U.S. DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA
FILED AUG 31 2011
CLERK

UNITED STATES DISTRICT COURT

MIDDLE DISTRICT OF LOUISIANA

INDICTMENT FOR CONSPIRACY TO COMMIT HEALTH CARE FRAUD, CONSPIRACY TO DEFRAUD THE UNITED STATES AND TO RECEIVE AND PAY HEALTH CARE KICKBACKS, FALSE STATEMENTS FOR USE IN DETERMINING RIGHTS FOR BENEFIT AND PAYMENT BY MEDICARE, AND FORFEITURE

UNITED STATES OF AMERICA	:	
	:	**Criminal No. 11-** 105-JJB-DLD
v.	:	
	:	
MICHAEL S. HUNTER, M.D.	:	**18 U.S.C. § 1349**
AYANNA A. ALVEREZ	:	**18 U.S.C. § 371**
LOUIS T. AGE	:	**42 U.S.C. § 1320a-7b(a)(2)**
VERNA S. AGE	:	**18 U.S.C. § 2**
KATHY A. PERIO, R.N.	:	**18 U.S.C. § 982**
MILTON L. WOMACK	:	
MARY L. JOHNSON	:	

THE GRAND JURY CHARGES:

General Allegations

At all times relevant to this Indictment:

The Medicare Program

1. The Medicare Program ("Medicare") was a federal health care program providing benefits to persons who were over the age of 65 or disabled. Medicare was administered by the United States Department of Health and Human Services ("HHS") through its agency, the Centers for Medicare & Medicaid Services ("CMS"). Individuals who received benefits under Medicare where referred to as Medicare "beneficiaries."

2. Medicare was a "health care benefit program," as defined by Title 18, United States Code, Section 24(b).

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3. "Part A" of the Medicare program covered certain eligible home health care costs for medical services provided by a home health agency ("HHA") to beneficiaries who required home health care services because of an illness or disability that caused them to be homebound. Payments for home healthcare medical services under Medicare Part A were typically made directly to an HHA or provider based on claims submitted to the Medicare program for qualifying services that had been provided to eligible beneficiaries, rather than directly to the beneficiary.

4. Physicians, clinics and other healthcare providers, including HHAs that provided services to Medicare beneficiaries were able to apply for and obtain a "provider number." A health care provider that was issued a Medicare provider number was able to file claims with Medicare to obtain reimbursement for services provided to beneficiaries. A Medicare claim was required to set forth, among other things, the beneficiary's name and Medicare information number, the services that had been performed for the beneficiary, the date the services were provided, the cost of the services, and the name and identification number of the physician or other healthcare provider that ordered the services.

5. CMS did not directly pay Medicare Part A claims submitted by Medicare-certified HHAs. CMS contracted with different companies to administer the Medicare Part A program throughout different parts of the United States. In the State of Louisiana, until September 30, 2009, CMS contracted with TriSpan Health Services to administer Part A HHA claims. After September 30, 2009, CMS contracted with Pinnacle Business Solutions, Inc. ("Pinnacle") to administer Part A HHA claims. As administrator, TriSpan and Pinnacle received, adjudicated, and paid claims submitted by HHA providers under the Part A program for home healthcare claims. Additionally, CMS separately contracted with AdvanceMed, a Zone

Program Integrity Contractor ("ZPIC"), formerly referred to as a Program Safeguard Contractor, to review HHA providers' claims data. AdvanceMed reviewed HHA provider's claims for potential fraud, waste and abuse.

Part A Coverage and Regulations

Reimbursements

6. The Medicare Part A program reimbursed 100% of the allowable charges for participating HHAs providing home health care services only if the patient qualified for home health care benefits. A patient qualifies for home health care benefits only if:

a. the patient was confined to the home, also referred to as homebound;

b. the patient was under the care of a physician who specifically determined that there was a need for home health care and established the Plan of Care ("POC"); and

c. the determining physician signed a certification statement specifying that the beneficiary needed intermittent skilled nursing services, physical therapy, or speech therapy, the beneficiary was confined to the home, that a POC for furnishing services was established and periodically reviewed, and that the services were furnished while the beneficiary was under the care of the physician who established the POC.

7. HHAs were reimbursed under the Home Health Prospective Payment System ("PPS"). Under PPS, Medicare paid Medicare-certified HHAs a predetermined base payment for each 60 days that care was needed. This 60-day period was called an "episode of care." The base payment was adjusted based on the health condition and care needs of the beneficiary. This adjustment was done through the Outcome and Assessment Information Set ("OASIS"), which

was a patient assessment tool for measuring and detailing the patient's condition. If a beneficiary was still eligible for care after the end of the first episode of care, a second episode could commence. There were no limits to the number of episodes of home health benefits a beneficiary could receive as long as the beneficiary remained eligible.

