

United States Court of Appeals
for the Fifth Circuit

No. 25-30528

United States Court of Appeals
Fifth Circuit

FILED

October 12, 2026

Thomas B. Plunkett, III
Clerk

UNITED STATES OF AMERICA,

Plaintiff—Appellee,

versus

BENJAMIN TEKIPPE,

Defendant—Appellant.

Appeal from the United States District Court
for the Eastern District of Louisiana
USDC No. 2:21-CR-122-1

Before SMITH, HAYNES, and ENGELHARDT, *Circuit Judges*.

JERRY E. SMITH, *Circuit Judge*:

A jury convicted chiropractor Benjamin Tekippe of six counts of health care fraud and one count of wire fraud after a seven-day trial.¹ Tekippe owned and operated Oak Tree Chiropractic LLC, doing business as Metairie Chiropractic & Rehab (“Metairie Chiropractic”). For about three and a half years, Tekippe executed a scheme of submitting fraudulent reimbursement

¹ The jury acquitted him of one count of making a false statement to federal agents (Count 7).

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claims to Blue Cross and Blue Shield of Louisiana (“BCBSLA”).

During that period, at least 93% of Tekippe’s BCBSLA-billed claims included the same six service codes. BCBSLA investigator Misty Jones stated that Tekippe “stuck out” because he billed more for massage therapy than any other chiropractor in Louisiana. Investigators noticed that there was minimal differentiation between patients’ records, which raised concerns of copying and pasting. Employees testified that Tekippe pressured them to fabricate notes and offered \$2 per note.

Tekippe appeals his sentence, questioning the district court’s finding that he engaged in pervasive fraud. Because that finding was at least plausible, and conscious of the deference we afford findings of fact, we affirm.

I.

We review “[a] district court’s interpretation or application of the . . . [g]uideline[] . . . *de novo*, and its factual findings . . . for clear error.” *United States v. Dennis*, 41 F.4th 732, 743 (5th Cir. 2022) (citation and internal quotation omitted). Because findings of pervasive and extensive fraud are findings of fact, we review for clear error. *United States v. Barnes*, 979 F.3d 283, 310–11 (5th Cir. 2020) (reviewing a district court finding of pervasive health-care fraud for clear error). “A factual finding” survives clear error review “if it is plausible in light of the record read as a whole.” *United States v. Puig-Infante*, 19 F.3d 929, 942 (5th Cir. 1994) (citation omitted).

II.

A.

BCBSLA’s financial investigations director Latisha Mire testified that Tekippe was an enrolled provider who agreed to comply with BCBSLA’s rules, including the one stipulating that BCBSLA covered only medically necessary services. “[F]or example, spa-type massages would not

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be a covered service[.]” BCBSLA also limited coverage to services performed by, or under the supervision of, a licensed provider and required documentation of every treatment session.

When BCBSLA investigators visited Tekippe’s Metairie clinic² to review his practice, they were not shown an adjacent massage suite that Tekippe operated. Licensed massage therapists (“LMTs”) Skyler Daniels and Ingrid Sabllos—who worked at Tekippe’s adjacent suite—testified that they received no chiropractic-massage training and gave clients whatever type of requested massage, typically a full body massage. Tekippe’s billings did not identify the LMTs providing the massages.

For some time, LMTs were asked not to write treatment notes, known as SOAP notes.³ But Tekippe changed course. He began requiring SOAP notes from LMTs and instructing them not to record giving full body massages. Tekippe asked Daniels, Saballos, and another LMT to write back-dated SOAP notes, offering to pay \$2 per note. Despite pressure from Tekippe, Daniels and Saballos refused Tekippe’s offer. Two substitute chiropractors—employed for Tekippe during the relevant period—testified that they did not perform, supervise, or certify patient need for massages, electrical stimulation, or mechanical traction.

BCBSLA investigator Jones found “hardly any differentiation from patient to patient” after reviewing one year’s records, which raised concerns about “copying and pasting.” FBI Special Agent Krista Bradford testified that “in a lot of medical records, things were cut and paste and said the same

² Though Tekippe opened a second location during the relevant period, the Metairie clinic was the focus of the trial evidence.

³ A SOAP note memorializes subjective complaints, objective findings, an assessment, and a plan for treatment.

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thing.” For instance, SOAP notes for client Logan Camus on three different dates were “all the same notes.” And chiropractic assistant Cindy Chu testified that Tekippe trained employees to use a “cheat sheet” to fabricate SOAP notes for repeat patients. Chu and office manager Nikoehl Hebert testified that assistants often provided chiropractic services without supervision. Chu and Hebert—who both received Metairie Chiropractic’s services—also testified that they did not receive some of the services that Tekippe billed for performing on the two.

Tekippe denied the intent to defraud BCBSLA, attributing irregularities to ignorance, oversights, and employee lapses. Chiropractic assistant Hannah Ruiz testified that she never falsified records or saw anyone else do so. She also testified witnessing Tekippe and another chiropractor perform adjustments⁴ on patients.

B.

