UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF KENTUCKY
SOUTHERN DIVISION
PIKEVILLE

UNITED STATES OF AMERICA

v. **INDICTMENT NO.** 7:22-cr-008-REW

LOEY KOUSA, M.D.

* * * * *

THE GRAND JURY CHARGES:

At all times material to this Indictment:

1. **LOEY KOUSA** was a physician who practiced at a clinic he owned called East KY Clinic, PLLC ("East KY Clinic"), located at 538 Main Street, Paintsville, KY 41240.

2. **KOUSA** was licensed to practice medicine in Kentucky and permitted by the United States Drug Enforcement Administration ("DEA") to prescribe controlled substances.

3. **KOUSA** was also an enrolled service provider in various health care benefit programs, including programs funded by the Government. **KOUSA** submitted claims or caused the submission of claims to these health care benefit programs for services that he purportedly provided to patients.

BACKGROUND ON CONTROLLED SUBSTANCES

4. The Controlled Substances Act ("CSA") governed the manufacture,

distribution, and dispensing of controlled substances in the United States.

5. Under the CSA, the DEA regulated certain pharmaceutical drugs designated as "controlled substances" because of their potential for abuse or dependence, their accepted medical use, and their accepted safety for use under medical supervision. *See* 21 U.S.C. § 802(6).

6. The DEA issued registration numbers to qualifying practitioners, including physicians, which permitted them to dispense Schedule II, III, IV, and V controlled substances consistent with the terms of that registration. 21 U.S.C. § 822.

7. Hydrocodone was a Schedule II controlled substance. Tramadol was a Schedule IV controlled substance.

8. "A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner . . . ." 21 C.F.R. § 1306.04(a).

BACKGROUND ON HEALTH CARE BENEFIT PROGRAMS

9. The Medicare Program ("Medicare") was a federal "health care benefit program," as defined by 18 U.S.C. § 24(b), that provided benefits to persons who were over the age of sixty-five or disabled. Medicare was administered by the United States Department of Health and Human Services through its agency, the Centers for Medicare & Medicaid Services ("CMS").

10. Individuals who qualified for Medicare benefits were commonly referred to as "beneficiaries," and as beneficiaries, they were eligible to receive a variety of goods and

services.

11. The Kentucky Medicaid Program ("Medicaid") was a "health care benefit program," as defined by 18 U.S.C. § 24(b), that provided benefits to Kentucky residents who met certain eligibility requirements, including income requirements. Medicaid was jointly funded by federal and state sources and administered by CMS and by the Kentucky Cabinet for Health and Family Services, Department for Medicaid Services ("DMS").

12. Individuals who qualified for Medicaid benefits were commonly referred to as "members," and as members, they were eligible to receive a variety of goods and services.

13. Among a variety of items and services, both Medicare and Medicaid provided coverage to beneficiaries and members for outpatient physician services, such as evaluation and management services, commonly referred to as office visits, and procedures, such as electrocardiograms.

14. Medical service providers, including clinics and physicians ("service providers"), meeting certain criteria, could enroll in and obtain Medicare and Medicaid provider numbers. Upon Medicare and Medicaid enrollment, service providers were permitted to provide medical services and items to beneficiaries and members, and subsequently submit claims, either electronically or in hardcopy, to Medicare and Medicaid, through fiscal intermediaries, seeking reimbursement for the cost of services and items provided.

15. When seeking reimbursement from Medicare and Medicaid, service providers certified that: (1) the contents of the claim forms were true, correct, and complete;

(2) the claim forms were prepared in compliance with the laws and regulations governing Medicare and Medicaid; and (3) the services purportedly provided, as set forth in the claim forms, were medically necessary.

16. Medicare and Medicaid reimbursed claims submitted by service providers if the services and items provided were medically necessary for the diagnoses and treatment of beneficiaries and members and were in fact provided to beneficiaries and members. Conversely, Medicare and Medicaid did not cover and would not reimburse claims for services and items that were not medically necessary or not in fact provided.

BACKGROUND ON HEALTH CARE BILLING CODES

17. The American Medical Association assigned and published numeric codes used to describe medical procedures performed by service providers commonly referred to as Common Procedure Terminology or "CPT" codes. CPT codes were intended to accurately identify, simplify, and standardize billing for medical services. CPT codes reimbursed specific amounts, which were determined by CMS based on the work involved in the procedure, the complexity of the procedure, practice expenses, and malpractice insurance expenses. Service providers used specific CPT codes to describe the services that they claimed were provided, and health care benefit programs, including Medicare and Medicaid, relied on the submitted CPT codes to decide whether to issue or deny reimbursement.

