IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

UNITED STATES OF AMERICA	§	
	§	
v.	§	NO. 6:13CR32
	§	Schneider
TARIQ MAHMOOD, M.D.	§	

INDICTMENT

THE UNITED STATES GRAND JURY CHARGES:

General Allegations

At all times relevant to this Indictment:

Medicare Program

1. The Medicare Program ("Medicare") is a federal health care program providing benefits to persons who are over the age of sixty-five and some persons under the age of sixty-five who are blind or disabled. Medicare is administered by the Centers for Medicare and Medicaid Services (CMS), a federal agency under the United States Department of Health and Human Services (HHS). Individuals who receive benefits under Medicare are referred to as Medicare "beneficiaries."

2. Medicare is a "health care benefit program," as defined by Title 18, United States Code, Section 24(b), in that it is a public plan affecting commerce under which medical benefits, items, and services are provided to individuals and under which individuals and entities who provide medical benefits, items, or services may obtain payments.

3. Medicare is a "Federal health care program," as defined by Title 42, United States Code, Section 1320a-7b(f), in that it is a plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government.

4. The Medicare program includes a hospital insurance benefit known as Part A, which is funded from payroll taxes paid by employees and employers and from other federal income taxes, premiums, government credits, and interest on federal securities. Financial operations for Part A are accounted for through the Hospital Insurance (HI) trust fund, which is maintained by the Department of Treasury. Payments for Part A services are made from the United States Treasury.

5. Medicare Part A provides coverage for inpatient hospital services, skilled nursing facility (SNF) services, home health services, and hospice care, subject to certain conditions and limitations.

6. Medicare Part A uses a "Prospective Payment System" (PPS) to pay for services provided for inpatient hospital services.

7. A key part of PPS is the categorization of medical and surgical services into diagnosis-related groups (DRGs). The DRGs "bundle" services (labor and non-labor resources) that are needed to treat a patient with a particular disease. The DRG payment rates cover most routine operating costs attributable to patient care, including routine nursing services, room and board, and diagnostic and ancillary services. CMS creates a rate of payment based on the "average" cost to deliver care (bundled services) to a patient with a particular disease.

8. The DRGs classify all human diseases according to the affected organ system, surgical procedures performed on patients, morbidity, and sex of the patient.

9. The classification process begins with the physician's documentation of the patient's principal diagnosis, secondary diagnosis, and other factors affecting the patient's care or treatment (referred to as complications and co-morbidities). The principal diagnosis is the diagnosis established to be chiefly responsible for causing the admission of the patient to the hospital for care. The condition must be treated or evaluated during the admission to the hospital. The secondary diagnoses are conditions that affect client care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care and/or monitoring, or have clinically significant implications for future healthcare needs.

10. This information is submitted to the hospital's medical records department where a medical record coder assigns diagnostic and procedures codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9). CMS issued official guidelines for coding and reporting using ICD-9. Adherence to the guidelines when assigning diagnostic and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA).

11. In the coding process, if diagnostic and procedure codes are added, deleted, changed, or incorrectly sequenced, the DRG will generally be altered. If the DRG is altered, then Medicare will reimburse the provider based on the altered DRG rather than based on the appropriate diagnostic and procedure codes.

12. After the medical record coder assigns ICD-9 code, the hospital then sends the data electronically to its Medicare Administrative Contractor (MAC) on a claim form known as a Form CMS-1450. The claim form is required to state, among other things, the beneficiary's name and health insurance claim number (HICN), the ICD-9 codes corresponding to the condition of the patient, the Healthcare Common Procedural Code Systems (HCPCS) code corresponding to the services provided to the Medicare beneficiary, the date the service was provided, the charge for the service, and the National Provider Identifier (NPI) number of the billing provider. All information contained in the form must be true, accurate, and complete.

13. The MAC inputs the data received from the hospital into its claims processing system, referred to as the Medicare Code Editor. Using an automated algorithm called "Grouper," the MAC groups all discharge cases into one of 25 Major Diagnostic Categories (MDCs) before assigning it to 1 of the approximately 746 DRGs. Then, the MAC creates a data file (referred to as the Medicare Provider Analysis and Review file) containing all the charge data that has been assigned to each DRG.

14. CMS assigns a unique weight to each DRG. The weight reflects the average level of resources for an average Medicare patient in the DRG, relative to the average level of resources for all Medicare patients. The weights are intended to account for cost variations between different types of treatments. More costly conditions are assigned higher DRG weights.

