IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS
AT PEORIA

UNITED STATES OF AMERICA,	)	
	)	No. 22-cr-10035
Plaintiff,	)	
	)	VIOLATIONS:
v.	)	
	)	18 U.S.C. § 1347 (Healthcare Fraud)
CARRIE A. MUSSELMAN,	)	18 U.S.C. § 1343 (Wire Fraud)
	)	18 U.S.C. § 1516 (Obstruction of Audit)
Defendant.	)	

INDICTMENT

The Grand Jury charges:

COUNT 1
(Healthcare Fraud)

Background

At all times material:

1. CARRIE A. MUSSELMAN ("MUSSELMAN") was a chiropractor, licensed by the State of Illinois, who owned and operated Preferred Care Medical Center ("Preferred Care").

2. Preferred Care was incorporated on or about February 26, 2014. MUSSELMAN was the Registered Agent and the only corporate officer listed with the Illinois Secretary of State for Preferred Care.

3. Preferred Care had, at various times, facilities in El Paso, Monticello, Metamora, Peoria, Roanoke, and Eureka. All the facilities were within the Central District of Illinois.

4. Preferred Care was a medically integrated clinic. Being medically integrated meant that in addition to having chiropractors, Preferred Care also had "mid-level" medical providers who were licensed to provide non-chiropractic medical services, such as primary healthcare, trigger-point injections, joint injections, and school physicals.

5. Mid-level providers were not licensed Medical Doctors or licensed Doctors of Osteopathy (collectively referred to as "physicians") but were individuals, licensed by the State of Illinois, as Nurse Practitioners or Physician Assistants. The State of Illinois provided a "scope of practice" for mid-level providers by defining the services that mid-level providers were allowed to perform. Mid-level providers were allowed to perform certain services on their own, but they were not authorized to perform all the services that a physician was authorized to perform.

6. The State of Illinois required mid-level providers to have a collaborative practice agreement ("CPA") with a collaborating physician. The CPA was to be in writing and was to outline treatment and procedures that a mid-level

provider was allowed to perform on their own, as well as outlining which procedures required the presence of a physician.

7. Illinois did not require the physical presence of the collaborating physician at the times and places where the mid-level provider treated patients. Instead, mid-level providers were supposed to consult with the collaborating physician at least once a month, but the consultation did not need to be face-to-face.

8. The CPA was required before a mid-level provider could see patients at Preferred Care. However, the CPA did not allow a medical provider to bill for the collaborating physician or to claim that the collaborating physician rendered the service that was provided by the mid-level provider.

9. During the relevant time period, the mid-level providers Preferred Care employed utilized three different collaborating physicians. The three collaborating physicians are identified herein as MA, EK, and BB. None of the three collaborating physicians were routinely present at Preferred Care.

10. On or about August 11, 2014, MUSSELMAN completed an application to enroll herself and Preferred Care in Medicare. Medicare was a federal health insurance program for certain people in the United States. It was a public "healthcare benefit program," as that term is defined in Title 18, United

States Code, Section 24(b) and received more than $100,000 annually from the United States in each of the relevant years.

11. As part of her Medicare application, MUSSELMAN agreed that she and Preferred Care would abide by the laws, regulations, and instructions of Medicare. She further acknowledged that the payment of a claim by Medicare was conditioned upon that claim, and the underlying transaction, complying with such laws, regulations, and program instructions.

12. On or about October 7, 2014, Preferred Care's application to enroll in Medicare was approved. As a result, insurance coverage and payment for Preferred Care's services were available through Medicare.

13. Preferred Care was required to submit claims to Medicare before it could receive payment for the services it provided to Medicare beneficiaries. These claims included, among other things, the name of the patient, the date of service, the service rendered, and the health professional who rendered the service.

14. When submitting claims to Medicare, medical providers used numeric codes that were established by the American Medical Association ("AMA"). The AMA established a definition for each code that linked the code to a specific service or product that was rendered.

15. By submitting claims using these codes, providers represented that the services associated with a code's description were performed by a qualified individual and that the provider was entitled to reimbursement for the services.

16. Upon receipt of claims from medical providers, Medicare was responsible for processing the claims and paying the provider, as appropriate.

