered by Defendant were almost always completely normal. On some very infrequent occasions, the CT scan noted minimal findings that did not justify FESS on any of the sinuses and certainly not on all or most of the sinuses.

51. Defendant routinely failed to share the findings of the CT scan with his patients prior to surgery. On those limited occasions when he did discuss the findings of the CT scan with his patients, Defendant did not inform the patients that the findings were normal and did not justify the FESS procedures he intended to perform. Instead, Defendant misled his patients by

telling them that FESS was medically necessary and by recording in the patient's medical records that the CT scan findings were abnormal when he knew they were not and he further knew that the report of the radiologist that interpreted the CT scan indicated that the sinuses were completely normal.

52. As a further part of the scheme to defraud, and in an effort to justify his surgical procedures, Defendant routinely "templated" his operative reports. Defendant knew that the billing and coding department would look for certain language in his operative report before allowing his billings for FESS procedures to be approved. Defendant used templates as part of his operative reports to ensure that the key language was part of his operative reports to justify CPT codes with even higher wRVUs and higher reimbursement.

53. By using "templated" language, Defendant repeatedly falsified his operative reports. Specifically, Defendant repeatedly described the presence of thick and infected polypoid disease, and other disease, in the OMC and the sinuses when he knew that this disease did not truly exist. Defendant also repeatedly reported that the OMC was obstructed or blocked when he knew that this statement was false.

EXECUTIONS OF THE SCHEME

54. On or about the dates set forth below, in the Western District of Michigan, Southern Division,

DANIEL CASTRO, M.D.,

defendant, knowingly and willfully executed the previously described scheme to defraud by causing the submission of claims for FESS procedures that were not medically necessary involving the patients, dates of service, and health care benefit programs set forth below:

Medically Unnecessary Procedures

COUNT	PATIENT	DATE OF SERVICE	PROCEDURE CODES	AMOUNT BILLED	CLAIM RECEIVED DATE	HEALTH CARE BENEFIT PROGRAM	CHIEF PRESENTING COMPLAINT
1	N.A.	8/4/16	31255 31267 31276 31288	1,852.00 1,586.00 2,666.00 1,508.00	08/16/16	Medicaid	Trauma/nose fracture
2	M.S.	8/5/16	31255 31267 31276 31288	1,852.00 1,586.00 2,666.00 1,508.00	08/09/16	BCBS	Tinnitus
3	J.L.	8/19/16	31255 31267 31276 31288	1,852.00 1,586.00 2,666.00 1,508.00	09/22/16	Accident Fund Workers Comp	Trauma/nose fracture
4	C.H.	9/12/16	31255 31267 31276 31288	1,852.00 1,586.00 2,666.00 1,508.00	10/07/16	Medicaid	Tonsils
5	M.C.	9/16/16	31255 31267 31276 31288	1,852.00 1,586.00 2,666.00 1,508.00	10/10/16	Medicaid	Child with recurring ear issues
6	D.F.	11/10/16	31255 31267 31276 31288	1,852.00 1,586.00 2,666.00 1,508.00	04/02/18	York Risk Services Workers Comp	Trauma from fall
7	H.S.	11/21/16	31255 31267 31276 31288	1,852.00 1,586.00 2,666.00 1,508.00	01/02/17	Medicaid	Child seen post-surgery for tonsils and adenoids
8	M.U.	12/9/16	31255 31267 31276 31288	1,852.00 1,586.00 2,666.00 1,508.00	12/30/16	Medicaid	Bump on bridge of nose
9	C.W.	12/9/16	31255	1,852.00	01/02/17	BCBS	Ears

COUNT	PATIENT	DATE OF SERVICE	PROCEDURE CODES	AMOUNT BILLED	CLAIM RECEIVED DATE	HEALTH CARE BENEFIT PROGRAM	CHIEF PRESENTING COMPLAINT
			31267 31276 31288	1,586.00 2,666.00 1,508.00			
10	P.T.	12/15/16	31255 31267 31276 31288	1,852.00 1,586.00 2,666.00 1,508.00	01/18/17	Medicare	Ears
11	L.M.	12/15/16	31255 31267 31276 31288	1,852.00 1,586.00 2,666.00 1,508.00	01/02/17	BCBS	Hoarseness
12	N.C.	1/13/17	31255 31267 31276 31288	1,852.00 1,586.00 2,666.00 1,508.00	01/31/17	BCBS	Ears

18 U.S.C. § 1347

COUNTS 13-22

(Health Care Fraud – Functional Endoscopic Sinus Surgery – Upcoding Tissue Removal)

Paragraphs 1 to 28 and 38 to 41 above are incorporated as if fully set forth herein.