8. In order to be reimbursed, the HHA would submit a Request for Anticipated Payment ("RAP") and subsequently receive a portion of their reimbursement payment in advance. At the end of a 60-day episode, when the final claim was submitted, the remaining portion of the payment would be reimbursed. As explained in more detail below, "Outlier Payments" are additional PPS reimbursements based on visits in excess of the norm. TriSpan and Pinnacle paid Outlier Payments to HHA providers under PPS when the providers' RAP submission established that the cost of care exceeded the established Health Insurance Prospective Payment System ("HIPPS") code threshold dollar amount.

Record Keeping Requirements

9. Medicare Part A regulations required HHAs providing services to Medicare patients to maintain complete and accurate medical records reflecting the medical assessment and diagnoses of their patients, as well as records documenting actual treatment of the patients to whom services were provided and for whom claims for reimbursement were submitted by the home health agency. These medical records were required to be sufficient to permit Medicare, through TriSpan, Pinnacle and other contractors, to review the appropriateness of Medicare payments made to the home health agency under the Part A program.

10. Among the written records required to document the appropriateness of home health care claims submitted under Part A of Medicare was a POC that included the physician order for home health care, diagnoses, types of services/frequency of visits,

prognosis/rehabilitation potential, functional limitations/activities permitted, medications/ treatments/nutritional requirements, safety measures/discharge plans, goals, and physician signature. Also required was a signed certification statement by an attending physician certifying that the patient was confined to his or her home and was in need of the planned home health services, and an OASIS.

11. Medicare Part A regulations required provider HHAs to maintain medical records of each visit made by a nurse, therapist, and home health aide to a beneficiary. The record of a nurse's visit was required to describe, among other things, any significant observed signs or symptoms, any treatment and drugs administered, any reactions by the patient, any teaching and the understanding of the patient, and any changes in the patient's physical or emotional condition. The home health nurse, therapist and aide were required to document the hands-on personal care provided to the beneficiary as the services were deemed necessary to maintain the beneficiary's health or to facilitate treatment of the beneficiary's primary illness or injury. These written medical records were generally created and maintained in the form of "clinical notes" and "home health aide notes/observations."

Special Outlier Provision

12. While payment for each episode of care was adjusted to reflect the beneficiary's health condition and needs, an "outlier" provision existed to ensure appropriate payment for those beneficiaries who have the most extensive care needs, which may result in an Outlier Payment to the HHA. Outlier Payments are additions or adjustments to the payment amount based on an increased type or amount of medically necessary care. Adjusting payments through Outlier Payments to reflect the HHA's cost in caring for each beneficiary including the sickest

beneficiaries ensured that all beneficiaries had access to home health services for which they are eligible.

13. Medicare regulations allowed certified HHAs to subcontract home health care services to nursing companies, registries, or groups (nursing groups), which would, in turn, bill the certified HHA. That certified agency billed Medicare for all services to the patient. The HHA's professional supervision over arranged-for services required the same quality controls and supervision of its own employees.

14. For beneficiaries for whom skilled nursing was medically necessary, Medicare paid for such skilled nursing provided by an HHA. The basic requirement that a physician certify that a beneficiary be confined to the home or homebound was a continuing requirement for a Medicare beneficiary to receive such home health care benefits.

South Louisiana Home Health Care, Inc.

15. South Louisiana Home Health Care, Inc. ("SLHH") was a Louisiana corporation incorporated on or about September 25, 1992, that did business throughout southern Louisiana, including in the Middle District of Louisiana, as a home healthcare provider. SLHH has maintained offices in Houma, Louisiana, most recently at 7529 Park Avenue, Houma, Louisiana 70364, and New Orleans, Louisiana, most recently as 9290 Morrison Road, Suite A, New Orleans, Louisiana 70127.

16. From in or about January 2005 through in or about December 2010, SLHH billed approximately $19.3 million to the Medicare program and was paid approximately $14.9 million for purportedly providing home healthcare services.

The Defendants

17. Defendant **MICHAEL S. HUNTER, M.D.**, a resident of New Orleans, Louisiana, was a medical doctor licensed by the State of Louisiana who referred beneficiaries to SLHH so that fraudulent claims could be filed with Medicare for home healthcare services that were not medically necessary and not rendered.