During the relevant fraud period, Tekippe submitted claims to BCBSLA totaling over \$2,300,000, of which BCBSLA paid \$740,842.36. The PSR identified the former as intended loss for Counts 1 through 6 and the latter as actual loss. After submitting a fraudulent application for unemployment insurance (“UI”) benefits to the Louisiana Workforce Commission (“LWC”) and improperly attesting that he was terminated or laid off from his job, Tekippe received “[sixteen] fraudulent UI payments totaling at least \$12,952.” Adding the UI fraud amount produced actual and intended loss amounts of \$753,794.36 and \$2,312,952, respectively. In part because the loss exceeded \$1,500,000, the PSR calculated a total offense level of thirty-three and a guideline range of 151 to 188 months. U.S.S.G.

⁴ Ruiz explained that adjustments included “[s]tretching patients when they needed it, and stuff like that.”

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§ 2B1.1(b)(1)(I).

Tekippe posited that the intended loss corresponded to actual loss because he allegedly knew that BCBSLA would reimburse only a fraction of what he billed. He also suggested that he was entitled to credit for legitimate services and that the government failed to show that the fraud was pervasive. Tekippe re-urged these contentions in a sentencing memorandum, which was accompanied by twenty-five patient declarations affirming that Tekippe personally treated the patients. *See* Def. Sent. Memorandum (dist. ct. dkt. entry 167), at 5–9; Exs. to Def. Sent. Memo. (dist. ct. dkt. entry 167–1), at 2–33. Tekippe calculated that these services accounted for over \$450,000 billed to BCBSLA and \$158,327.14 actually paid. Exs. to Def. Sent. Memo., 1. He averred that, “[a]t a minimum,” this supported reducing BCBSLA’s loss to \$582,515.12. Def. Sent. Memo, at 9.

But the government countered that Tekippe’s fraud was pervasive and the amount billed to BCBSLA was the appropriate measure of loss. *See* Gov’t Sent. Memo. (dist. ct. dkt. entry 170), at 5–9. The government maintained that the twenty-five declarations failed to demonstrate that claims for services to the declarants were legitimate. It reasoned that billings and recordings of several declarants contained indications of fraud. *See* Gov’t Sent. Memo at 9–10; Exs. to Gov’t Sent. Memo. (dist. ct. dkt. entry 170–1), at 1–13.

At sentencing, the district court sustained in part the objections as to loss amounts for the health care fraud, agreeing that the intended loss corresponded to BCBSLA’s actual loss, but refused to exclude any payments from that amount or to consider only the specific acts alleged in Counts 1 through 6. The district court observed that “[i]t was a scheme that was alleged and proved at trial,” and the defense had “not presented any evidence separating every legitimate claim . . . from all of the fraudulent ones[.]”

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Nevertheless, Tekippe requested a downward variance. But the government urged that Tekippe's pervasive fraud was the reason he was subject to an adverse presumption. The district court noted that when a scheme "is of such a nature that it's impossible to separate . . . the wheat from the chaff, . . . then it does become the defense's burden, and . . . that[] [is] a burden that was to be borne at trial." The district court added that this burden "wasn't borne, and so it's difficult to sort out the legitimate from the illegitimate," noting that the evidence at trial proved "a scheme" involving "some significant amount" and that "the Court must take that into account in fashioning a sentence."

After identifying a total loss of \$753,794.36, which lowered Tekippe's total offense level from 33 to 31,⁵ the district court adopted the PSR's factual statements and a guideline range of 121 to 151 months. The court sentenced Tekippe to 84 months, plus three years of supervised release, explaining that it varied downward "because the amount of intended loss resulted in a guideline sentence that was disproportionate with the nature and circumstance of the offense." The district court stated that it would impose the same sentence even if a higher guideline range applied.

III.

Considering the entire record, Tekippe's fraud was pervasive.

Tekippe's sole claim on appeal challenges the district court's finding of pervasive fraud underlying the determination of BCBSLA's loss under the guideline. Tekippe avers that, by providing twenty-five patient declarations acknowledging his services, he "proved that the counts of conviction

⁵ The district court "note[d] that even if it reduced the loss amount to the \$582,515.12 figure, [there] still would be a 14-level increase . . . because the guideline applicable, Section 2B1.1(b)(1)(H), . . . f[e]ll[] within that range."

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were the exception, not the norm,” maintaining that “the district court improperly rejected this evidence” because it was not offered at trial. He asserts that the “government failed to prove fraud beyond the counts of conviction” and that the government “elicited broad, misleading testimony . . . without explanation, context, or supporting evidence.” Tekippe conjures that the trial evidence showed no more than isolated billing discrepancies.

