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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

CR18-79TUC CKJ(DTF)

United States of America,

Plaintiff,

vs.

Elvia Lorena Lamont,
(counts 1 - 47)

Stephen Allen Lamont,
(counts 1 - 47)

Defendants.

INDICTMENT

Violations:
18 U.S.C. § 1349 (Conspiracy to Commit Health Care Fraud)
(Count 1)

18 U.S.C. § 1347 (Health Care Fraud)
(Count 2)

18 U.S.C. § 1035 (False Statement Relating to A Health Care Matter)
(Counts 3 - 36)

18 U.S.C.§ 1028A (Aggravated Identity Theft)
(Counts 37 – 47)

18 U.S.C. § 982(a)(7)
(Forfeiture Allegation)

A. Introductory Allegations and Scheme to Defraud:

At all times relevant to this Indictment:

1. Medicare was a federal health care benefit program, affecting commerce, that provided benefits to individuals, often referred to as beneficiaries, who were over

the age of 65 or disabled. Medicare was a "health care benefit program," as defined by 18 U.S.C. § 24(b).

2. Medicare was administered by the Centers for Medicare and Medicaid Services ("CMS"), a federal agency under the United States Department of Health and Human Services.

3. Medicare Part B was the part of the Medicare (CMS) program that covered some or all of the cost of medical services such as preventive services, outpatient care, and lab tests provided by physicians and non-physician practitioners, including physician assistants and nurse practitioners (collectively known as "health care providers"). Eligible Medicare beneficiaries paid monthly premiums to maintain coverage under Medicare Part B. Some beneficiaries also carried secondary insurance that would pay all or part of the amount remaining after Medicare Part B paid up to its limits of coverage.

4. Under certain circumstances, Medicare Part B covered the cost of home visits for evaluation and management services provided to a beneficiary by a physician approved non-physician provider in a private residence. To reimburse for home visits, Medicare (CMS) required that the medical record document the medical necessity of making a home visit in lieu of an office or outpatient visit. For a physician or approved non-physician provider to bill for home visits provided to a beneficiary, Medicare (CMS) required that the physician or approved non-physician provider actually be present in the beneficiary's home.

5. The Medicare Part B program was administered by private contractors, known as "carriers," that processed the Medicare (CMS) enrollment forms and insurance claims submitted by health care providers. The carrier for the region that included the State of Arizona was Noridian Administrative Services.

6. In order to be paid for the provision of medical services under the Medicare Part B program, a health care provider was first required to enroll in the program. In

order to enroll, a health care provider and his/her respective medical practice organization was required to:

a. have a unique 10-digit number known as the National Provider Identifier ("NPI"); and

b. complete a Medicare (CMS) Enrollment Application. Physicians and other health care providers enrolling as individuals were required to complete an application form called the CMS-855I whereas organizations such as clinics and other group practices were required to complete an application form called the CMS-855B.

7. As part of the conditions of enrollment, the applicant was required to certify, after notification of the criminal penalties for knowingly providing false information, that he/she would provide truthful information and follow the rules and regulations required of the Medicare (CMS) program.

8. Payments under the Medicare (CMS) program were made directly to a medical practice or provider of the goods or services. This occurred when the claim was provided to Medicare for payment, either directly or through a billing company.

Submitting Claims to Medicare Electronically

9. After submitting an Electronic Data Interchange Enrollment ("EDI") form and receiving approval from Medicare (CMS), a service provider could submit reimbursement claims to Medicare (CMS) electronically.

10. For each electronic claim, the service provider was required to supply, among other information, the beneficiary's identifying information, the date of service, the diagnosis, the NPI of the rendering provider, the tax identification number of the medical practice and the Current Procedural Terminology ("CPT") code, which identified the services provided.

11. Health care providers submitted electronic claims to Medicare (CMS) directly or contracted with third-party billing companies to process claims on their behalf. Health care providers who used billing contractors generally submitted all of the

information necessary to process the claims to the billing contractor, including the CPT codes, via hard copy forms (commonly known as superbills) or billing software.