18. Defendant **AYANNA A. ALVEREZ**, a/k/a Ayanna M. Age, a/k/a Ayanna A. Alvarez, a resident of New Orleans, Louisiana, was an officer and operator of SLHH and supervised and paid illegal kickbacks to patient recruiters in return for referring Medicare beneficiaries to SLHH for home health services that were not medically necessary and not rendered.

19. Defendant **LOUIS T. AGE**, a resident of New Orleans, Louisiana, was the owner and President of SLHH and paid illegal kickbacks to patient recruiters in return for referring Medicare beneficiaries to SLHH for home health services.

20. Defendant **VERNA S. AGE**, a resident of New Orleans, Louisiana, was a shareholder and Director of Nursing for SLHH and paid illegal kickbacks to patient recruiters in return for referring Medicare beneficiaries to SLHH for home health services.

21. Defendant **KATHY A. PERIO, R.N.**, a resident of Gray, Louisiana, was a registered nurse licensed by the State of Louisiana who falsified patient files to make it appear that Medicare beneficiaries qualified for and received services that were not medically necessary and that were not provided so that SLHH could file fraudulent claims with Medicare.

22. Defendant **MILTON L. WOMACK**, a resident of New Orleans, Louisiana, referred beneficiaries to SLHH in return for being paid illegal kickbacks.

23. Defendant **MARY L. JOHNSON**, a resident of New Orleans, Louisiana, referred beneficiaries to SLHH in return for being paid illegal kickbacks.

COUNT 1

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

24. Paragraphs 1 through 23 of the General Allegations section of this Indictment are realleged and incorporated by reference as if fully set forth herein.

25. From in or around 2005 through the present, the exact dates being unknown to the Grand Jury, in the Middle District of Louisiana, and elsewhere, defendants,

MICHAEL S. HUNTER, M.D.,
AYANNA A. ALVEREZ,
KATHY A. PERIO, R.N.,
MILTON L. WOMACK, and
MARY L. JOHNSON

did knowingly and willfully combine, conspire, confederate and agree with each other and with others, known and unknown to the Grand Jury, to violate Title 18, United States Code, Section 1347, that is, to execute a scheme and artifice to defraud a health care benefit program affecting commerce, as defined in Title 18, United States Code, Section 24(b), that is, Medicare, 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, said healthcare benefit program, in connection with the delivery of and payment for health care benefits, items, and services.

Purpose of the Conspiracy

26. It was a purpose of the conspiracy for defendants **MICHAEL S. HUNTER, M.D., AYANNA A. ALVEREZ, KATHY A. PERIO, R.N., MILTON L. WOMACK, and MARY L. JOHNSON** to unlawfully enrich themselves by, among other things, (a) paying, accepting and receiving kickbacks and bribes in exchange for providing false and fraudulent prescriptions, medical certifications and POCs; (b) arranging for the use of Medicare beneficiary

numbers as the bases of claims filed for home healthcare services that were medically unnecessary and not provided; (c) causing the submission and concealment of false and fraudulent claims to Medicare, the receipt and transfer of the proceeds from the fraud, and the payment of kickbacks; and (d) causing the diversion of the proceeds of the fraud for the personal use and benefit of the defendants and their co-conspirators.

Manner and Means of the Conspiracy

The manner and means by which the defendants and other co-conspirators sought to accomplish the object and purpose of the conspiracy included, among other things:

27. **MILTON L. WOMACK, MARY L. JOHNSON** and other co-conspirators, known and unknown, would recruit Medicare beneficiaries so that they could be placed at SLHH for skilled nursing services that were not medically necessary and not provided. In return, **AYANNA A. ALVEREZ**, LOUIS T. AGE and VERNA S. AGE would pay kickbacks to **WOMACK** and **JOHNSON** for referring those beneficiaries.

28. **MICHAEL S. HUNTER, M.D.** and other co-conspirators, known and unknown, would refer patients to SLHH for skilled nursing and sign POCs for beneficiaries so that SLHH could bill Medicare for these skilled nursing services that were not medically necessary and not rendered. In return, **HUNTER** would be paid kickbacks by **AYANNA A. ALVEREZ** for referring beneficiaries and signing POCs.