From in or about February 2015, and continuing to in or about May 2017, in the Southern Division of the Western District of Michigan,

DANIEL CASTRO, M.D.,

defendant, knowingly and willfully executed a scheme and artifice to defraud and to obtain money from various health care benefit programs, by means of false and fraudulent pretenses and representations, in connection with the delivery of and payment for health care benefits and services. Specifically, Defendant routinely upcoded procedures related to the maxillary and sphenoid sinuses by falsely billing the tissue removal codes when in truth and in fact he had not removed irreversibly abnormal or diseased tissue from inside those sinus cavities but simply performed a maxillary antrostomy or sphenoidotomy opening the entrance to those sinus cavities.

SCHEME TO DEFRAUD

55. It was part of the scheme to defraud that Defendant regularly billed for removing tissue from within the maxillary and sphenoid sinuses using CPT codes 31267 and 31288 even when irreversibly abnormal or diseased tissue was not present.

56. In furtherance of the scheme, Defendant removed and sent healthy tissue to the pathology department of the hospital.

57. Defendant also falsified his operative reports to make it appear as if he removed abnormal or diseased tissue from *inside* the maxillary and sphenoid sinuses. Specifically, Defendant regularly stated in his operative reports that "the Osteo meatal [sic] complex bilaterally was noted to be obstructed with polypoid disease," and that ". . . the sphenoid ostium

was opened medially and inferiorly and widened with the straight forceps cleaning the sphenoid sinus from disease, all specimen [sic] were sent to pathology."

EXECUTIONS OF THE SCHEME

58. On or about the dates set forth below, in the Western District of Michigan, Southern Division,

DANIEL CASTRO, M.D.,

defendant, knowingly and willfully executed the previously described scheme to defraud by causing the submission of claims for the removal of irreversibly abnormal or diseased tissue from inside the maxillary and sphenoid sinuses when he knew he did not actually remove such tissue, for the patients, dates of service, and health care benefit programs identified below:

Upcoded Surgical Procedures

COUNT	PATIENT	DATE OF SERVICE	PROCEDURE CODES	AMOUNT BILLED	CLAIM RECEIVED DATE	HEALTH CARE BENEFIT PROGRAM
13	N.A.	8/4/16	31267 31288	1,586.00 1,508.00	08/16/16	Medicaid
14	E.G.	8/4/16	31267 31288	1,586.00 1,508.00	08/11/16	Medicaid
15	M.S.	8/5/16	31267 31288	1,586.00 1,508.00	08/09/16	BCBS
16	J.L.	8/19/16	31267 31288	1,586.00 1,508.00	09/22/16	Accident Fund Workers Comp
17	C.H.	9/12/16	31267 31288	1,586.00 1,508.00	10/07/16	Medicaid
18	M.C.	9/16/16	31276 31288	1,586.00 1,508.00	10/10/16	Medicaid
19	D.F.	11/10/16	31267 31288	1,586.00 1,508.00	04/02/18	York Risk Services Workers Comp
20	H.S.	11/21/16	31267 31288	1,586.00 1,508.00	01/2/17	Medicaid
21	C.W.	12/9/16	31267 31288	1,586.00 1,508.00	01/02/17	BCBS

COUNT	PATIENT	DATE OF SERVICE	PROCEDURE CODES	AMOUNT BILLED	CLAIM RECEIVED DATE	HEALTH CARE BENEFIT PROGRAM
22	P.T.	12/15/16	31267 31288	1,586.00 1,508.00	01/18/17	Medicare

18 U.S.C. § 1347

COUNTS 23-26
(Health Care Fraud – Functional Endoscopic Sinus Surgery – Billing for Services Not Provided)

Paragraphs 1 to 28 and 38 to 41 above are incorporated as if fully set forth herein.

From in or about February 2015, and continuing to in or about May 2017, in the Southern Division of the Western District of Michigan,

DANIEL CASTRO, M.D.,

defendant, knowingly and willfully executed a scheme and artifice to defraud and to obtain money from various health care benefit programs, by means of false and fraudulent pretenses and representations, in connection with the delivery of and payment for health care benefits and services. Specifically, Defendant routinely billed for FESS procedures that he did not actually perform.

SCHEME TO DEFRAUD

59. As part of the fraud scheme, Defendant also billed for services that he did not provide. Specifically, Defendant billed for performing surgery on all of a patient's sinuses when, in truth and in fact, he did not perform surgery on some of the sinuses because his patients were children for whom the frontal sinuses had not yet developed or individuals who did not have some of the sinuses due to anatomical abnormalities.

