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FILED

AUG 27 2020

THOMAS G. BRUTON
CLERK, U.S. DISTRICT COURT

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

UNITED STATES OF AMERICA

v.

SARGON AUDISHO

UNDER SEAL

Case No. 20CR 558

Violations: Title 18, United States Code, Sections 1035(a)(2) and 1347

Judge Kness

MAGISTRATE JUDGE CUMMINGS

COUNTS ONE through EIGHT

The SPECIAL JANUARY 2020 GRAND JURY charges that:

1. At times material to this Indictment:

The Medicare Program

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

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

c. Medicare programs covering different types of benefits were separated into different program parts. "Part B" of Medicare covered, among other things, claims for medical services provided by physicians, medical clinics, laboratories, and other qualified health care providers, and office services and

outpatient care—including the ordering of (i) durable medical equipment, prosthetics, orthotics, and supplies ("DME"), and (ii) cancer genomic testing—that Medicare would reimburse if such items and services were medically necessary and ordered by licensed medical doctors or other qualified health care providers.

d. Physicians and other health care providers that provided services to Medicare beneficiaries were able to apply to enroll in Medicare and obtain a provider number. A health care provider that received a Medicare provider number was able to file claims with Medicare and receive reimbursement for services provided to beneficiaries. Providers could submit claims to Medicare only for services they rendered and were medically necessary.

e. By becoming a participating provider in Medicare, enrolled providers agreed to abide by the policies and procedures, rules, and regulations governing reimbursement. Enrolled providers also agreed not to knowingly present, or cause to be presented, a false and fraudulent claim for payment by Medicare. To receive Medicare funds, enrolled providers, together with their authorized agents, employees, and contractors, were required to abide by all the provisions of the Social Security Act, the regulations promulgated under the Act, and applicable policies and procedures, rules, and regulations issued by CMS and its authorized agents and contractors. Health care providers were given, and provided with online access to, Medicare manuals and service bulletins describing proper billing procedures and billing rules and regulations.

f. To receive reimbursement for a covered service from Medicare, a provider needed to submit a claim, either electronically or using a form, containing the required information appropriately identifying the provider, patient, and services rendered, among other things.

g. All Medicare claims were required to set forth, among other things, the beneficiary's name, the date the services, the type of services provided (using a Current Procedural Terminology, or "CPT" code), the billed amount of the services provided, and the name and identification number of the physician who provided the services.

Defendant and Other Relevant Entities

h. Defendant SARGON AUDISHO was a physician licensed in approximately sixteen states, including Illinois, and an enrolled provider of medical services to Medicare beneficiaries.

i. Defendant AUDISHO owned Bodhi Tree Integrative Medicine LLC ("Bodhi Tree"), an Illinois limited liability company. Defendant AUDISHO hired Employee A, Employee B, and Employee C to work at Bodhi Tree.

j. Employee A, Employee B, and Employee C were not licensed medical professionals.

k. Defendant AUDISHO worked at various telemedicine companies that arranged for physicians and other medical professionals to conduct consultations with, and prescribe diagnostic tests and durable medical equipment ("DME") products for, Medicare beneficiaries.

l. Upon receipt of the physician-signed orders, telemedicine companies submitted the orders to laboratories that processed diagnostic tests and DME pharmacies that provided DME products to beneficiaries. The laboratories and DME pharmacies then submitted claims to Medicare for the orders prescribed by physicians contracted with the telemedicine companies.

Durable Medical Equipment

m. Orthotic devices were a type of DME that included ankle braces, knee braces, back braces, elbow braces, wrist braces, and hand braces (collectively, "braces").

n. A claim for DME submitted to Medicare qualified for reimbursement only if the DME was medically necessary to the treatment of the beneficiary's illness or injury and prescribed by a licensed medical professional.

o. For braces billed to Medicare, Medicare denied reimbursement for certain braces, such as knee braces, unless the ordering physician, among other things, conducted an in-person examination of the beneficiary.

Cancer Genomic Tests

p. Cancer genomic ("CGx") testing used DNA sequencing to detect mutations in genes that could indicate a higher risk of developing certain types of cancers in the future. CGx testing was not a method of diagnosing whether an individual presently had cancer.

q. Because CGx testing did not diagnose cancer, Medicare only covered such tests in limited circumstances, such as when a beneficiary had a cancer diagnosis and the beneficiary's treating physician deemed such testing necessary for the beneficiary's treatment of that cancer. Medicare did not cover CGx testing for beneficiaries who did not have cancer or lacked symptoms of cancer.

r. A CGx test performed on a beneficiary was submitted to a laboratory capable of processing the test. A laboratory typically sent the results to a beneficiary's treating physician who was expected to share and discuss the results with the patient.

s. Medicare paid claims for CGx tests prescribed by a physician but only if, among other criteria, the tests were medically necessary.