12. After receiving the superbills or information via the billing software, the Medicare (CMS) program reimbursed health care providers using electronic funds transfer. To receive deposits, health care providers submitted their bank routing and account numbers to Medicare (CMS) via form CMS-588 (Electronic Funds Transfer Authorization Agreement).

CPT Coding

13. The American Medical Association created the CPT coding system to standardize the way health care providers reported medical services. Medical providers participating in the Medicare (CMS) program would bill Medicare (CMS) for services provided using appropriate CPT codes. A CPT code was a unique six-digit numeric code corresponding to a specific medical, surgical and/or diagnostic procedure. Each CPT code had a corresponding amount of reimbursement from Medicare (CMS) or other insurance companies. These CPT codes were listed on the superbills or submitted via the billing software.

14. CPT codes 99334-99337 represented the Evaluation and Management (E/M) codes for domiciliary or rest-home visits with established patients. CPT code 99337 was the Level 5 or highest complexity code in this category and provided the highest level of reimbursement for such services. For this code to have applied, the visit had to involve at least two of the following: (1) a comprehensive interval history, (2) a comprehensive examination, and (3) medical decision making of moderate to high complexity. Usually the presenting medical problem was of moderate to high severity. The patient may have been unstable or have developed a significant new problem requiring immediate attention. Billing CPT code 99337 typically meant that the health care provider spent 60 minutes face-to-face with the patient and/or the patient's family. The other CPT codes for

domiciliary or rest-home visits with established patients corresponded with progressively less complex services and typically involved shorter visits.

15. CPT codes 99347-99350 represented the E/M codes for home visits with established patients. CPT code 99350 was the Level 5 or highest complexity code in this category and provided the highest level of reimbursement for such services. For this code to have applied, the visit had to involve at least two of the following: (1) a comprehensive interval history, (2) a comprehensive examination, and (3) medical decision making of moderate to high complexity. Usually the presenting problem was of moderate to high severity. The patient may have been unstable or have developed a significant new problem requiring immediate attention. Billing CPT code 99350 typically meant that the health care provider spent 60 minutes face-to-face with the patient and/or the patient's family. The other CPT codes for home visits with established patients corresponded with progressively less complex services and typically involved shorter visits.

16. CPT code 99354 represented a prolonged service and was a supplement code billed, in addition to the E/M code, for services that involved direct face-to-face patient contact beyond the usual service. For this code to have applied, the visit must have exceeded the time associated with the E/M code by at least 30 additional minutes, but no more than 74 minutes. For instance, if CPT code 99350 and CPT code 99354 were billed together the total time spent face-to-face with the beneficiary was expected to be between 90 (60+30) minutes and 134 (60+74) minutes. CPT code 99354 was typically used on rare occasions when a beneficiary had extensive health related issues that had been neglected over time.

17. CPT codes 99324-99328 represented the E/M codes for domiciliary or rest home visits with new patients. CPT code 99328 was the Level 5 or highest complexity code in this category and provided the highest level of reimbursement for such services. For this code to have applied, the visit had to involve all three of the following: 1) a comprehensive history, 2) a comprehensive examination, and 3)

medical decision making of high complexity. The patient may have been unstable or have developed a significant new problem requiring immediate physician attention. Billing this code typically meant that the health care provider spent 75 minutes face-to-face with the patient and/or the patient's family. The other CPT codes for domiciliary or rest-home visits with new patients corresponded with progressively less complex services and typically involved shorter visits.

18. CPT codes 99341-99345 represented the E/M codes for home visits with new patients. CPT code 99345 was the Level 5 or highest complexity code in this category and provided the highest level of reimbursement for such services. For this code to apply, the visit had to involve all three of the following: 1) a comprehensive history, 2) a comprehensive examination, and 3) medical decision making of high complexity. The patient may have been unstable or have developed a significant new problem requiring immediate physician attention. Billing this code typically meant that the health care provider spent 75 minutes face-to-face with the patient and/or the patient's family. The other CPT codes for home visits with new patients corresponded with progressively less complex services and typically involved shorter visits.

