2013R01094/JHY

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA	:	Criminal No. 15-
v.	:	
ALBERT ADES	:	18 U.S.C. §§ 1347, 1035, and 2

INDICTMENT

The Grand Jury in and for the District of New Jersey, sitting at Newark, charges:

COUNT ONE
(Health Care Fraud)

1. At various times relevant to this Indictment:

The Relevant Parties

a. The defendant, ALBERT ADES, M.D. ("defendant ADES"), resided in Englewood, New Jersey and was a physician licensed to practice medicine in New Jersey. Defendant ADES operated ALBERT ADES, M.D., M.S., P.A., a medical practice with two locations in New Jersey, one at 129 Madison Avenue, in Cresskill ("the Cresskill Office"), and a second at 200 East Main Street, in Little Falls ("the Little Falls Office," together with Cresskill Office, "the Medical Practice"). Defendant ADES was the sole licensed physician at the Medical Practice.

b. Defendant Ades hired billing assistants and medical assistants, among other personnel, to work for the Medical Practice. Billing for services provided by the Medical Practice was generally performed at the Little

Falls Office, regardless of whether health care services were rendered at the Cresskill Office or the Little Falls Office.

c. The Medicare Program ("Medicare") was a federal program established by the Social Security Act of 1965 to assist qualified aged and disabled individuals in paying for the cost of health care. Medicare worked by reimbursing health care providers and suppliers for the costs of health care services and items at fixed rates. The Medicare program provided reimbursement only for those health care services and items that were: (i) medically necessary, (ii) ordered by a physician, and (iii) actually provided as billed. Medicare was a "health care benefit program" as defined in Title 18, United States Code, Section 24(b).

d. The Medicaid program ("Medicaid") was a program jointly funded by the federal government and individual states to assist low-income persons and other qualified persons in paying for the costs of health care. The Medicaid program worked by reimbursing hospitals, physicians and other health care suppliers, such as pharmacies, for providing health care services and items to qualified individuals at fixed rates in a manner similar to the Medicare program. Medicaid was a "health care benefit program" as defined in Title 18, United States Code, Section 24(b). In New Jersey, Medicaid was administered by the New Jersey Department of Human Services. Medicaid recipients were required to select a State-approved health maintenance organization for the provision of their health care services.

e. Defendant ADES was a participating provider in Medicare and Medicaid. As such, defendant ADES was approved to provide physician services to patients enrolled in these federal health care benefit programs, and was authorized to submit claims to, and receive payment from, both Medicare and Medicaid.

f. The Medical Practice also billed, and was paid by, various private health care insurance entities ("private payors") in the business of providing health care insurance coverage to individuals and entities under various health insurance benefit plans. Pursuant to these plans, private payors reimbursed defendant ADES for, among other things, examining patients at the Medical Practice. The private payors who paid defendant ADES included, among others: (i) Cigna, a business located in Connecticut; (ii) Horizon Blue Cross Blue Shield ("Horizon"), a business located in New Jersey; and (iii) the National Association of Letter Carriers (NALC) Health Benefit Plan, a business located in Virginia. NALC provided health insurance coverage to eligible members of NALC and/or their families, in addition to benefit management services through contractual arrangements with private payors, such as Cigna, Optum, and CVS Caremark (collectively, "the NALC Plan").

g. Patient 1 ("PT-1"), a resident of New Jersey, was an established patient of defendant ADES. From in and around 2010 through in and around 2014, PT-1 was enrolled in Cigna. PT-1's last face-to-face office visit with defendant ADES occurred on or about August 8, 2012, at the Cresskill Office.

h. Patient 2 ("PT-2") and Patient 3 ("PT-3"), were residents of New Jersey and married to each other, and were established patients of defendant ADES. From in and around 2009, through in and around 2014, PT-2 and PT-3 were enrolled in Cigna. PT-3 also was enrolled in Medicare since July 2001.

i. Patient 4 ("PT-4") and Patient 5 ("PT-5") were residents of New Jersey and married to each other, and were established patients of defendant ADES. From in or about 2009 through 2014, both PT-4 and PT-5 were enrolled in the NALC plan. PT-4 and PT-5 also were enrolled in Medicare, as of December 2013 and January 2013, respectively.

j. Patient 6 ("PT-6"), a resident of New Jersey, and PT-6's family members, were established patients of defendant ADES until in and around 2010. PT-6 was enrolled in Horizon Blue Cross Blue Shield when PT-6 visited defendant ADES.