29. **AYANNA A. ALVEREZ** and **KATHY A. PERIO, R.N.** and other co-conspirators, known and unknown, would falsify patient files to make it appear that Medicare beneficiaries qualified for and received services that were not medically necessary and not provided. Specifically, when conducting the Outcome and Assessment Information Set ("OASIS"), **ALVEREZ** and **PERIO** would falsify patient files to make it appear that the

beneficiary qualified for services, when those services were not medically necessary. Additionally, when conducting home health care visits to the beneficiaries' homes, and afterwards at SLHH, **ALVEREZ** and **PERIO** would falsify patient files to make it appear that they provided skilled nursing care when no such care was provided.

30. **MICHAEL S. HUNTER, M.D.** and **KATHY A. PERIO, R.N.** and other co-conspirators, known and unknown, would sign POCs that were not medically necessary. Specifically, in order to commence the first episode of care, **HUNTER** and **PERIO** would falsely certify that the beneficiaries needed skilled nursing. Additionally, if home health care was needed after the first 60-day episode of care was provided, a home health care company was required to provide a re-certification. **HUNTER** and **PERIO** would provide re-certifications when they knew the beneficiaries did not require any further home health care.

31. **MICHAEL S. HUNTER, M.D., AYANNA A. ALVEREZ, KATHY A. PERIO, R.N., MILTON L. WOMACK, and MARY L. JOHNSON** would submit and cause the submission of fraudulent claims to Medicare by billing for skilled nursing when such services were not medically necessary and not rendered.

Overt Acts

In furtherance of the conspiracy, and to accomplish its object and purpose, the conspirators committed and caused to be committed, in the Middle District of Louisiana and elsewhere, the following overt acts:

32. In or about January 2007, an unknown co-conspirator, acting under **AYANNA A. ALVEREZ's** direction, recruited Medicare beneficiary A.W. for the purpose of SLHH submitting claims to Medicare under A.W.'s name.

33. On or about March 7, 2007, **AYANNA A. ALVEREZ** and **KATHY A. PERIO, R.N.** falsified Medicare beneficiary A.W.'s patient file to make it appear that she qualified for and received services that were not medically necessary and not provided.

34. On or about May 9, 2007, **AYANNA A. ALVEREZ** and **KATHY A. PERIO, R.N.** falsified Medicare beneficiary A.W.'s patient file to make it appear that she qualified for and received services that were not medically necessary and not provided.

35. On or about July 6, 2007, **AYANNA A. ALVEREZ** and **KATHY A. PERIO, R.N.** falsified Medicare beneficiary A.W.'s patient file to make it appear that she qualified for and received services that were not medically necessary and not provided.

36. On or about September 6, 2007, **AYANNA A. ALVEREZ** and **KATHY A. PERIO, R.N.** falsified Medicare beneficiary A.W.'s patient file to make it appear that she qualified for and received services that were not medically necessary and not provided.

The above is a violation of Title 18, United States Code, Sections 1349 and 2.

COUNT 2

Conspiracy to Defraud the United States and to Receive and Pay Health Care Kickbacks (18 U.S.C. § 371)

37. Paragraphs 1 through 36 of the General Allegations section of this Indictment are realleged and incorporated by reference as if fully set forth herein.

38. From in or around 2005 through the present, the exact dates being unknown to the Grand Jury, in the Middle District of Louisiana, and elsewhere, defendants,

MICHAEL S. HUNTER, M.D.,
AYANNA A. ALVEREZ,
LOUIS T. AGE,
VERNA S. AGE,
MILTON L. WOMACK, and
MARY L. JOHNSON

did knowingly and willfully combine, conspire, confederate and agree with each other and with others known and unknown to the grand jury, to commit certain offenses against the United States, that is,

a. To defraud the United States by impairing, impeding, obstructing, and defeating through deceitful and dishonest means, the lawful government functions of the United States Department of Health and Human Services in its administration and oversight of the Medicare program;

b. to violate Title 42, United States Code, Section 1320a-7b(b)(1), by knowingly and willfully soliciting and receiving remuneration, specifically, kickbacks and bribes, directly and indirectly, overtly and covertly, in return for referring individuals for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole or in part by Medicare; and for the purchasing, leasing, ordering, and arranging for and recommending the purchasing, leasing, and ordering of any good, item, and service for which payment may be made in whole and in part by a Federal health care program, that is, Medicare; and

c. to violate Title 42, United States Code, Section 1320a-7b(b)(2), by knowingly and willfully offering and paying remuneration, specifically, kickbacks and bribes, directly and indirectly, overtly and covertly, in return for referring individuals for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole or in part by Medicare; and for the purchasing, leasing, ordering, and arranging for and recommending the purchasing, leasing, and ordering of any good, item, and service for which payment may be made in whole and in part by a Federal health care program, that is, Medicare.