15. The United States provides reimbursement for Medicare Part A claims through CMS. CMS contracts with private insurance organizations, referred to as MACs

under Part A, to receive, adjudicate, and pay Medicare claims submitted by approved and participating health care providers. These carriers are required to administer the Medicare program according to regulations established by CMS.

16. In order to become a provider authorized to bill Medicare for Part A services, a company is required to submit a Medicare Enrollment Application to CMS via the MAC. The MAC contracts with Medicare to receive, evaluate, and approve or deny Medicare Enrollment Applications. In this application, potential suppliers promise to comply with all Medicare-related laws and regulations. Only after the MAC approves an application and provides a company with a Medicare provider number may a company bill Medicare for benefits, items, and services provided to Medicare beneficiaries.

17. Medicare has specific guidelines for the billing and coverage of inpatient hospital services. These guidelines are published and made available to Medicare providers. They are also publically-available and accessible on the Internet.

18. A secondary insurance program may pay a portion of a claim originally submitted to Medicare in the event that the beneficiary/recipient has both Medicare and secondary insurance coverage. This portion is generally 20 percent of the Medicare allowance for the billed charge. An individual who is eligible under both Medicare and a secondary insurance program is referred to as a "dual-eligible beneficiary." A claim originally submitted to Medicare and subsequently to the secondary insurer for payment is referred to as a "crossover claim." Such claims are sent to the secondary insurer once processed by Medicare. The secondary insurer pays its portion if Medicare originally allowed the claim. The guidelines regarding submission and payment of these claims are

contained in the procedures manual made available to providers upon enrollment in the Medicare program.

19. Medicare providers sign an agreement with Medicare in which they state that they are familiar with Medicare's billing requirements and in which they promise not to submit false or fraudulent claims. Medicare requires providers to retain records for a period of six years and three months.

20. All payments made by Medicare are made to a provider in the form of a pre-arranged direct deposit into the provider's bank account.

Medicaid Program

21. The Texas Medical Assistance Program ("Medicaid") is a health care benefit program jointly funded by the State of Texas and the federal government. The Medicaid program helps pay for reasonable and necessary medical procedures and services provided to individuals who are deemed eligible under state low-income programs. Individuals eligible under the Medicaid program are referred to as Medicaid "recipients."

22. Medicaid is a "health care benefit program," as defined by Title 18, United States Code, Section 24(b), in that it is a public plan affecting commerce under which medical benefits, items, and services are provided to individuals and under which individuals and entities who provide medical benefits, items, or services may obtain payments.

23. Medicaid is a "Federal health care program," as defined by Title 42, United States Code, Section 1320a-7b(f), in that it is a State health care program, as defined by Title 42, United States Code, Section 1320a-7(h).

24. The Texas Health and Human Services Commission (HHSC) is responsible for administering the Medicaid program in the State of Texas. HHSC contracts with the Texas Medicaid and Healthcare Partnership (TMHP) to receive applications from prospective Medicaid providers, assign Medicaid provider numbers, educate providers as to Medicaid policies and regulations, and process and pay Medicaid claims.

25. Provider enrollment in the Medicaid program is voluntary. In order to obtain approval, the provider must submit an application to TMHP. If the provider meets certain qualifications, TMHP will approve the application, enter into a written contract with the provider, and issue a unique provider identification number to the provider. Upon assignment of a provider number, a current Texas Medicaid Provider Procedures Manual is distributed or made available online to the provider. Additionally, TMHP periodically mails Texas Medicaid Bulletins to the provider, which include updates to the procedures manual. The procedures manual, bulletins, and updates contain the rules and regulations pertaining to services covered by Medicaid as well as instructions regarding the proper submission of claims to Medicaid for services provided to Medicaid recipients. Each provider agrees to abide by the policies and procedures of the Medicaid program.

26. In order to receive payment from Medicaid, the hospital sends data electronically to Medicaid on a claim form known as a Form CMS-1450. The claim form is required to state, among other things, the beneficiary's name and health insurance

claim number (HICN), the ICD-9 codes corresponding to the condition of the patient, the Healthcare Common Procedural Code Systems (HCPCS) code corresponding to the services provided to the Medicaid beneficiary, the date the service was provided, the charge for the service, and the National Provider Identifier (NPI) number of the billing provider. All information contained in the form must be true, accurate, and complete.