18. Certain CPT codes were used to identify, among a variety of other services, visits, testing, and counseling.

Coding for Office Visits

19. Specific CPT codes were assigned to office visits, with different codes delineating certain aspects of the office visit, including type, complexity, and duration. Namely, CPT codes 99211, 99212, 99213, 99214, and 99215 were assigned to describe office visits for established patients. Medicare, Medicaid, and other health care benefit programs reimbursed service providers at increasing rates based upon the level of complexity indicated by the CPT code used to describe the office visit. The higher number codes were generally reserved for more complex and longer office visits.

20. At the times indicated in the below table and as relevant here, the CPT codes for 99214 through 99215 provided in relevant part:

CPT Code	Before January 1, 2021	After January 1, 2021
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: (1) a detailed history; (2) a detailed examination; (3) medical decision-making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	Office or outpatient visit for the evaluation and management of an	Office or other outpatient visit for the evaluation and management of an

CPT Code	Before January 1, 2021	After January 1, 2021
	established patient which requires at least 2 of these 3 key components: (1) a comprehensive history; (2) a comprehensive examination; (3) medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face to face with the patient and/or family.	established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

21. A similar set of CPT codes with similar standards, was used for office visits with new—as opposed to established—patients. The relevant CPT codes for new patient visits were 99201 through 99205. At the times indicated in the below table and as relevant here, the CPT code for 99205 provided in relevant part:

CPT Code	Before January 1, 2021	After January 1, 2021
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

CPT Code	Before January 1, 2021	After January 1, 2021
	the family's needs. Usually the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	

22. An office visit—for either a new or established patient—should have been billed according to the standards outlined in the above tables. If an office visit was billed at a higher level than what occurred during the visit, that office visit was "upcoded" or coded at a higher level than warranted for the visit.

Coding for Electrocardiograms

23. Health care benefit programs, including Medicare and Medicaid, reimbursed service providers for medically necessary procedures such as electrocardiograms that measured, among other things, heartrate. The CPT codes for these procedures were substantively as follows:

CPT Code	Description
93000	Routine electrocardiogram using at least 12 leads including interpretation and report.
93224	External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional.

ILLEGAL CONTROLLED SUBSTANCE DISTRIBUTION AND HEALTH CARE FRAUD SCHEMES

24. **KOUSA** wrote controlled substance prescriptions for opioids, like

hydrocodone and tramadol, to patients at East KY Clinic who had no legitimate need for controlled substance prescriptions in order to have continued access to these patients whose purported treatment was paid in part by health care benefit programs, including Medicare and Medicaid.

25. Regardless of whether patients had a legitimate need for controlled substance prescriptions, as a condition of writing such prescriptions, **KOUSA** also generally required patients to come to his clinic on a monthly, biweekly, or more frequent basis. Patients sometimes waited for hours to see **KOUSA** but had interactions with **KOUSA** that lasted only a few minutes and sometimes only a few seconds. These patient interactions with **KOUSA** included minimal or no substantive medical evaluation of the patient.

26. At these purported office visits, **KOUSA** required patients to receive medically unnecessary services, such as electrocardiograms.

27. **KOUSA** subsequently submitted claims or caused the submission of claims to health care benefit programs, including Medicare and Medicaid, for medical services he purportedly provided to his patients that were medically unnecessary, upcoded, and not provided. **KOUSA** tried to cover up this scheme by creating false medical records for patients to make it appear that he had performed services that would justify his prescribing and billing.

Purpose of the Scheme

28. It was a purpose of the scheme for **KOUSA** to unlawfully enrich himself and others involved in managing East KY Clinic by submitting claims or causing the submission of claims to health care benefit programs for services that were not provided,

unnecessary, and upcoded.

Manner and Means of the Scheme

29. It was part of the scheme that **KOUSA** submitted or caused the submission of claims to health care benefit programs for services like electrocardiograms that were medically unnecessary or did not occur.

30. It was further part of the scheme that **KOUSA** submitted or caused the submission of claims for upcoded office visits for established patients that were billed under CPT codes 99214 or 99215, falsely representing the level of visit, duration of the visit, and medical decision-making used during the visit, in order to receive a higher reimbursement from the health care benefit programs than what he was entitled to receive.