17. Reimbursement rates for the codes were set through the fee schedules created by Medicare. Though the fee schedule set the maximum amount for a given service, the fee a provider received could vary depending on the type of healthcare professional providing the service. For instance, a physician who provided a service could collect 100% of the maximum fee. However, a mid-level provider—if authorized to perform the same service—would have only received 85% of the maximum. In other words, if a physician and a mid-level provider both submitted reimbursement requests for the same service, the physician would have received 15% more than the mid-level provider even though each person performed the same task.

18. Oversight of the Medicare program included periodic post-payment audits of healthcare providers, like Preferred Care. These audits were performed by Universal Program Integrity Contractors ("UPIC"). One of the functions of these audits was to determine if the payments made by Medicare were

appropriate. The UPIC was authorized to quantify and collect overpayments from providers when appropriate.

19. Starting on or about November 5, 2018, and continuing until on or about November 8, 2018, the UPIC conducted an onsite audit of payments Medicare made to Preferred Care. As a part of that audit, the UPIC interviewed MUSSELMAN on or about November 5, 2018. As a follow up to the audit, on or about December 19, 2018, MUSSELMAN provided the UPIC with a written "attestation of facts" containing information related to the payments being reviewed by the UPIC.

The Scheme to Defraud

20. Beginning as early as May 2016 and continuing to at least November 2018, in the Central District of Illinois and elsewhere,

CARRIE MUSSELMAN,

defendant herein, did knowingly engage in a scheme and artifice to defraud Medicare, a health care benefit program, and others, and to obtain money and property by means of materially false and fraudulent pretenses, representations, and promises.

21. As part of the scheme and artifice to defraud, MUSSELMAN established policies and procedures at Preferred Care which directly benefitted

herself financially and which defrauded health care benefit programs, including Medicare.

22. It was further part of the scheme and artifice to defraud that Preferred Care used improper codes and mischaracterized care that was provided in order to receive payment from Medicare for services that would not otherwise have been covered and to receive payment in greater amounts than would have been allowed.

23. It was further part of the scheme and artifice to defraud that Preferred Care submitted claims for payment to Medicare falsely representing that services had been rendered by one of the collaborating physicians, when, in truth and fact, the services had been performed by a mid-level provider.

24. MUSSELMAN submitted and caused to be submitted these claims, despite the fact that Preferred Care did not have any physicians on staff and almost never had a physician in one of its facilities. In some instances, had Preferred Care disclosed that the service had been rendered by a mid-level provider, and not a physician, Medicare would not have paid anything for the service.

25. It was further part of the scheme and artifice to defraud that in the UPIC audit that began on or about November 5, 2018, MUSSELMAN made false statements regarding one of Preferred Care's collaborating physicians, MA, in whose name claims had been submitted to Medicare. MUSSELMAN falsely

represented that MA worked at Preferred Care and provided direct patient care, when, in truth and fact, MA did not.

26. It was further part of the scheme and artifice to defraud that MUSSELMAN transmitted a statement to the UPIC, on or about December 19, 2018, in which she asserted that she and another collaborating physician, BB, had discussed and agreed on the interpretation of terminology included in the definition for a certain code that Preferred Care had billed to Medicare. MUSSELMAN made this statement when, as she well knew, it was not true.

27. By submitting false and fraudulent claims, MUSSELMAN and Preferred Care received and attempted to receive compensation from Medicare, and other healthcare benefit programs, to which they were not entitled.

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

Counts 2 – 11
(Wire Fraud)

28. The grand jury realleges and incorporates by reference the allegations set forth in paragraphs 1 – 27 as if fully set forth herein as paragraph 28.

29. On or about each of the dates set forth below, in the Central District of Illinois and elsewhere,

CARRIE MUSSELMAN,

defendant herein, for the purpose of executing and attempting to execute the scheme and artifice to defraud, did knowingly cause to be transmitted by means of wire communication in interstate commerce the signals and sounds described below for each count, each transmission constituting a separate count.