27. The Medicaid program may pay a portion of a claim originally submitted to Medicare in the event that the beneficiary/recipient has both Medicare and Medicaid coverage. This portion is generally 20 percent of the Medicare allowance for the billed charge. An individual who is eligible under both the Medicare and Medicaid programs is referred to as a "dual-eligible beneficiary." A claim originally submitted to Medicare and subsequently to Medicaid for payment is referred to as a "crossover claim." Such claims are sent to Medicaid once processed by Medicare. Medicaid will pay its portion if Medicare originally allowed the claim.

28. Medicaid regulations require that a provider document every service rendered to a patient for whom a bill was submitted. This documentation is part of the recipient's medical record and is required to be retained by the provider for a period of not less than five years.

29. All payments made by Medicaid are made to a provider in the form of a pre-arranged direct deposit into the provider's bank account.

The Defendant and his Hospitals

30. **Tariq Mahmood, M.D.**, is a general practitioner, licensed by the Texas Medical Board.

31. **Tariq Mahmood, M.D.**, was a resident of Cedar Hill, Texas. He owned and operated several hospitals in the state of Texas.

32. TM Van Zandt Hospital, LLC, DBA Cozby Germany Hospital ("Cozby") was located in Grand Saline, Texas. Cozby was a Medicare and Medicaid provider.

33. RH Terrell Management, LLC, DBA Renaissance Hospital Terrell ("RH Terrell") was located in Terrell, Texas. RH Terrell was a Medicare and Medicaid provider.

34. Cameron Hospital, Inc., DBA Central Texas Hospital ("Central Texas") was located in Cameron, Texas. Central Texas was a Medicare and Medicaid provider.

35. Community General Hospital of Dilly, Texas, Inc., DBA Community General Hospital ("Community General") was located in Dilley, Texas. Community General was a Medicare and Medicaid provider.

36. Shelby Hospital, LLC, DBA Shelby Regional Medical Center ("Shelby Regional") was located in Center, Texas. Shelby Regional was a Medicare and Medicaid provider.

37. The hospitals identified above will be referred to collectively as the "Hospitals."

COUNT 1

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

1. The General Allegations section of this Indictment is realleged and incorporated by reference as though fully set forth herein.

2. From in or around April 2010, and continuing through in or around April 2013, the exact dates being unknown to the Grand Jury, in the Eastern District of Texas, and elsewhere, the defendant, **Tariq Mahmood, M.D.**, did knowingly and willfully combine, conspire, confederate, and agree with others, both known and unknown to the Grand Jury, to violate 18 U.S.C. § 1347, that is, to execute a scheme and artifice to defraud a health care benefit program affecting commerce, as defined in 18 U.S.C. § 24(b), that is, Medicare and Medicaid, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of Medicare and Medicaid, in connection with the delivery of and payment for health care benefits, items, and services.

Purpose of the Conspiracy

3. It was the general purpose of the conspiracy for the defendant to unlawfully obtain money from Medicare and Medicaid through misrepresentations and violations of Medicare and Medicaid rules. To this end, the defendant and co-conspirators would, among other things, (a) submit or cause the submission of false and fraudulent claims to Medicare and Medicaid, and (b) conceal the submission of false and fraudulent claims to Medicare and Medicaid.

Manner and Means of the Conspiracy

The manner and means by which the defendant and co-conspirators sought to accomplish the object and purpose of the conspiracy included, among others, the following:

4. To achieve the goals of the conspiracy, the defendant and co-conspirators devised and carried out a scheme to defraud Medicare and Medicaid through the submission of false and fraudulent claims. The defendant and co-conspirators added, changed, deleted, and incorrectly sequenced diagnostic codes in a manner inconsistent with the actual diagnoses and conditions of the patients. The defendant and co-conspirators then submitted false and fraudulent claims based on added, changed, deleted, and incorrectly sequenced diagnostic codes. Such changes resulted in altered DRGs, which in turn resulted in inflated and improper reimbursement from Medicare and Medicaid. By means of fraudulent billing practices, the defendant unlawfully obtained more than $375,000 from Medicare and Medicaid.

5. **Tariq Mahmood, M.D.**, obtained ownership and control of the Hospitals.

6. **Tariq Mahmood, M.D.**, with the assistance of co-conspirators, controlled the operations of the Hospitals.

7. **Tariq Mahmood, M.D.**, and others were designated as the authorized official, owner, and representative of the Hospitals on documents provided to Medicare and Medicaid.