31. It was further part of the scheme that **KOUSA** submitted or caused the submission of claims for upcoded office visits for new patients that were billed under CPT code 99205, falsely representing the level of exam and medical decision-making used during the office visit and the amount of time the visit took, in order to receive a higher reimbursement from the health care benefit programs than what he was entitled to receive.

32. It was part of the scheme that **KOUSA** would cover up his fraudulent billing by creating false medical records.

COUNTS 1-5
Distribution of a Controlled Substance
(21 U.S.C. § 841(a)(1))

33. Paragraphs 1 through 8 and 24 and 25 of this Indictment are realleged and incorporated by reference as though fully set forth herein.

34. On or about the dates listed below, in Johnson County, in the Eastern District

of Kentucky, and elsewhere,

LOEY KOUSA, M.D.,

did knowingly and intentionally distribute and dispense controlled substances to Patient M.S. pursuant to prescriptions that were not issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice, as set forth below:

Count	Approximate Date Prescription Written	Substance Name	Schedule of Controlled Substance	Quantity
1	June 10, 2021	Tramadol	IV	60
2	July 8, 2021	Hydrocodone	II	30
3	August 5, 2021	Hydrocodone	II	30
4	September 2, 2021	Hydrocodone	II	30
5	September 30, 2021	Hydrocodone	II	30

Each of the above in violation 21 U.S.C. § 841(a)(1) & 18 U.S.C. § 2.

COUNT 6
Health Care Fraud
(18 U.S.C. § 1347)

35. Paragraphs 1 through 3 and 9 through 32 of this Indictment are realleged and incorporated by reference as though fully set forth herein.

36. Beginning at least on or about January 1, 2016, and continuing through at least in or around February 2022, in Johnson County, in the Eastern District of Kentucky, and elsewhere,

LOEY KOUSA, M.D.,

did knowingly and willfully execute, and attempt to execute, a continuing scheme or artifice to defraud a health care benefit program affecting commerce, as defined in 18

U.S.C. § 24(b), that is, Medicare, Medicaid, and other health care benefit programs, and obtain, by means of materially false and fraudulent pretenses, representations, and promises, and omission and concealment of material facts, money and property owned by, and under the custody and control of, these health care benefit programs, in connection with the delivery of and payment for health care benefits, items, and services. He did so by submitting or causing the submission of claims to health care benefit programs for medical services that were upcoded, including but not limited to office visits billed under CPT codes 99214 and 99215.

37. In furtherance of this scheme, **KOUSA** knowingly submitted, or caused to be submitted, claims for payment to health care benefit programs for medical services that were upcoded, including, but not limited to, the office visits billed to health care benefit programs that are identified in the table below:

Approximate Date of Service	Visit Billed As	Patient
4/15/2021	99205	M.S.
5/13/2021	99214	M.S.
6/10/2021	99214	M.S.
7/8/2021	99214	M.S.
8/5/2021	99214	M.S.
9/2/2021	99215	M.S.
9/8/2021	99215	M.S.
9/30/2021	99214	M.S.
8/2/2021	99215	L.G.
8/30/2021	99214	L.G.
9/27/2021	99214	L.G.

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

COUNT 7
Health Care Fraud
(18 U.S.C. § 1347)

38. Paragraphs 1 through 3 and 9 through 32 of this Indictment are realleged and incorporated by reference as though fully set forth herein.

39. Beginning at least on or about January 1, 2016, and continuing through at least in or around February 2022, in Johnson County, in the Eastern District of Kentucky, and elsewhere,

LOEY KOUSA, M.D.,

did knowingly and willfully execute, and attempt to execute, a continuing scheme or artifice to defraud a health care benefit program affecting commerce, as defined in 18 U.S.C. § 24(b), that is, Medicare, Medicaid, and other health care benefit programs, and obtain, by means of materially false and fraudulent pretenses, representations, and promises, and omission and concealment of material facts, money and property owned by, and under the custody and control of, these health care benefit programs, in connection with the delivery of and payment for health care benefits, items, and services. He did so by submitting or causing the submission of claims to health care benefit programs for medical services that were medically unnecessary or not provided, including, but not limited to, electrocardiograms billed under CPT codes 93000 and 93224.