Telemedicine

t. Telemedicine provided a means of connecting patients to doctors by using telecommunications technology to interact with a patient.

u. Medicare covered expenses for specified telemedicine services if certain requirements were met. These requirements included, but were not limited to, that (a) the beneficiary was located in a rural or health professional shortage area; (b) services were delivered via a two-way, real-time interactive audio and video telecommunications system; and (c) the beneficiary was at a practitioner's office or a specified medical facility – not at a beneficiary's home – during the telemedicine consultation with a remote practitioner. A practitioner who provided telemedicine services was required to be licensed in the state where the beneficiary was located.

2. From in or around October 2016 continuing through in or around September 2019, in the Northern District of Illinois, and elsewhere,

SARGON AUDISHO,

defendant herein, and others known and unknown to the Grand Jury, participated in a scheme to defraud a health care benefit program, namely, Medicare, 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, in connection with the delivery of and payment for health care benefits, items, and services, which scheme is further described below.

Purpose of the Scheme and Artifice

3. It was the purpose of the scheme and artifice for defendant AUDISHO and others to unlawfully enrich themselves by: (a) submitting and causing the submission of false and fraudulent claims to Medicare that falsely represented that Medicare beneficiaries medically needed DME products and CGx tests, and (b) concealing and causing the concealment of these false and fraudulent claims.

The Scheme and Artifice

4. It was part of the scheme and artifice that defendant AUDISHO maintained an active medical license in Illinois and Indiana, which he had first obtained in or around April 2013.

5. It was further part of the scheme that, beginning in or around October 2016, defendant AUDISHO sought employment with telemedicine companies which would send him doctors' orders to sign in exchange for payment.

6. It was further part of the scheme that, beginning in or around April 2017, defendant AUDISHO sought to become licensed in additional states, including "high demand states," to increase the number of prescriptions he could sign, and became licensed as a medical doctor in Alabama, Arizona, Colorado, Idaho, Iowa, Louisiana, Michigan, Minnesota, Montana, Nebraska, Nevada, New Hampshire, Utah, Wisconsin, and Wyoming.

7. It was further part of the scheme that defendant AUDISHO, while working at various telemedicine companies, signed and caused to be signed, false and fraudulent orders for DME products and CGx testing for Medicare beneficiaries.

8. It was further part of the scheme that defendant AUDISHO and others signed, and caused to be signed, physician's orders for DME items and CGx testing for beneficiaries, when defendant AUDISHO knew that the items and services were not prescribed by a physician, were prescribed for beneficiaries he did not personally examine or consult with, and were not medically necessary.

9. It was further part of the scheme that defendant AUDISHO instructed Employee A, Employee B, and Employee C (the "Employees") to sign defendant AUDISHO's name on orders for DME products and CGx testing for beneficiaries knowing that the orders falsely and fraudulently represented that defendant AUDISHO completed the orders.

10. It was further part of the scheme that defendant AUDISHO made, and caused to be made, false entries in beneficiaries' orders for DME items, including statements that the beneficiaries needed the DME and CGx testing and that

defendant AUDISHO examined the beneficiaries to substantiate the false claims, knowing that the statements were untrue.

11. It was further part of the scheme that, as the result of the false and fraudulent orders he signed and caused to be signed, defendant AUDISHO caused diagnostic testing laboratories and DME pharmacies to submit false claims for beneficiaries to Medicare, when defendant AUDISHO knew that the items and services were not prescribed by a physician, were prescribed for beneficiaries he did not personally examine or consult with, and were not medically necessary.

12. It was further part of the scheme that defendant AUDISHO and Bodhi Tree received payment from telemedicine companies, in return for signed DME and CGx testing orders that defendant AUDISHO signed and caused to be signed and that he knew the items and services were not prescribed by a physician, were prescribed for beneficiaries he did not personally examine or consult with, and were not medically necessary.

13. It was further part of the scheme that after defendant AUDISHO learned of the law enforcement investigation into his conduct, defendant AUDISHO told Employee A to tell federal investigators that defendant AUDISHO, not others, signed the physician's orders, when in fact, defendant AUDISHO did not do so.

14. It was further part of the scheme that defendant AUDISHO misrepresented, concealed and hid, and caused to be misrepresented, concealed and hidden, the existence, purpose, and acts done in furtherance of the scheme.

15. During the course of the scheme, defendant AUDISHO and others submitted and caused to be submitted claims for DME to Medicare for at least approximately $16.4 million, and caused Medicare to pay at least approximately $8.7 million, and submitted and caused to be submitted claims for CGx testing services to Medicare for at least approximately $129 million, and caused Medicare to pay at least approximately $45.9 million.