The fraud guideline, § 2B1.1, includes the amount of loss as an offense-level enhancement. U.S.S.G. § 2B1.1(b)(1). A district court “need only make a reasonable estimate of the loss” for purposes of this provision.⁶ “The applicable loss is generally the greater of actual loss—which includes only reasonably foreseeable harm resulting from the fraud—and intended loss—which includes the harm intended to result from the offense.” *United States v. Hebron*, 684 F.3d 554, 560 (5th Cir. 2012) (citing U.S.S.G. § 2B1.1 cmt. 3(A)). “[A]lthough the government generally bears the burden of showing that the alleged intended loss was garnered by fraudulent means, where the government has shown that the fraud was so extensive and pervasive that separating legitimate benefits from fraudulent ones is not reasonably practicable, the burden shifts to the defendant to make a showing that particular amounts are legitimate.” *Id.* at 563. In the absence of such a showing, “the district court may reasonably treat the entire claim for benefits as intended loss.” *Id.*

Extensive evidence from the record supports the conclusion that the finding of pervasive fraud was at least plausible. *First*, Tekippe acknowledged billing the *same bundle* of five or six services for every patient during the

⁶ U.S.S.G. § 2B1.1, cmt. n.3(B); *see also id.* (“The sentencing judge is in a unique position to assess the evidence and estimate the loss based upon that evidence. For this reason, the court’s loss determination is entitled to appropriate deference.” (citations omitted)).

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relevant fraud period.⁷ In fact, those six codes account for roughly 93% of the claims Tekippe billed to BCBSLA. Tekippe's practice "stuck out" because he billed more for massage therapy than any other chiropractor in Louisiana. This disparity is not insignificant and likely did not occur "by . . . chance."⁸

Second, several witnesses, including employees and patients, testified that Tekippe *did not perform* services that he billed to BCBSLA. For example, employees Chu and Hebert described Tekippe's BCBSLA billings, which included nearly 600 claims for services rendered to the two, as highly inaccurate. Camus, who recounted visiting Tekippe's clinic, testified that he received two or three therapeutic exercises, not the fifty-five billed to BCBSLA, and one or two chiropractic adjustments (i.e., manipulations), not the fifty-three billed.

Third, there is considerable evidence that billed services were improperly performed *without* regard to medical necessity. Even though Mire, the director of BCBSLA's financial investigations department, testified that BCBSLA covered only medically necessary treatment, which meant that the services rendered "ha[d] to be very specific for what the person's complaint [wa]s," LMTs said they performed whatever massage clients requested, without corresponding input from Tekippe or another chiropractor. Mire testified that services had to be performed or supervised by a licensed provider and that corresponding records needed to be prepared before claims were filed. Though Tekippe points to evidence of patients' receiving some

⁷ The bundled services and corresponding billing codes were: (i) mechanical traction (97012); (ii) electrical stimulation (97014); (iii) therapeutic exercises (97110); (iv) massage therapy (97124); and (v) chiropractic manipulation (98941 and 98943).

⁸ See *Barnes*, 979 F.3d at 312 (affirming the district court's pervasiveness finding after noting that a witness's "testimony indicated that a greater percentage of [the co-defendant]'s patients had been diagnosed with each of those [six or seven] diagnostic codes than other providers in Louisiana.")

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legitimate services, he largely ignores testimony indicating that many services were not appropriately documented or performed. And the government provided evidence that there was widespread record fabrication and that unsupervised assistants provided services.

Tekippe's counterarguments prove unavailing. *First*, he theorizes that testimony about his records and practices could have been more detailed and better corroborated. But "[e]ven hearsay evidence . . . may be sufficiently reliable" to support a factual determination at sentencing. *See United States v. Malone*, 828 F.3d 331, 337 (5th Cir. 2016) (citation and internal quotation omitted). And sentencing facts "need only be found by a *preponderance of the evidence*." *United States v. Mazkouri*, 945 F.3d 293, 303 (5th Cir. 2019) (citation omitted) (emphasis added); *see also id.* at 304 (concluding that "[t]he PSR's distillation of the facts" sufficed to show pervasive fraud). The government's trial evidence, including testimony from relevant witnesses, was appropriate and reinforced the district court's sound conclusion that Tekippe's fraud was pervasive, not just isolated billing discrepancies.

Second, Tekippe's reliance on the twenty-five patient declarations is likely misplaced. Although that evidence might show that he provided some legitimate services, the evidence is not inconsistent with extensive fraud. Even if these declarant-supported claims were all non-fraudulent—a stretch considering the instant record—such claims would account for less than a quarter of the amount billed and received. *See Exs. to Def. Sent. Mem.*, at 1. And in any event, legitimate *services* are not necessarily synonymous with legitimate *claims*, namely claims made in compliance with BCBSLA's policies.⁹ Neither does Tekippe attempt to demonstrate that claims for those

⁹ *See also United States v. Jones*, 664 F.3d 966, 984 (5th Cir. 2011) (noting that the defendants' contention that "their treatment[s] provided value to their patients" was misplaced because their services had no value to the defrauded victim, Medicare).

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services met BCBSLA's reimbursement criteria, nor does he address the suggestion that the records of several declarants contain signs of fraud. The instant record refutes Tekippe's theory that the district court refused to consider the patient declarations. After all, the district court stated that a reduction of BCBSLA's loss to \$582,515.12, Tekippe's proposed figure factoring in the patient declarations, would not affect the guideline calculations. *See* U.S.S.G. § 2B1.1(b)(1)(H).

AFFIRMED.