40. In furtherance of this scheme, **KOUSA** knowingly submitted, or caused to be submitted, claims for payment to health care benefit programs for medical services that were not performed or were not medically necessary, including but not limited to the electrocardiograms billed under CPT codes 93224 and 93000 that are further detailed in

the table below:

Date of Service	Code Billed	Patient
2/18/2019	93000	L.G.
5/13/2019	93000	L.G.
7/8/2019	93000	L.G.
9/4/2019	93000	L.G.
9/30/2019	93224	L.G.
10/28/2019	93000	L.G.
11/25/2019	93000	L.G.
12/20/2019	93000	L.G.
1/20/2020	93000	L.G.
2/17/2020	93000	L.G.

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

COUNTS 8-9
False Statements Relating to Health Care Matters
(18 U.S.C. § 1035(a)(1) & (a)(2))

41. Paragraphs 1 through 3 and 9 through 32 of this Indictment are realleged and incorporated by reference as though fully set forth herein.

42. On or about the dates identified in the below table, in Johnson County, in the Eastern District of Kentucky, and elsewhere,

LOEY KOUSA, M.D.,

did knowingly and willfully (a) falsify, conceal, and cover up by trick, scheme, and device material facts, (b) make a materially false, fictitious, and fraudulent statement and representation, and (c) make and use a materially false writing and document knowing the same to contain materially false, fictitious, and fraudulent statements and entries, in connection with the delivery of and payment of health care benefits, items, and services.

Specifically, in this time period, **KOUSA** made false and fraudulent entries in the patient record of Patient M.S. for office visits and evaluations, including physical evaluations. In truth and fact, as **KOUSA** then well knew, he had not performed such evaluations and such office visits never occurred.

Count	Approximate Date Record Created	Record
8	5/13/2021	Record of Physical Exam of Patient M.S.
9	4/23/2021	Encounter Note for Patient M.S.

Each in violation of 18 U.S.C. § 1035(a)(1) & (a)(2).

FORFEITURE ALLEGATIONS

1. The allegations contained in Counts 1 through 9 of this Indictment are incorporated here for the purpose of alleging forfeiture pursuant to the provisions of Title 21 United States Code, Section 853 and Title 18, United States Code, Section 982.

2. Upon conviction of the offenses in violation of the Controlled Substances Act, including a violation of Title 21, United States Code, Section 841(a)(1), as set forth in Counts 1 through 5 of this Indictment, **LOEY KOUSA** shall forfeit to the United States of America, pursuant to 21 U.S.C. § 853(a), any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offenses.

3. The property to be forfeited includes, but is not limited to, the following:

a. **LOEY KOUSA**'s medical license(s) and any rights and privileges associated with those licenses;

b. any DEA registration(s) for **LOEY KOUSA**; and

c. a forfeiture money judgment in the amount of the gross proceeds obtained by **LOEY KOUSA** as a result of the violations noted above.

4. Upon conviction of any federal health care offense, including a violation of Title 18, United States Code, Sections 1347 and 2 and Sections 1035(a)(1) & (a)(2), as set forth in Counts 6 through 9 of this Indictment, **LOEY KOUSA** 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.

5. If any of the property described above as being subject to forfeiture, 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 that cannot be subdivided without difficulty;

it is the intent of the United States to seek the forfeiture of any other property in which the defendant has an interest, up to the value of the property and proceeds described above.

A TRUE BILL

[redacted]

FOREPERSON

CARLTON S. SHIER, IV
UNITED STATES ATTORNEY

(Desmat Lynch for JSB)

JOSEPH S. BEEMSTERBOER
ACTING CHIEF, FRAUD SECTION
U.S. DEPARTMENT OF JUSTICE

PENALTIES

COUNT 1:	Not more than 5 years imprisonment, a fine of $250,000, and 1 year of supervised release.
COUNTS 2-5:	Not more than 20 years imprisonment, a fine of $1,000,000, and 3 years supervised release.
COUNTS 6-7:	Not more than 10 years of imprisonment, 3 years supervised release, and a fine of not more than $250,000 or twice the gross gain or loss, whichever is greater.
COUNT 8-9:	Not more than 5 years imprisonment, 3 years supervised release, and a fine of not more than $250,000 or twice the gross gain or loss, whichever is greater.
PLUS:	Mandatory special assessment of $100 per count.
PLUS:	Restitution, if applicable.
PLUS:	Forfeiture as listed.