19. When a health care provider provided medical services, the provider typically generated or maintained documentation sometimes referred to as an "encounter form," that detailed the services rendered by the provider to the beneficiary. In order to obtain reimbursement, Federal regulations required that any services billed by a provider be supported by documentation maintained by the provider.

20. Under the Medicare (CMS) regulations for domiciliary or in-home services for the above-specified CPT codes, in order to obtain reimbursement from Medicare (CMS), the in-home/domiciliary service was required to be personally administered by the rendering provider listed on the Medicare Part B reimbursement claim. In other words, if a Medicare Part B approved provider rendered a service in a domiciliary setting and a claim was submitted for

reimbursement under CPT codes 99341-99350, that claim would have to be submitted under the provider's NPI. This is because a claim for reimbursement under a CPT code for a service in a domiciliary setting required the presence of the doctor or other approved non-physician provider.

21. Per Medicare (CMS) regulations, Medicare (CMS) did not reimburse any of the above services conducted at a domiciliary or in-home setting performed by auxiliary personnel to include registered nurses, medical assistants, or other technicians such as phlebotomists.

Scheme to Defraud

22. The defendants, ELVIA LORENA LAMONT and STEPHEN ALLEN LAMONT, owned and operated Ascension in Home Medical Care NP'S Group Inc. ("Ascension") located in Tucson, Arizona. Ascension was continuously enrolled and a participating Medicare (CMS) provider since September 2009.

23. Ascensions' business operations included the treatment of elderly patients in domiciliary (assisted living facilities) or other home settings.

24. It was part of the scheme and artifice to defraud that defendants, ELVIA LORENA LAMONT and STEPHEN ALLEN LAMONT, knowingly and with the intent to defraud, caused to be submitted to Medicare (CMS) fraudulent claims for payment for medical services. The defendants knowingly caused to be submitted claims that contained material false statements and the intentional concealment of material facts. The defendants caused to be submitted reimbursement claims to Medicare (CMS) using CPT codes such as 99337, 99350 (medical services involving domiciliary or home visits for established patients by either physicians or nurse practitioners) and other codes requiring that the service had been conducted by an approved Medicare (CMS) provider. In fact, the defendants knew that these services were not performed by the physicians or nurse practitioners and had actually been performed by auxiliary personnel such as nurses, medical assistants, technicians or a phlebotomist. Medical services

completed by the auxiliary personnel who actually completed the service would not allow for any reimbursement under the Medicare (CMS) program. By knowingly and fraudulently submitting these material false statements to Medicare (CMS), the defendants fraudulently obtained reimbursement from the Medicare (CMS) program to which they were not lawfully entitled.

25. In furtherance of the scheme, the defendants also fraudulently billed Medicare (CMS) for services at the highest complexity level and included extended service CPT codes (e.g., CPT code 99354) in order to be reimbursed at a higher rate. However, there was no basis to bill under the higher code and the extended service code was not applicable. This method of fraud is commonly referred to in the Medicare-world as "upcoding."

26. At times, the defendants would also forge, or knowingly cause to be forged, the signature, or fraudulently used the signature stamp of a medical doctor or other Medicare (CMS) approved provider, on the beneficiary's medical chart or superbill when the defendants knew that the doctor or other enrolled provider had not in fact personally rendered any service to the patient on the specified treatment date. The defendants would fraudulently bill Medicare (CMS) for these services using the NPI of the enrolled provider without the knowledge or consent of the provider and without the provider having rendered the medical service. These acts of forgery and fraudulent misuse of the provider's signature stamp were committed by the defendants in an attempt to conceal and advance their Medicare (CMS) fraud scheme. The forged signatures and signature stamps were also used by the defendants without the authorization or consent of the enrolled Medicare (CMS) provider.

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COUNT ONE
CONSPIRACY TO COMMIT HEALTH CARE FRAUD
18 U.S.C. § 1349

27. The factual allegations in paragraphs 1 – 26 are re-alleged and incorporated by reference as though fully stated herein.