Current Procedural Terminology ("CPT") Codes

k. The American Medical Association maintained a set of procedural billing codes called Current Procedural Terminology ("CPT") codes. These CPT codes described medical, surgical, and diagnostic services, and were designed to communicate uniform information about medical services and procedures for health care providers, patients, and third-party payers for medical services, such as Medicare, Cigna, Horizon, and the NALC plan. The Centers for Medicare and Medicaid Services and the Health Insurance Portability and Accountability Act ("HIPAA") mandated use of these CPT codes for purposes of billing.

l. Outpatient services for which programs like Medicare and insurance companies like Cigna could be billed were required to be designated with codes described in the manual of Physician's Current Procedural Terminology (CPT) published by the American Medical Association. Each of the codes in the CPT manual described a specific procedure that could be completed by a health care provider. Many procedures found within the CPT manual were designated Evaluation and Management Codes (E&M Codes). E&M Codes were designated for the evaluation and management of a patient at a physician's office or other outpatient facility, and required direct, face-to-face contact between a physician or non-physician health care provider, such as a nurse, and the patient.

m. Under the AMA guidelines, there were at least five different E&M Codes for the evaluation and management of established patients during physician office visits: CPT Codes 99211, 99212, 99213, 99214, and 99215 ("the Office Visit Codes"). For any of the Office Visit Codes to be billed, a patient must have been seen at a physician's office or other outpatient health care facility. The CPT code to be billed depended upon the level of E&M services that were performed, from the simplest (i.e., CPT Code 99211, in a "Level 1" office visit) to the more involved (i.e., CPT Codes 99212 or 99213, in "Level 2" or "Level 3" office visits, respectively), to the complex (i.e., CPT Code 99215, in a "Level 5" office visit). The level of office visit code to be billed depended upon various factors, such as the complexity of the presenting problems and the amount of physician time spent face-to-face with the patient. Reimbursement amounts for CPT

codes 99211 through 99215 generally increased as the level of office visit increased, with Level 1 office visits (CPT 99211) reimbursing at the lower end and Level 5 office visits (CPT 99215) reimbursing at the higher end.

The Scheme to Defraud

2. From at least as early as 2005 through in or about June 2014, in Bergen County, Passaic County, in the District of New Jersey, and elsewhere, the defendant,

ALBERT ADES,

did knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud health care benefit programs, 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, health care benefit programs, in connection with the delivery of and payment for health care benefits, items, and services, which scheme and artifice was in substance as set forth below.

Objects of the Scheme

3. The object of the scheme was for defendant ADES to enrich himself by falsely and fraudulently representing to Medicare, Medicaid and various private payors, such as Cigna, that he performed evaluation and management services for patients in connection with office visits, which he in fact had not provided.

4. It was a further object of the scheme for defendant ADES to enrich himself by obtaining payments for services by falsely and fraudulently representing to Medicare, Medicaid and various private payors that he had

conducted face-to-face physician office visits with patients on specified dates, when he in fact had written prescriptions, authorized refills for patients, or performed other tasks, all without ever seeing his patients face-to-face, on those dates.

Manner and Means

5. It was part of the scheme and artifice to defraud that defendant ADES routinely submitted and caused to be submitted claims for reimbursement to Medicare, Medicaid, and various private payors, in which he falsely represented that he had conducted face-to-face office visits with patients, which he then knew to be false, in order to receive payment for services that he had not provided.

