FELONY

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

INDICTMENT FOR HEALTH CARE FRAUD

UNITED STATES OF AMERICA	*	**CRIMINAL NO.**	26-155
v.	*	**SECTION:**	SECT. G MAG. 4
CHRISTOPHER K. WHIPPLE, M.D.	*	**VIOLATIONS:**	**18 U.S.C. § 1347** **18 U.S.C. § 2**
	*		

* * *

The Grand Jury charges that:

GENERAL ALLEGATIONS

At all times material herein:

Health Care Benefit Programs

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

2. The Louisiana Medicaid Program ("Medicaid") was a health care benefit program, as defined by 18 U.S.C. § 24(b), that provided benefits to Louisiana residents who met certain eligibility requirements, including income requirements. Medicaid was jointly funded by federal and state sources. Individuals who qualified for Medicaid benefits were commonly referred to as "members."

3. Humana Incorporated ("Humana") was a private health insurance program, affecting commerce, and a "health care benefit program," as defined by Title 18, United States Code, Section 24(b). Individuals receiving Humana benefits were also referred to as "members."

4. Medical providers, like clinics and physicians, could enroll in health care benefit programs to be reimbursed for items and services provided to beneficiaries and members. Upon enrollment, service providers were permitted to provide items and services to beneficiaries and members, and subsequently submit claims to the health care benefit programs, through fiscal intermediaries, seeking reimbursement for the cost of items and services provided.

5. When seeking reimbursement from health care benefit programs, providers certified that: (a) the contents of the claim forms were true, correct, and complete; (b) the claim forms were prepared in compliance with the governing laws and regulations; and (c) the services purportedly provided, as set forth in the claim forms, were medically reasonable and necessary.

6. Health care benefit programs reimbursed claims submitted by providers if the items and services were medically reasonable and necessary for the diagnosis and treatment of beneficiaries and members; were in fact provided to beneficiaries and members; and were based on representations from providers that were true, correct, and complete.

7. Conversely, health care benefit programs did not cover and would not reimburse claims for items and services that were medically unreasonable and unnecessary; not in fact provided; and not based on claim forms that were true, correct, and complete.

8. Medicare and Medicaid relied on contractors to conduct audits, process claims, and flag potential fraudulent billing. Three such contractors relied on by Medicare and Louisiana Medicaid were Novitas Solutions, Inc. ("Novitas"), Qlarant Integrity Solutions, LLC ("Qlarant"), and AmeriHealth Caritas.

The Defendant and Related Individuals and Entities

11. The defendant, **CHRISTOPHER K. WHIPPLE, M.D. ("WHIPPLE")**, was a medical doctor and resident of New Orleans, Louisiana. **WHIPPLE** owned and operated two health care companies, Trompe Couillon Adventures, LLC ("Trompe") and Prestige Medical Staffing and Marketing ("Prestige").

12. **WHIPPLE**, individually and through his companies, employed certain individuals, including:

Provider Initials	Position
S.O.	Physician
J.C.	Physician
J.H.	Physician's Assistant
J.F.	Nurse Practitioner

13. **WHIPPLE**, through Trompe, submitted claims for various Medicare and Medicaid beneficiaries who resided at health care facilities in the Eastern District of Louisiana. These health care facilities provided nursing home services to the following beneficiaries, among others:

Beneficiary	Location
G.M.	Health Care Facility-1
J.B.	Health Care Facility-2
J.B.J.	Health Care Facility-2
K.J.	Health Care Facility-3

COUNTS 1–2
(Health Care Fraud)

A. AT ALL TIMES RELEVANT:

The General Allegations Section of this Indictment is re-alleged and incorporated by reference as if fully set forth herein.

B. THE SCHEME:

Beginning in or around January 2020, and continuing through the present, in the Eastern District of Louisiana and elsewhere, the defendant, **CHRISTOPHER K. WHIPPLE, M.D.**, did knowingly and willfully 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, Medicaid, and Humana, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money owned by, and under the custody and control of, Medicare, Medicaid, and Humana, in connection with the delivery of and payment for health care benefits, items, and services.

C. THE PURPOSE OF THE SCHEME:

It was a purpose of the scheme for **WHIPPLE** to unlawfully enrich himself by, among other things:

1. submitting and causing the submission of false and fraudulent claims to health care benefit programs;

2. receiving and obtaining reimbursement from health care benefit programs based on the false and fraudulent claims submitted; and

3. diverting the proceeds of the fraud for the personal benefit of himself and others.

D. THE MANNER AND MEANS OF THE SCHEME:

The manner and means by which **WHIPPLE** sought to accomplish the objects and purpose

of the scheme included, among others, the following:

***WHIPPLE's** Business Practices*

1. Prior to 2020, **WHIPPLE** enrolled as a provider with Medicare, Medicaid, and Humana. He also enrolled his company, Trompe, with both programs. As part of the enrollment process, **WHIPPLE** agreed not to submit false and fraudulent claims under risk of criminal penalty.

2. Over the course of the scheme, **WHIPPLE** hired various medical providers to work at Trompe, including providers S.O., J.C., J.H., and J.F., each of whom worked in the Eastern District of Louisiana. The providers assigned to Trompe the right to bill health care benefit programs for care the providers provided to patients while working for Trompe.

3. **WHIPPLE** set up paper and computer systems to handle billing after a provider entered a claim. While **WHIPPLE** hired individuals to maintain and support these systems, at all times, **WHIPPLE** maintained system access and could and did edit claims. **WHIPPLE** exercised control over these systems and trained and directed the billers he hired.

4. **WHIPPLE** contracted with health care hospitals and facilities, including Health Care Facility-1, Health Care Facility-2 and Health Care Facility-3.