Count	Date	Wire Communication	Patient
2	8/1/2017	Claim 620917213210350, submitted to Medicare Part B	S.O.
3	8/23/2017	Claim 620917235064720, submitted to Medicare Part B	H.B.
4	9/26/2017	Claim 620917269185000, submitted to Medicare Part B	N.W.
5	10/13/2017	Claim 620917286004670, submitted to Medicare Part B	J.W.
6	11/8/2017	Claim 620917312048660, submitted to Medicare Part B	J.M.
7	12/6/2017	Claim 620917340161770, submitted to Medicare Part B	P.C.
8	7/11/2018	Claim 620918192229590, submitted to Medicare Part B	D.R.
9	7/24/2018	Claim 620918205020940, submitted to Medicare Part B	D.B.

10	9/21/2018	Claim 620918264133040, submitted to Medicare Part B	I.D.
11	10/18/2018	Claim 620918291246950, submitted to Medicare Part B	C.N.

All in violation of Title 18, United States Code, Section 1343.

Count 12
(Obstruction of Federal Audit)

30. The grand jury realleges and incorporates by reference the allegations set forth in paragraphs 1 – 27 as if fully set forth herein as paragraph 30.

31. On or about November 5, 2018, in the Central District of Illinois and elsewhere,

CARRIE MUSSELMAN,

defendant herein, with the intent to deceive and defraud the United States, endeavored to influence, obstruct, and impede Medicare's Universal Program Integrity Contractors (UPIC), a Federal auditor in the performance of official duties relating to a Medicare contract receiving in excess of $100,000, directly and indirectly, from the United States in the one year period from January 1, 2018 to January 1, 2019, pursuant to UPIC's responsibilities to provide oversight in the administration of Medicare contracts.

All in violation of Title 18, United States Code, 1516.

Count 13
(Obstruction of Federal Audit)

32. The grand jury realleges and incorporates by reference the allegations set forth in paragraphs 1 – 27 as if fully set forth herein as paragraph 32.

33. On or about December 19, 2018, in the Central District of Illinois and elsewhere,

CARRIE MUSSELMAN,

defendant herein, with the intent to deceive and defraud the United States, endeavored to influence, obstruct, and impede Medicare's Universal Program Integrity Contractors (UPIC), a Federal auditor in the performance of official duties relating to a Medicare contract receiving in excess of $100,000, directly and indirectly, from the United States in the one year period from January 1, 2018 to January 1, 2019, pursuant to UPIC's responsibilities to provide oversight in the administration of Medicare contracts.

All in violation of Title 18, United States Code, 1516.

FORFEITURE ALLEGATION

34. The grand jury realleges and incorporates by reference the allegations of paragraphs 1 – 27 as if fully set forth herein as paragraph 34 for the purpose of alleging forfeitures pursuant to Title 18, United States Code, Section 982(a)(7).

35. Upon conviction of the offenses as set forth in Counts 1 through 13 of this Indictment, the defendant, CARRIE MUSSELMAN, shall forfeit to the United States of America, pursuant to Title 18, United States Code, Section 982(a)(7), any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offenses.

36. The United States seeks a personal money judgment against the defendant, CARRIE MUSSELMAN, in the amount of at least $1,659,063.37, representing the amount of the gross proceeds obtained as a result of the offenses described in the Indictment.

37. 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, including, but not limited to, the following:

(1) One parcel of real estate, together with all buildings, appurtenances, improvements, fixtures, attachments, and easements thereon, and all rights appertaining thereto, commonly known as 1459 County 475 North, Eureka, Illinois 61530.

(2) Four parcels of real estate, together with all buildings, appurtenances, improvements, fixtures, attachments, and easements thereon, and all rights appertaining thereto, commonly known as: 575 Reaba Ave, Congerville, Illinois 61729.

38. Moreover, it is the intent of the United States, pursuant to Title 21, United States Code, Section 853(p), as incorporated by Title 18, United States Code, Section 982(b)(1), to seek forfeiture of any other property of the defendant up to the value of the forfeitable property described in this forfeiture allegation.

All pursuant to Title 18, United States Code, Sections 982(a)(7) and 982(b)(1); Title 21, United States Code, Section 853(p); Title 28 United States Code, Section 2461(c); and Federal Rule of Criminal Procedure 32.2.

A True Bill,
s/Foreperson

Foreperson

s/Doug McMeyer

Gregory K. Harris
UNITED STATES ATTORNEY
DFM