UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

UNITED STATES OF AMERICA	§	
	§	
v.	§	**Criminal No. 4:25-cr-346**
	§	
DR. CARLOS MUNOZ, M.D.,	§	
	§	
	§	
Defendant.	§	

INFORMATION

The United States Attorney for the Southern District of Texas charges:

General Allegations

At times material to this Information, unless otherwise specified:

The Medicare Program

1. The Medicare Program ("Medicare") was a federal health care program providing benefits to individuals who were 65 years or older or disabled. The United States Department of Health and Human Services, through its agency, the Centers for Medicare and Medicaid Services ("CMS"), oversaw and administered Medicare. Individuals who received benefits under Medicare were commonly referred to as Medicare "beneficiaries."

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

3. To enroll in Medicare, all health care providers were required to submit a Medicare enrollment application. In submitting the Medicare application, health care providers certified that they understand and will abide by the federal laws and regulations governing their participation in Medicare.

4. When Medicare approved a provider's application, Medicare issued the provider a unique provider number. Upon enrollment, Medicare issued providers a provider manual that describes the requirements to participate in the Medicare program as well as newsletters advising them of any additional requirements for participation and instructions on what services Medicare covers.

5. CMS contracted with Palmetto Government Benefit Administrators ("Palmetto GBA") to administer Medicare Part A claims in the State of Texas which include claims for hospice services. Each time a provider submits a claim to Medicare, the provider certified that the claim is true, correct, and complete, and complies with all Medicare laws and regulations. The claims are generally submitted electronically.

6. A provider enrolled as a Medicare provider is able to file claims with Medicare to obtain reimbursement for services provided to beneficiaries. A Medicare claim is required to set forth, among other things, the beneficiary's name and Medicare HICN, the services that were 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 health care provider who ordered the services.

7. Medicare regulations required that a provider document every service rendered to a beneficiary for whom a claim is submitted. This documentation is part of the beneficiary's medical record and is required to be retained by the provider for a period of not less than five years.

The Medicaid Program

8. The Medicaid Program (“Medicaid”) was a state-administered health insurance program funded by the United States Government and by individual states, including the States of Texas and Ohio. Medicaid helped pay for reasonable and necessary medical procedures and

services provided by qualified health care professionals to individuals who were deemed eligible under state low-income programs. Medicaid was implemented in 1967 under the provisions of Title 19 of the Social Security Act of 1965.

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

10. In order participate in the Medicaid program, a provider must submit an application to the Texas Medicaid and Healthcare Partnership ("TMHP"). If the provider met certain qualifications, TMHP approved the application, entered into a written contract with the provider, and issued a unique provider identification number to the provider. The provider is then allowed to submit bills for services, known as "claims," to Medicaid for reimbursement for the cost of providing medically necessary services to Medicaid clients.

11. By entering into a contract with Medicaid, a provider agrees to abide by the policies and procedures of the Medicaid program. Medicaid regulations required that a provider document every service rendered to a beneficiary for whom a claim is submitted. This documentation is part of the beneficiary's medical record and is required to be retained by the provider for a period of not less than five years.

Medicare Coverage of Hospice Care

12. Medicare was divided into different programs "parts": Part A, Part B, Part C, and Part D. Hospice services were covered under Medicare Part A (hospital-related services).

13. Section 1861(dd) of the Social Security Act defined "hospice care" as certain items and services provided to a terminally ill individual by a hospice program under a written plan established and periodically reviewed by the individual's attending physician and by the medical director of the hospice program. The services may include doctor and nursing care, certain medical

equipment and supplies, certain drugs for pain or symptoms, home health aide services, therapy, social work and counseling, and short-term inpatient stays. Medicare would not pay for treatment to cure the terminal illness under the hospice benefit. Rather, hospice uses medicine, equipment, and supplies to make a patient as comfortable and pain-free as possible.

