UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

v.

KENNETH GREGORY NASH,

Defendant.
_____/

FELONY INFORMATION

The United States Attorney charges:

At all times relevant to this Information:

The Medicare Program

1. The Medicare Program ("Medicare") is a federal health care program that pays for the costs of certain health care services. Entitlement to Medicare benefits is based on age, disability, or affliction with end-stage renal disease. Individuals who receive Medicare benefits are referred to as Medicare "beneficiaries." The U.S. Department of Health and Human Services ("HHS") is responsible for the administration and supervision of Medicare. The Centers for Medicare and Medicaid Services ("CMS"), a component agency of HHS, is directly responsible for the administration of Medicare.

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

3. The Medicare program provides coverage under different components, including hospital insurance ("Part A") and medical insurance ("Part B"). Medicare claims for Part A and Part B are processed and paid by insurance organizations, known as fiscal intermediaries and carriers, who contract with CMS to administer their specific part of the Medicare program.

4. National Government Services was the CMS fiscal intermediary for Medicare Part A in the State of Michigan. Wisconsin Physicians Service was the CMS contracted carrier for Medicare Part B, which includes home visits, in the State of Michigan.

5. By becoming a participating provider in Medicare, enrolled providers agree to abide by the policies, procedures, rules and regulations governing reimbursement. In order to receive Medicare funds, enrolled providers, together with their authorized agents, employees, and contractors, are required to abide by all the provisions of the Social Security Act, the regulations promulgated under the Act, and applicable policies, procedures, rules, and regulations issued by CMS and its authorized agents and contactors.

6. Upon certification, the medical provider is assigned a provider identification number ("PIN") for billing purposes. When the medical provider renders a service, the provider submits a claim for reimbursement to the Medicare contractor/carrier that includes the PIN assigned to that medical provider.

7. Health care providers are provided online access to Medicare manuals and services bulletins describing proper billing procedures and billing rules and regulations. Providers can submit claims to Medicare only for services they rendered, and providers are required to maintain patient records to verify that the services were provided as described on the claim form.

8. In order to receive reimbursement for a covered service from Medicare, a provider is required to submit a claim, either electronically or using a form (e.g., a CMS-1500 form or UB-92) containing the required information appropriately identifying the provider, patient, and services rendered.

9. Medicare regulations require health care providers enrolled with Medicare 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 payment were submitted. These records are required to be sufficient to permit Medicare, through WPS and other contractors, to review the appropriateness of Medicare payments to the health care provider under the program.

Home Health Services Covered By Medicare

10. A Home Health Agency ("HHA") is an entity that provides health services, including but not limited to skilled nursing, physical and occupational therapy, and speech pathology services to homebound patients.

11. Medicare's regulations for home health services require an HHA to be licensed by the state in which it is located, submit an application to Medicare, and be certified by a state agency.

12. Under Medicare Part A and Part B, home health care services provided are to be reasonably and medically necessary to the treatment of a patient's illness or injury. Reimbursement for home health care services requires that a physician certify the need for services and establish a Plan of Care. Home health care services that are not certified by a physician or were not provided are not reasonable and necessary. Medicare Part B covers the costs of physicians' services, including physician home visits, physician certification and recertification of home health care services, and physician supervision of home health care services. Generally, Medicare Part B covered these costs only if, among other requirements, they were medically necessary and ordered by a physician.

13. Physical therapy and skilled nursing services are some of the services typically provided by home health agencies. Medicare coverage for home health services requires that the following qualifying conditions, among others, be met: (a) the Medicare beneficiary is confined to the home; (b) the beneficiary needs skilled nursing services, physical therapy, or speech and

language therapy; (c) the beneficiary is under the care of a qualified physician who reviews, approves, and signs a written Plan of Care for the beneficiary that typically involves 60-day episodes of care; (d) the beneficiary be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language therapy; and (e) the services provided are medically necessary.

14. To determine the proper level of care for a particular beneficiary, Medicare requires that HHAs perform a comprehensive initial evaluation, which includes a beneficiary specific, comprehensive assessment that accurately reflects the beneficiary's current health and provides information to measure the beneficiary's progress. Medicare requires that (1) a registered nurse or qualified therapist perform the initial assessment, typically as part of an Outcome and Assessment Information Set ("OASIS") depending on whether the services are nursing services or therapy services, and (2) HHAs maintain a clinical record of services they provide to each beneficiary, including signed and dated clinical and progress notes recording each home visit made to the beneficiary. Clinical and progress notes must include the identity of the individual who performed the visit, the name of the beneficiary, and the type of service performed.

15. Medicare compensation to HHAs is based upon a prospective payment system ("PPS"), which pays the HHA a base payment that can be adjusted to reflect the severity of the beneficiary's condition and care and that is based on the clinician's OASIS assessment. Medicare PPS pays HHAs for every 60-day "episode" of services provided to each beneficiary. Medicare will pay 60% of the estimated cost of the episode once the beneficiary has been evaluated and a qualified Plan of Care determined. This initial 60% payment claim, which can be submitted after the first service under the plan of care has been delivered, is called the Request for Anticipated

Payment ("RAP"). At the end of the episode, the HHA submits a final claim for the services actually provided, and Medicare pays the balance, if any, for the episode of care.

16. If the beneficiary is still eligible for care at the end of an episode, additional episodes of service can be provided. Each subsequent episode must be based upon a re-certificated OASIS, wherein the beneficiary's physician and registered nurse or physical therapist re-certifies that the beneficiary has a continued medical need for services. The beneficiary's physician must sign a new Plan of Care.

The Home Health Agency

17. Universall Home Health Care, LLC ("UHHC") was a Michigan corporation doing business at 1210 Phoenix Street, Suite 7, South Haven, Michigan. UHHC was a home health agency that provided in-home physical therapy, skilled nursing services and home health assistance to beneficiaries. UHHC was a Medicare provider and submitted claims to Medicare.

The Defendant

18. KENNETH GREGORY NASH, a resident of Van Buren County, Michigan, was the owner and operator of UHHC.

CHARGE
(Health Care Fraud)

19. Paragraphs 1 through 18 of this Information are realleged and incorporated by reference.

20. On or about the date set forth below, in Van Buren County, in the Western District of Michigan, and elsewhere,

KENNETH GREGORY NASH,

in connection with the delivery of and payment for health care benefits, items, and services, knowingly and willfully executed, and attempted to execute, a scheme and artifice to defraud a health care benefit program affecting interstate commerce, that is, Medicare.

Purpose of the Scheme and Artifice To Defraud

21. It was the purpose of the scheme and artifice for KENNETH GREGORY NASH to unlawfully enrich himself through the submission of false and fraudulent Medicare claims for services that were not rendered and that were not provided pursuant to a written Plan of Care approved by a physician.

Act In Execution of The Scheme and Artifice To Defraud

22. On the date specified below, the defendant, 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:

Medicare Beneficiary	Date of Falsified Plan of Care	Services Not Provided	Episode of Service	Billed Date	Amount Paid
C.G.	4/5/17	Physical Therapy	3/22/17-5/20/17	7/20/17	$4,168.76

18 U.S.C. § 1347(a)(1)

ANDREW BYERLY BIRGE
United States Attorney

Date:

RAYMOND E. BECKERING III
Assistant United States Attorney