***WHIPPLE's** Fraudulent Claims as the Rendering Provider*

5. In furtherance of the scheme, **WHIPPLE** submitted, and caused to be submitted, false and fraudulent claims to Medicare, Medicaid, and Humana for services that were not provided as represented, and were never provided, where **WHIPPLE** was identified on the claim as the rendering provider. Specifically, he submitted, and caused the submission of:

a. claims to Medicare and Medicaid for care **WHIPPLE** allegedly provided to certain patients, despite having not treated those patients. For instance, **WHIPPLE**

submitted, and caused to be submitted, over 70 claims for treatment of patient K.J., despite having never treated K.J.

b. claims for in-person care of patients in Louisiana, despite being outside the state of Louisiana at the time the services were purportedly performed. For instance, **WHIPPLE** submitted over 29 claims for in-person care purportedly provided by **WHIPPLE** while **WHIPPLE** was in Hawaii on or about July 18, 2024, through on or about August 2, 2024.

6. **WHIPPLE's** billing caught the attention of Medicare contractors. Over the course of the scheme, **WHIPPLE** received notices from AmeriHealth Caritas and Novitas of his abnormal billing practices, informing him that for certain categories, he was a statistical billing outlier compared to his peers. These notices included educational resources to correct his billing. Despite these notices, **WHIPPLE** continued to fraudulently bill using the same codes.

WHIPPLE's *Fraudulent Claims with Other Providers as the Rendering Provider*

7. In furtherance of the scheme, **WHIPPLE** submitted, and caused to be submitted, false and fraudulent claims to Medicare, Medicaid, and Humana for services that were not provided as represented, and were never provided, where other providers were identified on the claims as the rendering providers. Specifically, he submitted, and caused the submission of:

a. claims with dates of service on dates the provider did not work. For instance, **WHIPPLE** submitted, and caused to be submitted, over 500 claims alleging provider J.C. provided care on dates provider J.C. did not work.

b. claims in a specific provider's name, after that provider had left Trompe or at locations that provider never worked. For instance, Trompe submitted, and caused to be submitted, over 100 claims listing provider S.O. as rendering care for

beneficiaries at nursing homes after S.O. stopped providing beneficiary care at nursing homes.

c. claims purporting to show a beneficiary received care after that beneficiary had passed away. For instance, Trompe submitted, and caused to be submitted, over 350 claims for deceased beneficiaries with dates of service after the beneficiary had passed away.

8. **WHIPPLE** directed providers to sign records for care they did not render and for patients they did not treat. For instance, **WHIPPLE** pressured provider S.O. to sign approximately 99 patient records for care S.O. did not provide; S.O. refused to do so.

WHIPPLE's *Use of Funds*

9. **WHIPPLE** received funds from health care benefit programs into Regions Bank account x0301, owned and controlled by **WHIPPLE**. With those funds, **WHIPPLE**, among other things, transferred funds to other accounts; financed the purchase of a 2025 Ford ~~Explorer~~; and paid expenses for his yacht in Biloxi, Mississippi, including fuel and the boat captain's salary, among other lavish spending.

10. In total, from in or around January 2020, and continuing through the present, in the Eastern District of Louisiana and elsewhere, **WHIPPLE** submitted, and caused to be submitted, at least $5.9 million in false and fraudulent claims to Medicare and Medicaid, for which Medicare and Medicaid reimbursed at least $800,000.

E. EXECUTIONS OF THE SCHEME:

In order to execute and attempt to execute the scheme to defraud and to obtain money and property, and to accomplish the objects of the scheme, the defendant, **CHRISTOPHER K. WHIPPLE, M.D.**, submitted, caused others to submit, and aided and abetted others in submitting,

from the Eastern District of Louisiana, the following false and fraudulent claims, seeking the identified dollar amounts, and representing that such benefits, items, and services were medically necessary and eligible for Medicare reimbursement, with each execution set forth below forming a separate count:

Count	Medicare Beneficiary	Approx. Date Claim Submitted	Purported Date of Service	Claim Description	Purported Rendering Provider	Approx. Amount Billed
1	G.M.	9/6/2023	12/27/2022	99309 - Subsequent Nursing Facility Care With Moderate Level Of Medical Decision Making, Per Day, If Using Time, At Least 30 Minutes (as submitted by **WHIPPLE**)	J.H.	$232
2	J.B.	12/12/2023	7/9/2023	99309 - Subsequent Nursing Facility Care With Moderate Level Of Medical Decision Making, Per Day, If Using Time, At Least 30 Minutes	**WHIPPLE**	$232

Each of the above is a violation of Title 18, United States Code, Sections 1347 and 2.

NOTICE OF FORFEITURE

1. The allegations of Counts 1 and 2 of this Indictment are incorporated by reference as though set forth fully herein for the purpose of alleging forfeiture to the United States.

2. As a result of the offenses alleged in Counts 1 and 2, the defendant, **CHRISTOPHER K. WHIPPLE, M.D.**, 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 offenses.

3. If any of the property 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 which cannot be divided without difficulty,

the United States shall seek a money judgment and, pursuant to Title 21, United States Code, Section 853(p), forfeiture of any other property of the defendant up to the value of said property.

[redacted]

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June 22, 2026

FORM OBD-34

*No.*_____

UNITED STATES DISTRICT COURT

Eastern *District of* Louisiana

Criminal *Division*

THE UNITED STATES OF AMERICA

vs.

CHRISTOPHER K. WHIPPLE, M.D.

INDICTMENT

INDICTMENT FOR HEALTH CARE FRAUD

VIOLATION: Title 18, U.S.C., Section 1347 and 2

[redacted]

Filed in open court this _____ *day of* _____ *A.D. 2026.*

_____

Clerk

Bail, $ _____

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