6. It was a further part of the scheme and artifice to defraud that defendant ADES routinely approved, submitted, and caused to be submitted, claims for reimbursement, falsely representing to Medicare, Medicaid, and various private payors that he had conducted face-to-face office visits with patients on specified dates, while then knowing that he had only written prescriptions, authorized prescription refills on those dates, or performed other tasks, without ever seeing these patients face-to-face at the Medical Practice, on those specified dates. It was part of the scheme and artifice to defraud for defendant ADES to submit false and fraudulent claims to Medicare, Medicaid, and various private payors for PT-1, PT-2, PT-3, PT-4, PT-5, and PT-6 among many other patients, to obtain payment for services he had not provided.

7. For example, between November 2012 and July 2013, defendant ADES billed, and was paid by, PT-1's health insurance plan, Cigna, five separate times. On each of these five occasions, defendant ADES falsely claimed that he had conducted physician office visits with PT-1, even though the last time that PT-1 visited defendant ADES at the Medical Practice was months earlier, in and around August 2012. On at least two of the five dates billed by defendant ADES, defendant ADES had authorized refills for PT-1, but on none of the five dates had an office visit with PT-1 occurred.

8. It was further part of the scheme and artifice to defraud that defendant ADES altered, and instructed individuals working at the Medical Practice to alter, his patients' medical charts, by inserting fabricated blood pressure readings, among other notations, to make it appear as if patients had visited the Medical Practice on dates for which defendant ADES had billed their insurance companies for physician office visits, when, in fact, defendant ADES had not seen these patients face-to-face, but rather had written prescriptions, authorized prescription refills, or performed some other task, on those dates.

9. For example, on or about December 19, 2012, defendant ADES prescribed medication for PT-4 and billed the NALC Plan, PT-4's health insurance plan. In the claim submitted to the NALC Plan, defendant ADES falsely represented that he had conducted a Level 2 office visit (i.e., CPT 99212) with PT-4 on December 19, 2012, when no such office visit had occurred. Although PT-4 did not visit the Medical Practice on December 19, 2012,

defendant ADES falsely recorded PT-4's blood pressure on December 19, 2012, to be "126/82" in PT-4's medical chart.

10. It was a further part of the scheme and artifice to defraud that defendant ADES destroyed, and instructed at least one other person to destroy, patients' medical records, and created new medical records in order to make it appear as if patients had visited the Medical Practice on dates for which defendant ADES had billed office visits, which had never occurred, and to obstruct at least one insurance company audit.

11. Specifically, in and around January 2010, PT-6 contacted the Medical Practice and PT-6's insurance plan, Horizon, after PT-6 noticed that Horizon had been billed by defendant ADES for office visits on dates when PT-6 and/or PT-6's family members only had obtained prescriptions or prescription refills, without having seen defendant ADES. In and around January 2010, Horizon commenced an audit and requested certain medical records from defendant ADES. In response, defendant ADES shredded, and instructed at least one other person working at the Medical Practice to shred, the original medical records, and created new bogus medical records that were intended to be disclosed to Horizon. The records that defendant ADES ultimately disclosed to Horizon included prescriptions with altered dates that did not correspond to the dates of the purported office visits, for which defendant ADES had billed and been paid by Horizon.

12. It was a further part of the scheme and artifice to defraud that defendant ADES concealed his scheme to defraud from patients and others by

routinely waiving or writing off, or instructing his staff to waive or write off, co-payments or coinsurance payments that patients ordinarily owed defendant ADES in connection with genuine physician office visits. Instead, defendant ADES wrote prescriptions or authorized refills for patients on specified dates, obtained payment from patients' insurers for these prescriptions by falsely claiming that he had provided physician office visits on these specified dates when he had not done so, and waived or wrote off the associated co-payments or coinsurance payments that patients ordinarily were required to pay defendant ADES in connection with genuine physician office visits.