EXECUTIONS OF THE SCHEME

60. On or about the dates set forth below, in the Western District of Michigan, Southern Division,

DANIEL CASTRO, M.D.,

defendant, knowingly and willfully executed the previously described scheme to defraud by causing the submission of claims for sinus surgery procedures that he did not actually provide for the patients, dates of service, and health care benefit programs identified below:

Billing for Services Not Rendered

COUNT	PATIENT	DATE OF SERVICE	PROCEDURE CODE	AMOUNT BILLED	CLAIM RECEIVED DATE	HEALTH CARE BENEFIT PROGRAM	FRAUD DESCRIPTION
23	E.G.	8/4/16	31276	2,666.00	08/11/16	Medicaid	No frontal sinuses
24	M.C.	9/16/16	31276	2,666.00	10/10/16	Medicaid	No right frontal sinus
25	H.S.	11/21/16	31276	2,666.00	01/02/17	Medicaid	No left frontal sinus
26	P.T.	12/15/16	31276	2,666.00	01/18/17	Medicare	No right frontal sinus

18 U.S.C. § 1347

COUNTS 27-34

(Health Care Fraud – Upcoding – Modified Radical Neck Dissections)

The United States incorporates paragraphs 1 to 13 and 29 to 41 above as if fully set forth herein.

From in or about February 2015, and continuing to in or about May 2017, in the Southern Division of the Western District of Michigan,

DANIEL CASTRO, M.D.,

defendant, knowingly and willfully executed a scheme and artifice to defraud and to obtain money from various health care benefit programs, by means of false and fraudulent pretenses and representations, in connection with the delivery of and payment for health care benefits and services. Specifically, when causing the submission of claims to health insurance programs for certain neck surgeries, Defendant routinely billed CPT code 38724 for performing a modified radical or selective neck dissection that he knew he did not actually perform but instead performed a different procedure that was assigned a lower wRVU value and would have been reimbursed at a lower rate.

THE PURPOSE OF THE SCHEME TO DEFRAUD

61. It was the purpose of the scheme to defraud that Defendant fraudulently billed for modified radical or selective neck dissections that he knew he did not actually perform because he knew that the procedure was associated with a high number of wRVUs that would allow him to maximize his salary and bonus compensation.

THE SCHEME TO DEFRAUD

62. Defendant regularly billed for modified radical or selective neck dissections using CPT Code 38724 when he did not actually perform either of those surgical procedures.

63. It was part of the scheme to defraud that Defendant billed for performing modified radical or selective neck dissections on patients who had no history of cancer and who were not undergoing a comprehensive cancer treatment program.

64. Instead, Defendant actually performed much simpler surgical neck procedures, not associated with cancer treatment, that involved removal of the submandibular gland, a cyst, or excisional lymph node biopsy. The surgical specimens sent to pathology for these procedures were not consistent with a modified radical or selective neck dissection.

65. It was further part of the scheme to defraud that on some occasions Defendant falsified his operative reports. Specifically, Defendant prepared an operative report containing language consistent with having performed a modified radical or selective neck dissection, even though he actually performed a different procedure. Defendant created the false operative reports so that the language of the operative reports appeared to justify billing CPT Code 38724.

EXECUTIONS OF THE SCHEME

66. On or about the dates set forth below, in the Western District of Michigan, Southern Division,

DANIEL CASTRO, M.D.,

defendant, knowingly and willfully executed the previously described scheme to defraud by causing the submission of claims for modified radical neck dissections that he knew he did not perform for the patients, dates of service, and health care benefit programs identified below:

Modified Radical Neck Dissections

COUNT	PATIENT	DATE OF SERVICE	PROCEDURE CODE	AMOUNT BILLED	CLAIM RECEIVED DATE	HEALTH CARE BENEFIT PROGRAM	DESCRIPTION OF PROCEDURE ACTUALLY PERFORMED
27	L.H.	7/21/16	38724	3,917.00	08/03/16	BCBS	excisional lymph node biopsy
28	J.W.	7/22/16	38724	3,917.00	08/03/16	BCBS	submandibular gland excision