Acts in Execution of the Scheme and Artifice

16. On or about the dates set forth as to each count below, in the Northern District of Illinois and elsewhere,

SARGON AUDISHO,

defendant herein, did knowingly and willfully execute, and attempt to execute, the above described scheme by submitting and causing to be submitted claims to a health care benefit program, namely, Medicare, for services that were not medically necessary, as follows:

Count	Medicare Beneficiary Initials	Type of Doctor's Order	Approximate Date of Doctor's Order	Approximate Amount Billed to Medicare
1	F.C	DME	3/8/17	$3,700
2	M.F.	DME	6/27/17	$1,320
3	M.F.	DME	7/14/17	$1,895
4	D.G.	DME	2/20/18	$3,507
5	J.Q.	CGx	10/12/18	$12,758
6	L.S.	CGx	8/26/18	$13,614
7	A.C.	CGx	3/21/19	$10,401
8	K.B.	CGx	3/28/19	$12,601

All in violation of Title 18, United States Code, Section 1347.

COUNT NINE

The SPECIAL JANUARY 2020 GRAND JURY further charges that:

1. Paragraph 1 of Count One is incorporated here.

2. On or about October 1, 2018, in the Northern District of Illinois and elsewhere,

SARGON AUDISHO,

defendant herein, knowingly and willfully made and caused to be made materially false, fictitious, and fraudulent statements and representations, and made and caused to be made a materially false writing and document, knowing the same to contain a materially false, fictitious, and fraudulent statement and entry, in a matter involving a health care benefit program in connection with the payment for health care benefits and services, namely, notations in a physician's order, plan of care and notes, and letter of medical necessity to a telemedicine company, stating that defendant performed a medical examination of Beneficiary V.P.;

In violation of Title 18, United States Code, Section 1035(a)(2).

COUNT TEN

The SPECIAL JANUARY 2020 GRAND JURY further charges that:

1. Paragraph 1 of Count One is incorporated here.

2. On or about October 2, 2018, in the Northern District of Illinois and elsewhere,

SARGON AUDISHO,

defendant herein, knowingly and willfully made and caused to be made materially false, fictitious, and fraudulent statements and representations, and made and caused to be made a materially false writing and document, knowing the same to contain a materially false, fictitious, and fraudulent statement and entry, in a matter involving a health care benefit program in connection with the payment for health care benefits and services, namely, notations in a physician's order, plan of care and notes, and letter of medical necessity to a telemedicine company stating that defendant performed a medical examination of Beneficiary D.H.;

In violation of Title 18 United States Code, Section 1035(a)(2).

COUNT ELEVEN

The SPECIAL JANUARY 2020 GRAND JURY further charges that:

1. Paragraph 1 of Count One is incorporated here.

2. On or about October 8, 2018, in the Northern District of Illinois and elsewhere,

SARGON AUDISHO,

defendant herein, knowingly and willfully made and caused to be made materially false, fictitious, and fraudulent statements and representations, and made and caused to be made a materially false writing and document, knowing the same to contain a materially false, fictitious, and fraudulent statement and entry, in a matter involving a health care benefit program in connection with the payment for health care benefits and services, namely, notations in a physician's order, plan of care and notes, and letter of medical necessity to a telemedicine company stating that defendant performed a medical examination of Beneficiary S.L.;

In violation of Title 18 United States Code, Section 1035(a)(2).

FORFEITURE ALLEGATION

The SPECIAL JANUARY 2020 GRAND JURY further alleges that:

1. The allegations in Counts One through Eleven are incorporated here for the purpose of alleging forfeiture pursuant to the provisions of Title 18, United States Code, Section 982(a)(7).

2. Upon conviction of a violation of Title 18, United States Code, Section 1347, or Title 18, United States Code, Section 1035, as alleged in Counts One through Eleven of this Indictment, the defendant shall forfeit to the United States of America, pursuant to Title 18, United States Code, Section 982(a)(7), any and all right, title, and interest, he may have in any property, real or personal, that constitutes and is derived, directly or indirectly, from gross proceeds traceable to the commission of the offenses.

3. Pursuant to Title 21, United States Code, Section 853(p), as incorporated by Title 28, United States Code, Section 2461(c), if any of the property described above, 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, 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 intends to seek forfeiture of any other property of the defendant up to the value of the forfeitable property described above;

All pursuant to Title 18, United States Code, Section 982(a)(7).

A TRUE BILL

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FOREPERSON

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ROBERT ZINK
U.S. Department of Justice
Criminal Division, Fraud Section
Chief

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ALLAN J. MEDINA
U.S. Department of Justice
Criminal Division, Fraud Section
Chief, Health Care Fraud Unit