28. From a time unknown to the Grand Jury, and continuing through approximately July, 2015, at or near Tucson, in the District of Arizona and elsewhere, the defendants, ELVIA LORENA LAMONT and STEPHEN ALLEN LAMONT, did knowingly, unlawfully, and voluntarily combine, conspire, and agree to commit health care fraud in violation of Title 18, United States Code, Section 1347, that is, the defendants conspired to execute a scheme and artifice to defraud Medicare (CMS), a health care benefit program, and to obtain money under the custody and control of the Medicare (CMS) program, in connection with the delivery of or payment for health care benefits, items or services, by material false statements, representations, promises and the intentional concealment of material facts.

29. The primary purpose of the conspiracy was for the defendants to fraudulently and unlawfully enrich themselves with money under the custody and control of the Medicare (CMS) program to which the defendants were not legally entitled all in violation of Title 18, United States Code, Section 1349.

COUNT TWO
HEALTH CARE FRAUD
18 U.S.C. § 1347

30. The factual allegations in paragraphs 1 – 26 are re-alleged and incorporated by reference as though fully stated herein.

31. From a time unknown to the Grand Jury, and continuing from at least April, 2011 through approximately July, 2015, at or near Tucson, in the District of Arizona and elsewhere, the defendants, ELVIA LORENA LAMONT and STEPHEN ALLEN LAMONT, did knowingly, willfully and unlawfully execute and attempt to execute a scheme and artifice to defraud the Medicare (CMS) program, a health

care benefit program, and a scheme to obtain money under the custody and control of the Medicare (CMS) program, in connection with the delivery of or payment of health care benefits, items or services, by material false statements, representations, promises and the intentional concealment of material facts in violation of Title 18, United States Code, Section 1347.

COUNTS THREE THROUGH TWENTY-THREE
FALSE STATEMENTS RELATING TO HEALTH CARE MATTERS
18 U.S.C. § 1035

32. The factual allegations in paragraphs 1–26 are re-alleged and incorporated by reference as though fully stated herein.

33. On or about the dates set forth below and relating to a matter involving Medicare (CMS), at or near Tucson, in the District of Arizona and elsewhere, the defendants, ELVIA LORENA LAMONT and STEPHEN ALLEN LAMONT, knowingly, intentionally and willfully made and caused to be made materially false, fictitious and fraudulent statements and representations in connection with the delivery of and payment for health care benefits, items, and services involving Medicare (CMS), that is, the defendants knowingly caused to be submitted to Medicare (CMS) materially false and fraudulent statements and claims for medical services, including domiciliary or home visits for Medicare (CMS) beneficiaries by either physicians or nurse practitioners, when the defendants actually knew such services had not in fact been performed by such medical personnel and the defendants knew that Medicare required the services to be performed by such medical personnel on or about the indicated date of service:

COUNT	Medicare (CMS) Beneficiary Initials	Date of Service	False/Fraudulent CPT Codes Submitted to Medicare (CMS)	Amount Billed	Date Claim Submitted to Medicare (CMS)
3	F.F.	10/16/13	99350	$230.00	10/27/13

COUNT	Medicare (CMS) Beneficiary Initials	Date of Service	False/Fraudulent CPT Codes Submitted to Medicare (CMS)	Amount Billed	Date Claim Submitted to Medicare (CMS)
4	O.S.	10/17/13	99337	$260.00	10/27/13
5	R.W.	10/22/13	99350	$230.00	10/27/13
6	L.A.	10/23/13	99337	$260.00	11/5/13
7	W.G.	10/21/14	99350	$230.00	11/3/14
8	C.K.	10/22/14	99337	$285.00	11/3/14
9	J.L.	10/23/14	99350	$230.00	11/3/14
10	E.G.	10/23/14	99337	$285.00	11/3/14
11	K.K.	10/23/14	99350 99354	$230.00 $150.00	11/4/14
12	J.F.	10/24/14	99337	$285.00	11/3/14
13	O.S.	01/28/15	99337	$285.00	2/9/15
14	B.T.	6/30/15	99350	$230.00	7/14/15
15	R.W.	6/30/15	99350	$230.00	7/10/15
16	G.L.	6/30/15	99337	$285.00	7/10/15
17	J.L.	7/1/15	99337	$285.00	7/10/15
18	M.P.	7/2/15	99337	$285.00	7/14/15
19	J.O.	7/2/15	99350	$230.00	7/10/15
20	G.M.	6/28/13	99345 99354	$309.00 $150.00	7/7/13
21	B.C.	9/10/13	99328 99354	$300.00 $150.00	9/27/13
22	L.A.	10/4/13	99328 99354	$300.00 $150.00	10/23/13
23	P.B.	10/29/13	99345 99354	$309.00 $150.00	11/10/13