14. Medicare reimbursed providers for hospice services provided to a beneficiary only if the beneficiary was terminally ill, as certified by as certified by both the beneficiary's attending physician, if the beneficiary had one, and the medical director or a physician member of the hospice's interdisciplinary group ("IDG"). Specifically, they must sign a "Certification of Terminal Illness" certifying the patient is terminally ill and the terminal illness is most likely to result in death of the patient within 6 months if the illness runs its normal course. The attending physician was the physician that the beneficiary identified when he/she elected to receive hospice care as the medical practitioner with the most significant role in the determination and delivery of the beneficiary's medical care. Medicare considered a beneficiary to be "terminally ill" if the beneficiary's life expectancy was six months or less if the beneficiary's illness ran its normal course.

15. A beneficiary was required to elect to receive hospice services. The beneficiary needed to complete an election form that included an acknowledgement that the beneficiary had been provided a full understanding of hospice care, including the palliative rather than curative nature of treatment, and an acknowledgement that the beneficiary understood that certain Medicare services were waived by the election of hospice care. Once a beneficiary elects to receive hospice services, Medicare will not cover treatment intended to cure the terminal illness and/or related conditions. The beneficiary, once on hospice, waived all rights to Medicare coverage of services to treat or reverse the beneficiary's terminal illness while the beneficiary was on hospice.

16. A beneficiary could elect to receive hospice benefits for two periods of 90 days and, thereafter, additional services for periods of 60 days per period. For the first 90-day period of hospice coverage, the hospice must obtain a physician certification of terminal illness ("CTI"), no later than 2 calendar days after hospice care was initiated, (that is, by the end of the third day),. The physician certification, which could be oral or written, must be provided by the medical director of the hospice or the physician member of the hospice interdisciplinary group ("IDG") and the individual's attending physician if the individual has an attending physician

17. After the second 90-day period, for the beneficiary to continue to receive reimbursable hospice benefits, Medicare required that a physician re-certify that the beneficiary was terminally ill and include clinical findings or other documentation supporting the diagnosis of terminal illness. For re-certifications, Medicare required a hospice physician or nurse practitioner to meet with the beneficiary in person and conduct a face-to-face evaluation before the CTI is signed by the physician.

18. The hospice must obtain written certification of terminal illness for each benefit period, even if a single election continues in effect. A written certification must be on file in the hospice patient's record before any claims could be submitted to the Medicare contractor. Clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with the written certification. Initially, the clinical information may be provided verbally, and must be documented in the medical record and included as part of the hospice's eligibility assessment. The CTI was a statement relied upon by Medicare to ensure the patient is eligible and thus covered for the hospice service. Medicare paid the hospice claims billed by a hospice assuming the statement was accurate.

19. Hospice entities could provide services in various locations. If the hospice service

was provided in the patient's home, nursing home, or assisted living facility, then it is usually billed as Routine Home Care and referred to as outpatient.

Relevant Entities, Defendants, and Individuals

20. United Palliative & Hospice Care, Inc. ("UPHC") was a hospice facility located at 1811 First Oaks Street, Suite 120, Richmond, Texas 77406. UPHC was enrolled in Medicare and Medicaid.

21. **DR. CARLOS MUNOZ** ("**DR. MUNOZ**") was a physician licensed in the State of Texas and employed by UPHC as the medical director.

22. Dera Ogudo ("Ogudo") was the owner and operator of UPHC.

COUNT 1
Conspiracy to Defraud the United States and to Pay and Recieve Health Care Kickbacks
(Violations of 18 U.S.C. §§ 371 and 2)

23. Paragraphs 1 through 22 of this Indictment are realleged and incorporated by reference as if fully set forth herein.

24. Beginning in or around 2019 and continuing through 2024, in the Houston Division of the Southern District of Texas and elsewhere, the defendant,

DR. CARLOS MUNOZ

did knowingly and willfully combine, conspire, confederate, and agree with Ogudo and others, known and unknown to the U.S. Attorney, to commit certain offenses against the United States, that is,

a. 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 Medicare, and to commit certain offenses against the United States;

b. to violate Title 42, United States Code, Section 1320a-7b(b)(1)(B), by knowingly and willfully soliciting and receiving any remuneration, specifically kickbacks and

bribes, directly and indirectly, overtly and covertly, in cash and in kind in return for ordering any service or item for which payment may be made in whole or in part under a Federal health care program, that is, Medicare.

c. to violate Title 42, United States Code, Section 1320a-7b(b)(2)(B), by knowingly and willfully offering and paying remuneration, specifically kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind to any person to induce such person to order any item or service for which payment may be made in whole or in part under a Federal health care program, that is, Medicare.