COUNT	PATIENT	DATE OF SERVICE	PROCEDURE CODE	AMOUNT BILLED	CLAIM RECEIVED DATE	HEALTH CARE BENEFIT PROGRAM	DESCRIPTION OF PROCEDURE ACTUALLY PERFORMED
29	A.R.	7/29/16	38724	3,917.00	08/03/16	Medicaid	submandibular gland excision
30	S.B.	7/29/16	38724	3,917.00	08/24/16	BCBS	submandibular gland excision
31	P.R.	9/20/16	38724	3,917.00	10/04/16	BCBS	excisional lymph node biopsy
32	K.M.	10/14/16	38724	3,917.00	11/18/16	Medicaid	excisional lymph node biopsy
33	W.F.	12/5/16	38724	3,917.00	01/06/17	BCBS/Medicare	parotidectomy
34	C.C.	12/16/16	38724	3,917.00	01/27/17	Medicare	Submandibular gland excision

18 U.S.C. § 1347

COUNTS 35-42
(False Statements Relating to Health Care Matters)

On or about the dates set forth below, in the Western District of Michigan, Southern Division,

DANIEL CASTRO, M.D.,

defendant, knowingly and willfully made and used a materially false writing or document knowing the same to contain materially false, fictitious, and fraudulent statements and entries, in connection with the delivery of or payment for health care benefits, items, or services:

COUNT	PATIENT	DATE	DOCUMENT OR WRITING	DESCRIPTION OF FALSIFIED, CONCEALED, OR COVERED UP FACT	HEALTH CARE BENEFIT PROGRAM
35	M.C.	9/16/16	Operative Report	Describes obstructed osteomeatal complex and polypoid disease	Medicaid
36	P.R.	9/20/16	Operative Report	Describes dissecting the entire length of the trapezius muscle in level 5 and dissecting the retrojugular nodes.	BCBS
37	K.M.	10/14/16	Operative Report	Describes the boundaries of dissection being the strap muscles to the trapezius muscle and the entire length of the neck along the trapezius.	Medicaid
38	D.F.	11/10/16	Operative Report	Describes obstructed osteomeatal complex and polypoid disease	York Risk Services Workers Comp
39	H.S.	11/14/16	Office Note	History and physical describes CT report as finding that osteomeatal complexes, frontal, and sphenoethmoidal recess are narrowed with mucoperiosteal thickening ethmoids	Medicaid
40	H.S.	11/21/16	Operative Report	Describes obstructed osteomeatal complex and polypoid disease	Medicaid

COUNT	PATIENT	DATE	DOCUMENT OR WRITING	DESCRIPTION OF FALSIFIED, CONCEALED, OR COVERED UP FACT	HEALTH CARE BENEFIT PROGRAM
41	P.T.	12/12/16	Office Note	History and physical section describes that CT scan was reviewed with patient and that CT report shows paranasal drainage pathways are narrowed bilaterally.	Medicare
42	L.M.	12/15/16	Office Note	History and physical describes CT report as showing an S shape curvature and the paranasal drainage pathways are narrowed bilaterally	BCBS

18 U.S.C. § 1035(a)(2)

FORFEITURE ALLEGATION

(Health Care Fraud, False Statements Relating to Health Care Matters)

The allegations contained in Counts 1 to 34 (health care fraud) and Counts 35 to 42 (false statement relating to health care matters) of this Indictment are hereby re-alleged and incorporated by reference for the purpose of alleging forfeitures pursuant to 18 U.S.C. § 982(a)(7).

Pursuant to 18 U.S.C. § 982(a)(7), upon conviction any of the offenses in violation of 18 U.S.C. § 1347 set forth in Counts 1 to 34 of this Indictment, and upon conviction of any of the offenses in violation of 18 U.S.C. § 1035 set forth in Counts 35 to 42 of this Indictment,

DANIEL CASTRO, M.D.,

defendant, shall forfeit to the United States of America any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offenses. The property to be forfeited includes, but is not limited to, the following:

1. MONEY JUDGMENT: A sum of money equal to at least $754,359, which represents the gross proceeds traceable to the offenses charged in Counts 1 to 34 (health care fraud) and counts 35 to 42 (false statement relating to health care matters).

2. SUBSTITUTE ASSETS: 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 of America shall be entitled to forfeiture of substitute property pursuant to 21 U.S.C. § 853(p), as incorporated by 18 U.S.C. § 982(b)(1) and 28 U.S.C. § 2461(c).

18 U.S.C. § 982(a)(7)
18 U.S.C. § 982(b)(1)
21 U.S.C. § 853(p)
28 U.S.C. § 2461(c)
18 U.S.C. § 1347

A TRUE BILL

[redacted]

GRAND JURY FOREPERSON

ANDREW BYERLY BIRGE
United States Attorney

RONALD M. STELLA
Assistant United States Attorney