8. **Tariq Mahmood, M.D.**, would maintain valid Medicare and Medicaid provider numbers for the Hospitals.

9. **Tariq Mahmood, M.D.**, maintained bank accounts for the purpose of receiving, concealing, and disbursing Medicare and Medicaid payments.

10. **Tariq Mahmood, M.D.**, directly and indirectly, instructed hospital personnel to improperly assign diagnostic codes which were not accurate representations of the actual diagnoses and conditions of the patients.

11. **Tariq Mahmood, M.D.**, directly and indirectly, instructed hospital personnel to add, change, delete, and incorrectly sequence diagnostic codes in a manner inconsistent with the actual diagnoses and conditions of the patients.

12. **Tariq Mahmood, M.D.**, directly and indirectly, added, changed, deleted, and incorrectly sequenced diagnostic codes in medical records, in many cases for patients he had never seen.

13. **Tariq Mahmood, M.D.**, directly and indirectly, instructed hospital personnel to add, change, delete, and incorrectly sequence diagnostic codes without reviewing medical records.

14. **Tariq Mahmood, M.D.**, directly and indirectly, instructed hospital personnel at Central Texas to add, change, delete, and incorrectly sequence diagnostic codes that had been entered correctly by hospital personnel at Cozby and RH Terrell.

15. **Tariq Mahmood, M.D.**, and co-conspirators caused to be submitted false and fraudulent claims to Medicare and Medicaid by representing that certain diagnoses and conditions of patients were accurate when in truth and fact they were not.

16. **Tariq Mahmood, M.D.**, and co-conspirators caused to be submitted false and fraudulent claims to Medicare and Medicaid by representing that certain diagnoses and conditions of patients were more severe than they actually were.

17. **Tariq Mahmood, M.D.**, and co-conspirators caused to be submitted false and fraudulent claims of more than $1,150,000 to Medicare and Medicaid using the Hospitals' Medicare and Medicaid provider numbers.

18. Based on these false and fraudulent claims, reimbursement of more than $375,000 was paid by Medicare and Medicaid to accounts controlled by **Tariq Mahmood, M.D.**

19. **Tariq Mahmood, M.D.**, and co-conspirators obtained control of the funds paid to the Hospitals and diverted these monies for their personal use and benefit, as well as that of others.

All in violation of 18 U.S.C. § 1349.

COUNTS 2-8

Violation: 18 U.S.C. §§ 1347 and 2 (Health Care Fraud)

1. The General Allegations section of this Indictment is realleged and incorporated by reference as though fully set forth herein.

2. From in or around April 2010, and continuing through in or around April 2013, the exact dates being unknown to the Grand Jury, in the Eastern District of Texas, and elsewhere, the defendant, **Tariq Mahmood, M.D.**, in connection with the delivery of and payment for health care benefits, items, and services, did knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud a health care benefit program affecting commerce, as defined in 18 U.S.C. § 24(b), that is, Medicare and Medicaid, and to obtain, by means of materially false and fraudulent pretenses,

representations, and promises, money and property owned by, and under the control of Medicare and Medicaid, in connection with the delivery of and payment for health care benefits, items, and services.

Purpose of the Scheme and Artifice

3. It was the general purpose of the scheme and artifice for the defendant to unlawfully obtain money from Medicare and Medicaid through misrepresentations and violations of Medicare and Medicaid rules. To this end, the defendant would, among other things, (a) submit and cause the submission of false and fraudulent claims to Medicare and Medicaid, and (b) conceal the submission of false and fraudulent claims to Medicare and Medicaid.

The Scheme and Artifice

4. Paragraphs 4 through 19 of Count 1 of this Indictment are realleged and incorporated by reference as though fully set forth herein as a description of the scheme and artifice.