Purpose of the Conspiracy

25. It was a purpose of the conspiracy for the defendant and his co-conspirators to unlawfully enrich themselves by paying and receiving kickbacks in exchange for the certification of Medicare beneficaries as terminally ill for whom UPHC submitted claims to Medicare.

Manner and Means of the Conspiracy

26. From in or around June 2019 to in or around January 2024, Defendant conspired with Ogudo and others, known and unknown, to pay and receive illegal health care kickbacks and bribes in exchange for fraudulently certifying and re-certifying Medicare and Medicaid beneficiaries for hospices services that was often medically unnecessary.

27. From in and around July 2019 to in or around January 2024, Ogudo paid $305,000 in kickbacks and bribes to **DR. MUNOZ** to falsely certify that Medicare and Medicaid beneficiaries were eligible for hospice services when they were not. UPHC and Ogudo paid **DR. MUNOZ** approximately $2,000 to $10,000 a month during this time period. Ogudo gradually increased **DR. MUNOZ**'s pay as the number of Medicare and Medicaid beneficiaries certified and re-certified by **DR. MUNOZ** for UPHC increased.

28. Specifically, Ogudo paid kickbacks and bribes to **DR. MUNOZ** to fraudulently certify and re-certify that patients were terminally ill when many of the patients were not in fact terminally ill. **DR. MUNOZ** did not have any face-to-face visits with UPHC patients and did not review medical records to determine if patients actually qualified for hospice services under

Medicare and Medicaid rules and regulations. **DR. MUNOZ** relied only on patient assessments written by UPHC employees that **DR. MUNOZ** knew were false and/or exaggerated patients' actual medical conditions and diagnoses. **DR. MUNOZ** signed certificates of terminal illness for many Medicare and Medicaid beneficiaries because Ogudo paid him to do so, not because these patients were actually terminally ill.

29. Ogudo maintained a Medicare and Medicaid provider number, which was used to submit false and fraudulent claims to Medicare and Medicaid for hospice services that were not medically necessary. From in or around September 2019 through in or around September 2024, UPHC and Ogudo submitted or caused the submission of claims to Medicare for approximately $59,094,566.65 in claims for hospice services that were often not medically necessary and/or predicated on an illegal kickback to **DR. MUNOZ**. Medicare paid UPHC and Ogudo approximately $42,246,099.68 on those claims.

Overt Acts

30. In furtherance of the conspiracy, and to accomplish its object and purpose, at least one co-conspirator committed and caused to be committed, in the Southern District of Texas, at least one of the following overt acts, among others:

a. From in and around July 2019 to in or around January 2024, **DR. MUNOZ** received $305,000 in kickbacks and bribes to falsely certify that Medicare and Medicaid beneficiaries were eligible for hospice services when they were not.

b. **DR. MUNOZ** received approximately $2,000 to $10,000 per month during this time period. Ogudo gradually increased **DR. MUNOZ**'s pay as **DR. MUNOZ** certified and re-certified more and more Medicare and Medicaid beneficiaries for UPHC.

c. From in or around September 2019 through in or around September 2024, UPHC and Ogudo submitted or caused the submission of claims to Medicare for approximately $59 million in claims for hospice services that were often not medically necessary and/or predicated on the illegal kickbacks to **DR.**

MUNOZ. Medicare paid UPHC and Ogudo approximately $42 million on those claims.

All in violation of Title 18, United States Code, Section 371.

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