All in violation of Title 18, United States Code, Section 1035(a)(2).

COUNTS TWENTY-FOUR THROUGH THIRTY-SIX
FALSE STATEMENTS RELATING TO HEALTH CARE MATTERS
18 U.S.C. § 1035

34. The factual allegations in paragraphs 1 –26 are re-alleged and incorporated by reference as though fully stated herein.

35. On or about the dates set forth below and relating to a matter involving Medicare (CMS), at or near Tucson, in the District of Arizona and elsewhere, the defendants, ELVIA LORENA LAMONT and STEPHEN ALLEN LAMONT, knowingly, intentionally and willfully made and caused to be made materially false, fictitious and fraudulent statements and representations in connection with the delivery of and payment for health care benefits, items, and services involving Medicare (CMS), that is, the defendants knowingly caused to be submitted to Medicare (CMS) materially false statements and fraudulent claims for medical services that falsely and fraudulently represented to Medicare (CMS) that a service was performed at the highest complexity level and involved extended service when the defendants knew that there was no basis to bill under the higher code and supplemental CPT code.

COUNT	Beneficiary Initials	Date of Service	False/Fraudulent CPT Codes Submitted to Medicare (CMS)	Amount Billed	Date Claim Submitted to Medicare (CMS)
24	K. K.	4/13/13	99350 99354	$230.00 $150.00	04/21/13
25	C. K.	04/13/13	99337 99354	$260.00 $150.00	04/21/13
26	L. K.	04/13/13	99337 99354	$260.00 $150.00	04/21/13
27	R. H.	04/13/13	99337 99354	$260.00 $150.00	04/21/13
28	E. H.	04/13/13	99337 99354	$260.00 $150.00	04/21/13
29	E. Y.	04/13/13	99350 99354	$230.00 $150.00	04/21/13
30	E. E.	04/13/13	99337 99354	$230.00 $150.00	04/21/13
31	O. S.	04/13/13	99337 99354	$260.00 $150.00	04/21/13

COUNT	Beneficiary Initials	Date of Service	False/Fraudulent CPT Codes Submitted to Medicare	Amount Billed	Date Claim Submitted to Medicare (CMS)
32	N. K.	04/13/13	99337 99354	$260.00 $150.00	04/21/13
33	C. M.	04/13/13	99337 99354	$260.00 $150.00	04/21/13
34	R.K.	04/13/13	99337 99354	$260.00 $150.00	04/21/13
35	D.H.	04/13/13	99337 99354	$260.00 $150.00	04/21/13
36	C.H.	04/13/13	99337 99354	$260.00 $150.00	04/21/13

All in violation of Title 18, United States Code, Section 1035(a)(2).

COUNTS THIRTY-SEVEN THROUGH FORTY-SEVEN
(Aggravated Identity Theft)
18 U.S.C. § 1028A

36. The factual allegations in paragraphs 1–26 are re-alleged and incorporated by reference as though fully stated herein.

