UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

UNITED STATES OF AMERICA	)	
	)	No. _____
v.	)	Violations: Title 18, United
	)	States Code, Section 1347
OTTO GARCIA MONTENEGRO	)	

COUNT ONE

The United States Attorney charges:

1. At times material herein:

a. Defendant OTTO GARCIA MONTENEGRO ("Montenegro") was a physician, licensed in Illinois. Montenegro owned and operated a private medical practice, located in Elmwood Park, Illinois (hereinafter referred to as "the clinic"). Montenegro was the sole owner. Montenegro saw and treated dozens of patients each week.

b. Montenegro caused claims to be submitted to health care benefit programs ("insurers"), including but not limited to Blue Cross, Blue Shield of Illinois ("Blue Cross").

c. Insurers that received claims from Montenegro's clinic ordinarily authorized payment only if the services were actually provided, and the services were medically necessary, that is, the services were needed to help treat the patients.

d. The insurers that received claims from Montenegro's clinic ordinarily required that patients pay deductibles and co-payments, and prohibited a blanket waiver of those deductibles and co-payments by providers. Those insurers ordinarily made payments on claims only after the patients had satisfied payment of their deductibles. Many of

Montenegro's patients had deductibles and co-payments as part of their health care plan.

e. Montenegro ordinarily filled out bills for his patients identifying the services that were provided to the patients by Montenegro, together with a diagnosis. The bills were sent to Montenegro's billing service, which handled billing and collection activities for the clinic. The billing service prepared claim forms based on the bills, and submitted the claim forms to insurers.

2. Beginning in or about early 2003, and continuing until in or about May 2007, at Elmwood Park, in the Northern District of Illinois, Eastern Division, and elsewhere,

OTTO GARCIA MONTENEGRO,

defendant herein, did knowingly and willfully execute and attempt to execute a scheme and artifice to defraud health care benefit programs, within the meaning of Title 18, United States Code, Section 24(b), including Blue Cross and other private medical insurance plans, which affected interstate commerce, and to obtain money and property owned by and under the custody and control of such health care benefit programs by means of materially false and fraudulent pretenses, representations, promises, and by means of material omissions, in connection with the delivery of and payment for health care benefits, items, and services.

3. It was part of the scheme that Montenegro did not collect deductibles and co-payments from patients, and, instead, caused the submission of hundreds of fraudulent insurance claim forms to insurers for services and treatments that he knew were not actually provided, in order to exhaust patients' deductibles and co-payments, and to obtain monies for himself. Montenegro caused false and fraudulent claims to be submitted to insurers that he

believes totalled at least in or about approximately $500,000. Based on those false claims, insurers paid out in or about approximately $373,000.

4. It was further part of the scheme that Montenegro created hundreds of fraudulent bills falsely identifying visits and treatments that never occurred, and thereby intentionally causing the submission of false claims to insurers.

5. It was further part of the scheme that Montenegro told numerous patients to sign false bills so that Montenegro could submit false claims to insurers to use up the patients' deductibles and co-payments. Based on Montenegro's instructions, certain patients signed multiple bills falsely indicating that they were at the clinic and received services on dates when they were not at the clinic, in order to support the fraudulent claims that Montenegro submitted to insurers. In some instances, Montenegro photocopied patients' signatures on the bills in order to create false bills for dates on which the patients had not been at the clinic.

6. It was further part of the scheme that Montenegro made notations on the false bills, which included false diagnoses, in order to make it appear that Montenegro had actually seen the patient on dates when Montenegro had not actually seen them.

7. It was further part of the scheme that between in or about early 2003, and in or about May 2007, approximately one-third of the claims that Montenegro submitted to insurers were false, totaling in or about at least $500,000, and Montenegro fraudulently caused insurers to suffer actual losses totaling in or about approximately $373,000.

8. It was further part of the scheme that Montenegro misrepresented and

concealed, and caused to be misrepresented and concealed the purposes of, and acts done in furtherance of, this scheme.

9. On or about April 9, 2007, at Elmwood Park, in the Northern District of Illinois, Eastern Division, and elsewhere,

OTTO GARCIA MONTENEGRO,

defendant herein, did knowingly and willfully execute and attempt to execute the above described scheme to defraud health care benefit programs, by causing Blue Cross to issue a check to Montenegro's clinic, dated April 9, 2007, made payable to the clinic, which Blue Cross sent to Montenegro's clinic;

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

UNITED STATES ATTORNEY