Acts in Execution of the Scheme and Artifice

5. On or about the dates specified as to each count below, in the Eastern District of Texas, and elsewhere, the defendant, **Tariq Mahmood, M.D.**, in connection with the delivery of and payment for health care benefits, items, and services, did knowingly and willfully execute, and attempt to execute, the above-described scheme and artifice to defraud a health care benefit program, that is, Medicare and Medicaid, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by and under the custody and control of Medicare

and Medicaid, in that he submitted and caused the submission of claims to Medicare and Medicaid for approximately the identified dollar amounts, and represented that, on or about the identified dates of service, the identified diagnosis code sequence for each identified beneficiary was true, accurate, and complete:

Count	Medicare Beneficiary	Dates of Service	Payment Date	ICD-9 Code Sequence	Billed Amount
2	T.C.	05/13/2011 - 05/15/2011	05/27/2011	49121	$8,065.40
3	S.C.	05/11/2011 - 05/13/2011	05/27/2011	5990 4359 42823 49121 34590	$11,972.40
4	J.G.	05/11/2011 - 05/12/2011	06/10/2011	5859 5990 2761 5920 7880	$8,187.80
5	A.G.	05/24/2011 - 05/27/2011	06/17/2011	515 2761 49121 25002 4019	$17,727.25
6	L.H.	05/13/2011 - 05/13/2011	05/27/2011	4370	$6,489.70
7	Y.R.	05/23/2011 - 05/26/2011	06/10/2011	3310	$14,410.60

Count	Medicare Beneficiary	Dates of Service	Payment Date	ICD-9 Code Sequence	Billed Amount
8	J.W.	05/26/2011 - 05/29/2011	09/09/2011	416	$15,825.60

All in violation of 18 U.S.C. §§ 1347 and 2.

NOTICE OF INTENT TO SEEK CRIMINAL FORFEITURE
Pursuant to 18 U.S.C. § 981(a)(1)(C), 28 U.S.C. § 2461(c), and
18 U.S.C. § 982(a)(7)

1. The allegations contained in Counts 1 through 8 of this Indictment are realleged and incorporated by reference as though fully set forth herein for the purpose of alleging forfeiture to the United States of America of certain property in which the defendant has an interest.

2. Upon conviction of any violation of 18 U.S.C. § 1349, the defendant shall forfeit to the United States any property, real or personal, that constitutes or is derived from proceeds traceable to a violation of any offense constituting "specified unlawful activity," or a conspiracy to commit such offense, pursuant to 18 U.S.C. § 981(a)(1)(C) and 28 U.S.C. § 2461(c).

3. Upon conviction of any violation of 18 U.S.C. § 1347, the defendant shall forfeit to the United States any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense, pursuant to 18 U.S.C. § 982(a)(7).

4. The property which is subject to forfeiture, includes but is not limited to the following:

A money judgment in the amount of $375,801.81, which represents proceeds of the fraud.

5. Pursuant to 21 U.S.C. § 853(p), as incorporated by reference by 18 U.S.C. § 982(b), if any of the forfeitable property, or any portion thereof, 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 subdivided without difficulty;

it is the intent of the United States to seek the forfeiture of other property of the defendant up to the value of the above-described forfeitable properties, including, but not limited to, any identifiable property in the name of **Tariq Mahmood, M.D.**

6. By virtue of the commission of the offenses alleged in this Indictment, any and all interest the defendant has in the above-described property is vested in the United States and hereby forfeited to the United States pursuant to 18 U.S.C. § 981(a)(1)(C), 28 U.S.C. § 2461(c), and 18 U.S.C. § 982(a)(7).

All pursuant to 18 U.S.C. § 981(a)(1)(C), 28 U.S.C. § 2461(c), and 18 U.S.C. § 982(a)(7) and the procedures set forth at 21 U.S.C. § 853, as made applicable through 18 U.S.C. § 982(b)(1).

A TRUE BILL

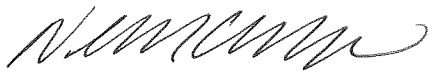
BB

GRAND JURY FOREPERSON

4/11/2013

Date

JOHN M. BALES
UNITED STATES ATTORNEY



NATHANIEL C. KUMMERFELD
ASSISTANT UNITED STATES ATTORNEY

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

UNITED STATES OF AMERICA	§	
	§	
v.	§	NO. 6:13CR__
	§	
TARIQ MAHMOOD, M.D.	§	

NOTICE OF PENALTY

COUNT 1

VIOLATION: Title 18, United States Code, Section 1349
Conspiracy to Commit Health Care Fraud

PENALTY: Imprisonment of not more than ten years and a fine of $250,000 to be followed by not more than three (3) years supervised release.

SPECIAL ASSESSMENT: $100.00 each count

COUNTS 2-8

VIOLATION: Title 18, United States Code, Section 1347
Health Care Fraud

PENALTY: Imprisonment of not more than ten years and a fine of $250,000 to be followed by not more than three (3) years supervised release.

SPECIAL ASSESSMENT: $100.00 each count