13. From as early as 2008 through late 2013, at least four individuals who previously worked at the Medical Practice told defendant ADES that it was impermissible to bill patients' insurance plans for having conducted office visits with patients when those services were never rendered. On one of these occasions, which was consensually recorded on or about October 16, 2013, defendant ADES responded, in sum and substance, "I wrote something -- the fact that I wrote something, documented something – somebody's paying me for that."

All in violation of Title 18, United States Code, Section 1347 and Section 2.

COUNTS TWO THROUGH THIRTY-SIX

(False Statements Relating to Health Care Matters)

1. The allegations set forth in paragraphs 1 and 3 through 13 of Count One of this Indictment are hereby re-alleged and incorporated by reference as though set forth fully herein.

2. On or about the dates enumerated below as to each Count, in Bergen County and Passaic County, in the District of New Jersey, and elsewhere, the defendant,

ALBERT ADES,

in a matter involving a health care benefit program, did knowingly and willfully falsify, conceal, and cover up by a trick, scheme, and device a material fact, and did make a materially false, fictitious, and fraudulent statement and representation, and did make and use a materially false writing and document knowing the same to contain a materially false, fictitious, and fraudulent statement and entry, in connection with the delivery of and payment for health care benefits, items, and services, as follows:

Count	**Date**	**Defendant's Billing to Payors**	**Fraudulent Representation**
2	Nov. 12, 2012	CPT 99212 (Cigna)	CPT 99212, for office visit with **PT-1**, when no office visit occurred
3	Nov. 28, 2012	CPT 99212 (Cigna)	CPT 99212, for office visit with **PT-1**, when no office visit occurred
4	Jan. 29, 2013	CPT 99213 (Cigna)	CPT 99213, for office visit with **PT-1**, when no office visit occurred
5	May 16, 2013	CPT 99212 (Cigna)	CPT 99212, for office visit with **PT-1**, when no office visit occurred
6	Jul. 8, 2013	CPT 99213 (Cigna)	CPT 99213, for office visit with **PT-1**, when no office visit occurred
7	Dec. 7, 2012	CPT 99213 (Cigna)	CPT 99213, for office visit with **PT-2**, when no office visit occurred
8	Mar. 27, 2013	CPT 99213 (Cigna)	CPT 99213, for office visit with **PT-2**, when no office visit occurred
9	Jul. 3, 2013	CPT 99213 (Cigna)	CPT 99213, for office visit with **PT-2**, when no office visit occurred
10	Sept. 4, 2013	CPT 99212 (Cigna)	CPT 99212, for office visit with **PT-2**, when no office visit occurred

Count	**Date**	**Defendant's Billing to Payors**	**Fraudulent Representation**
11	Oct. 22, 2013	CPT 99213 (Cigna)	CPT 99213, for office visit with **PT-2**, when no office visit occurred
12	May 14, 2012	CPT 99214 (Cigna)	CPT 99214, for office visit with **PT-3**, when no office visit occurred
13	Jul. 6, 2012	CPT 99212 (Medicare & Cigna)	CPT 99212, for office visit with **PT-3**, when no office visit occurred
14	Oct. 3, 2012	CPT 99213 (Cigna)	CPT 99213, for office visit with **PT-3**, when no office visit occurred
15	Oct. 29, 2012	CPT 99213 (Cigna)	CPT 99213, for office visit with **PT-3**, when no office visit occurred
16	Nov. 5, 2012	CPT 99213 (Cigna)	CPT 99213, for office visit with **PT-3**, when no office visit occurred
17	Dec. 3, 2012	CPT 99212 (Cigna)	CPT 99212, for office visit with **PT-3**, when no office visit occurred
18	Mar. 27, 2013	CPT 99212 (Cigna)	CPT 99212, for office visit with **PT-3**, when no office visit occurred
19	Aug. 10, 2012	CPT 99212 (NALC)	CPT 99212, for office visit with **PT-4**, when no office visit occurred
20	Aug. 29, 2012	CPT 99213 (NALC)	CPT 99213, for office visit with **PT-4**, when no office visit occurred