37. On or about the dates referenced below, in the District of Arizona and elsewhere, the defendants, ELVIA LORENA LAMONT and STEPHEN ALLEN LAMONT, did knowingly use, without lawful authority, a means of identification of another person during and in relation to a felony violation enumerated in 18 U.S.C. § 1028A(c), to wit, health care fraud in violation of 18 U.S.C. § 1347 as charged in count two of this indictment, knowing that the means of identification belonged to another actual person, as set forth in each count below:

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Count	Beneficiary Initials	Date of Service	CPT Code falsely billed as services rendered by enrolled provider NPI whose initials are set forth below	Date Claim Submitted to Medicare (CMS)
37	F.F.	10/16/13	99350/ Falsely billed as services rendered by Dr. T.J.; Fraudulent use of signature of T.J. on medical chart/superbill	10/27/13
38	L.A.	10/23/13	99337/ Falsely billed as services rendered by Dr. T.J.; fraudulent use of signature of T.J. on medical chart/superbill/	11/5/13
39	W.G.	10/21/14	99350/ Falsely billed as services rendered by N.P., A.D.; fraudulent use of signature of A.D. on medical chart/superbill	11/3/14
40	K.K.	10/23/14	99350/99354 Falsely billed as services rendered by N.P., A.D.; fraudulent use of signature of A.D. on medical chart/superbill	11/4/14

Count	Beneficiary Initials	Date of Service	CPT Code falsely billed as services rendered by enrolled provider NPI whose initials are set forth below	Date Claim Submitted to Medicare (CMS)
41	O.S.	01/28/15	99337/ Falsely billed as services rendered by N.P., A.D; Fraudulent use of signature of A.D. on medical chart/superbill	02/09/15
42	B.T.	06/30/15	99350/ Falsely billed as services rendered by N.P., A.D; fraudulent use of signature of A.D. on medical chart/superbill	07/14/15
43	R.W.	06/30/15	99350/ Falsely billed as services rendered by N.P., A.D; fraudulent use of signature of A.D. on medical chart/superbill	07/10/15
44	G.M.	06/28/13	99345/99354 Falsely billed as services rendered by Dr. T.J.; fraudulent use of signature of Dr. T.J. on medical chart/superbill	07/07/13

Count	Beneficiary Initials	Date of Service	CPT Code falsely billed as services rendered by enrolled provider NPI whose initials are set forth below	Date Claim Submitted to Medicare (CMS)
45	B.C.	09/10/13	99328/99354 Falsely billed as services rendered by Dr. T.J.; fraudulent use of signature of Dr. T.J. on medical chart/superbill	09/27/13
46	L.A.	10/04/13	99328/99354 Falsely billed as services rendered by Dr. T.J.; fraudulent use of signature of Dr. T.J. on medical chart/superbill	10/23/13
47	P.B.	10/29/13	99345/99354 Falsely billed as services rendered by Dr. T.J.; fraudulent use of signature of Dr. T.J. on medical chart/superbill	11/10/13

All in violation of Title 18, United States Code, Section 1028A(a)(1).

FORFEITURE ALLEGATION

Upon conviction of one or more of the offenses alleged in this Indictment, the defendants, ELVIA LORENA LAMONT and STEPHEN ALLEN LAMONT shall forfeit to the United States of America, pursuant to Title 18, United States Code, Sections 981(a)(1)(C), 982(a)(7), and Title 28, United States Code, Section 2461(c), any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offenses.

If any of the property described above, as a result of any act or omission of the defendants: (a) cannot be located upon the exercise of due diligence; (b) has been transferred or sold to, or deposited with, a third party; (c) has been placed beyond the jurisdiction of the court; (d) has been substantially diminished in value; or (e) has been commingled with other property which cannot be divided without difficulty, it is the intent of the United States, pursuant to Title 21, United States Code, Section 853(p), as incorporated by Title 28, United States Code, Section 2461(c), to seek forfeiture of any other property of said defendants up to the value of the above forfeitable property, including, but not limited to, all property, both real and personal, owned by the defendants.

All in violation of Title 18, United States Code, Sections 1349, 1347, 1035, Title 18, United States Code, Sections 981(a)(1)(C), 982(a)(7), Title 28, United States Code, Section 2461(c), and Rule 32.2(a), Federal Rules of Criminal Procedure.

A TRUE BILL

/s/

Presiding Juror

ELIZABETH A. STRANGE
First Assistant United States Attorney
District of Arizona

/s/

Assistant U.S. Attorney
Dated: January 10, 2018

REDACTED FOR
PUBLIC DISCLOSURE