Purpose Of The Conspiracy

39. It was a purpose of the conspiracy for defendants **MICHAEL S. HUNTER, M.D., AYANNA A. ALVEREZ, LOUIS T. AGE, VERNA S. AGE, MILTON L. WOMACK, and MARY L. JOHNSON** and their co-conspirators to unlawfully enrich themselves by paying and receiving kickbacks and bribes in exchange for providing Medicare beneficiary information that was used to submit claims to Medicare.

Manner And Means Of The Conspiracy

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

40. Paragraphs 27 through 31 of this Indictment are realleged and incorporated by reference as if fully set forth herein.

Overt Acts

In furtherance of the conspiracy, and to accomplish its object and purpose, the conspirators committed and caused to be committed, in the Middle District of Louisiana and elsewhere, the following overt acts:

41. In or about January 2007, an unknown co-conspirator, acting under **AYANNA A. ALVEREZ's** direction, recruited Medicare beneficiary A.W. for the purpose of SLHH submitting claims to Medicare under A.W.'s name.

42. On or about June 1, 2007, **AYANNA A. ALVEREZ** paid, and caused to be paid, kickbacks in the amount of $2,500 to **MICHAEL S. HUNTER, M.D.** for the referral of Medicare beneficiaries and for signing POCs and certifications for Medicare beneficiaries, in whose names SLHH would submit claims to Medicare.

43. On or about September 14, 2007, **LOUIS T. AGE** paid, and caused to be paid, kickbacks in the amount of $1,500 to **MILTON L. WOMACK** for the referral of Medicare beneficiaries, in whose names SLHH would submit claims to Medicare.

44. On or about May 23, 2008, **VERNA S. AGE** paid, and caused to be paid, kickbacks in the amount of $1,600 to **MARY L. JOHNSON** for the referral of Medicare beneficiaries, in whose names SLHH would submit claims to Medicare.

The above is a violation of Title 18, United States Code, Sections 371 and 2.

COUNT 3

False Statements for Use in Determining Rights for Benefit and Payment by Medicare (42 U.S.C. § 1320a-7b(a)(2) and 18 U.S.C. § 2)

45. Paragraphs 1 through 23 of the General Allegations section of this Indictment are realleged and incorporated by reference as if fully set forth herein.

46. On or about the dates enumerated below, in the Middle District of Louisiana, and elsewhere, the defendants set forth below, did knowingly and willfully make and cause to be made false statements and representations of material facts, as set forth below, in patient files for the beneficiary set forth below, for use in determining rights for any benefit and payment under a Federal healthcare program, that is, Medicare:

Count	Defendant(s)	Approximate Dates	Medicare Beneficiary	False Statement and Representation
3	**AYANA A. ALVEREZ, and KATHY A. PERIO, R.N.**	January 2007 through April 2007	A.W.	Describing symptoms that were not-existent and services that were not rendered

The above is a violation of Title 42, United States Code, Section 1320a-7b(a)(2) and Title 18, United States Code, Section 2.

Forfeiture Allegation

47. Paragraphs 1 through 44 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 defendants have an interest pursuant to the provisions of Title 18, United States Code, Section 982(a)(7) and the procedures outlined at Title 21, United States Code, Section 853.

48. Upon conviction of Counts 1 and 2 of this Indictment, defendants shall forfeit to the United States, 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 offense.

49. The property that is subject to forfeiture includes, but is not limited to, the following:

a. A money judgment in the amount of up to the gross proceeds of the health care fraud offenses set forth in Counts 1 and 2 of the Indictment;

b. All funds on deposit at Capital One, in the name of South Louisiana Home Health Care, Inc.

50. If, as a result of any act or omission of the defendants, the property described above that is subject to forfeiture,

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, pursuant to Title 21, United States Code, Section 853(p), as made applicable by Title 18, United States Code, Section 982(b), to seek forfeiture of any other property of the defendants up to the value of the above forfeitable property.

All pursuant to Title 18, United States Code, Sections 982(a)(7) and 982(b) and the procedures outlined at Title 21, United States Code, Section 853.

UNITED STATES OF AMERICA, by

A TRUE BILL

DONALD J. CAZAYOUX, JR.
UNITED STATES ATTORNEY
MIDDLE DISTRICT OF LOUISIANA

FOR

DAVID M. MARIA
TRIAL ATTORNEY
CRIMINAL FRAUD SECTION
DEPARTMENT OF JUSTICE

8/31/2011
DATE