Count	**Date**	**Defendant's Billing to Payors**	**Fraudulent Representation**
21	Sept. 14, 2012	CPT 99213 (NALC)	CPT 99213, for office visit with **PT-4**, when no office visit occurred
22	Dec. 19, 2012	CPT 99212 (NALC)	CPT 99212, for office visit with **PT-4**, when no office visit occurred
23	Mar. 27, 2013	CPT 99213 (NALC)	CPT 99213, for office visit with **PT-4**, when no office visit occurred
24	May 20, 2013	CPT 99213 (NALC)	CPT 99213, for office visit with **PT-4**, when no office visit occurred
25	May 21, 2013	CPT 99212 (NALC)	CPT 99212, for office visit with **PT-4**, when no office visit occurred
26	Jul. 10, 2013	CPT 99213 (NALC)	CPT 99213, for office visit with **PT-4**, when no office visit occurred
27	Aug. 21, 2013	CPT 99212 (NALC)	CPT 99212, for office visit with **PT-4**, when no office visit occurred
28	Aug. 10, 2012	CPT 99212 (NALC)	CPT 99212, for office visit with **PT-5**, when no office visit occurred
29	Dec. 5, 2012	CPT 99212 (NALC)	CPT 99212, for office visit with **PT-5**, when no office visit occurred
30	Dec. 10, 2012	CPT 99212 (NALC)	CPT 99212, for office visit with **PT-5**, when no office visit occurred

Count	**Date**	**Defendant's Billing to Payors**	**Fraudulent Representation**
31	Dec. 26, 2012	CPT 99213 (NALC)	CPT 99213, for office visit with **PT-5**, when no office visit occurred
32	Jan. 25, 2013	CPT 99213 (Medicare & NALC)	CPT 99213, for office visit with **PT-5**, when no office visit occurred
33	Mar. 4, 2013	CPT 99212 (Medicare)	CPT 99212, for office visit with **PT-5**, when no office visit occurred
34	May 20, 2013	CPT 99213 (Medicare & NALC)	CPT 99213, for office visit with **PT-5**, when no office visit occurred
35	Jul. 8, 2013	CPT 99213 (Medicare & NALC)	CPT 99213, for office visit with **PT-5**, when no office visit occurred
36	Aug. 2, 2013	CPT 99212 (Medicare & NALC)	CPT 99212, for office visit with **PT-5**, when no office visit occurred

All in violation of Title 18, United States Code, Section 1035 and Section 2.

FORFEITURE ALLEGATION

1. As the result of committing one or more of the Federal health care offenses as defined in 18 U.S.C. § 24 alleged in Counts 1 through 36 of this Indictment, defendant ALBERT ADES shall forfeit to the United States, pursuant to 18 U.S.C. § 982(a)(7), all property, real and personal, that constitutes or is derived, directly and indirectly, from gross proceeds traceable to the commission of the offense.

Substitute Assets Provision

2. If any of the above-described forfeitable property, as a result of any act or omission of the defendant(s):

(a) cannot be located upon the exercise of due diligence;
(b) has been transferred or sold to, or deposited with, a third person;
(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 subdivided without difficulty;

it is the intent of the United States, pursuant to 21 U.S.C. § 853(p), as incorporated by 18 U.S.C. § 982(b), to seek forfeiture of any other property of said defendant(s) up to the value of the above forfeitable property.

A TRUE BILL

FOREPERSON

PAUL J. FISHMAN
United States Attorney

CASE NUMBER: _____

United States District Court
District of New Jersey

UNITED STATES OF AMERICA

v.

ALBERT ADES

INDICTMENT FOR

Title 18, United States Code, Sections 1347, 1035, & 2

A True Bill,

Foreperson

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