SEALED

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

FELONY

INDICTMENT FOR CONSPIRACY TO COMMIT HEALTH CARE FRAUD, HEALTH CARE FRAUD, AND FORFEITURE

UNITED STATES OF AMERICA	*	**CRIMINAL ACTION NO.** 15-155
VERSUS	*	**SECTION:** SECT. M MAG. 3
ELAINE DAVIS **PRAMELA GANJI, M.D.** **GODWIN OGBUOKIRI, M.D.**	*	**VIOLATIONS:** 18 U.S.C. § 1349 18 U.S.C. § 1347 18 U.S.C. § 2 18 U.S.C. § 982
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The Grand Jury charges that:

COUNT ONE
Conspiracy to Commit Health Care Fraud (18 U.S.C. § 1349)

A. AT ALL MATERIAL TIMES HEREIN:

The Medicare Program

1. The Medicare Program ("Medicare") was a federal health care program providing benefits to persons who were over the age of 65 or disabled. Medicare was administered by the United States Department of Health and Human Services ("HHS") through its agency, the Centers for Medicare & Medicaid Services ("CMS").

2. Medicare was a "health care benefit program," as defined by Title 18, United States Code, Section 24(b). Individuals who received benefits under Medicare were referred to as Medicare "beneficiaries."

3. "Part A" of the Medicare program covered certain eligible home health care costs for medical services provided by a home health agency ("HHA") to beneficiaries who required home health care services because of an illness or disability that caused them to be homebound. Payments for home health care medical services under Medicare Part A were typically made directly to an HHA or provider based on claims submitted to the Medicare program for qualifying services that had been provided to eligible beneficiaries, rather than directly to the beneficiary.

4. "Part B" of the Medicare program covered certain physician services, outpatient and other services, that were medically necessary and were ordered by licensed medical doctors or other health care providers.

5. Physicians, clinics and other health care providers, including HHAs, that provided services to Medicare beneficiaries were able to apply for and obtain a "provider number." A health care provider that was issued a Medicare provider number was able to file claims with Medicare to obtain reimbursement for services provided to beneficiaries. A Medicare claim was required to set forth, among other things, the beneficiary's name and Medicare number, the services that had been 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 that ordered the services.

Reimbursements for Home Health Services

6. Medicare Part A, through a Medicare contractor, reimbursed 100% of the allowable charges for participating HHAs providing home health care services only if a patient qualified for home health care services. A patient qualified for home health care services only if:

a. the patient was confined to the home, also referred to as homebound;

b. the patient was under the care of a physician who specifically determined that there was a need for home health care and established the Plan of Care ("POC"); and

c. the determining physician signed a certification statement specifying that the beneficiary needed intermittent skilled nursing services, physical therapy, or speech therapy, the beneficiary was confined to the home, that a POC for furnishing services was established and periodically reviewed, and that the services were furnished while the beneficiary was under the care of the physician who established the POC.

7. HHAs were reimbursed under the Home Health Prospective Payment System ("PPS"). Under PPS, Medicare paid Medicare-certified HHAs a pre-determined base payment for each 60 days that care was needed. This 60-day period was called an "episode of care." The base payment was adjusted based on the health condition and care needs of the beneficiary. This adjustment was done through the Outcome and Assessment Information Set ("OASIS"), which was a patient assessment tool for measuring and detailing the patient's condition. If a beneficiary was still eligible for care after the end of the first episode of care, a second episode could

commence. There were no limits to the number of episodes of home health benefits a beneficiary could receive as long as the beneficiary remained eligible.

Record Keeping Requirements

8. Medicare Part A regulations required HHAs providing services to Medicare patients 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 reimbursement were submitted by the home health agency. These medical records were required to be sufficient to permit a Medicare contractor or auditor to review the appropriateness of Medicare payments made to the home health agency under the Part A program.

9. Among the written records required to document the appropriateness of home health care claims submitted under Part A of Medicare was a POC that included the physician order for home health care, diagnoses, types of services/frequency of visits, prognosis/ rehabilitation potential, functional limitations/activities permitted, medications/treatments/ nutritional requirements, safety measures/discharge plans, goals, and physician signature. Also required was a signed certification statement by an attending physician certifying that the patient was confined to his or her home and was in need of the planned home health services, and an OASIS.

10. Medicare Part A regulations required provider HHAs to maintain medical records of each visit made by a nurse, therapist, and home health aide to a beneficiary. The record of a nurse's visit was required to describe, among other things, any significant observed signs or symptoms, any treatment and drugs administered, any reactions by the patient, any teaching and

the understanding of the patient, and any changes in the patient's physical or emotional condition. The home health nurse, therapist and aide were required to document the hands-on personal care provided to the beneficiary as the services were deemed necessary to maintain the beneficiary's health or to facilitate treatment of the beneficiary's primary illness or injury.

11. "Part B" of the Medicare program covered certain physician services, outpatient and other services, that were medically necessary and were ordered by licensed medical doctors and other qualified health care professional.

12. The Healthcare Common Procedure Coding System (HCPCS) was established to provide a standardized coding system for describing the specific items and services provided in the delivery of health care. Such coding is necessary for Medicare and other health insurance programs to ensure that insurance claims are processed in an orderly and consistent manner.

13. Medicare established a usual, customary and reasonable fee for each service rendered, as described by its corresponding HCPCS code. Codes were based upon the complexity of the service, the severity of the illness or injury and the average amount of time generally required to perform the service, and the fees paid are commensurate with the amount of work required.

14. HCPCS G0180 and G0179 were codes for physician certification and re-certifications, respectively, for Medicare-covered home health services that included contacts with the home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the POC that meets a patient's needs, per the certification or re-certification period.

15. HCPCS G0181 was physician supervision of a patient receiving Medicare-covered services provided by a home health agency that required complex and multidisciplinary care modalities involving regular physician development and/or revision of POCs, review of subsequent reports of patient status, review of laboratory and other studies, communication, including telephone calls with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, lasting 30 or more minutes.

The Medicare Provider

16. Christian Home Health Care, Inc. ("Christian") was a Louisiana corporation incorporated on or about October 5, 1988. Christian purported to provide home health care and related services to Medicare beneficiaries. Christian had a Medicare provider number and was eligible to receive payments from Medicare. From on or about January 1, 2007, through on or about January 21, 2015, Christian submitted approximately 14,891 claims for home health care and related services to Medicare, amounting to approximately $33,232,134, and was paid approximately $28,265,071 on those claims.

The Defendants

17. **ELAINE DAVIS (DAVIS)**, a resident of New Orleans, Louisiana, owned and operated Christian.

18. **PRAMELA GANJI, M.D. (GANJI)**, a resident of New Orleans, Louisiana, was a medical doctor licensed by the State of Louisiana. **GANJI** was the referring physician for approximately $5,748,381 in claims that Christian submitted to Medicare.

19. **GODWIN OGBUOKIRI, M.D. (OGBUOKIRI)**, a resident of New Orleans, Louisiana, was a medical doctor licensed by the State of Louisiana. **OGBUOKIRI** was the referring physician for approximately $3,499,842 in claims that Christian submitted to Medicare.

B. THE CONSPIRACY:

20. Beginning in or around January 2007, and continuing through the present, in the Eastern District of Louisiana, and elsewhere, defendants **ELAINE DAVIS, PRAMELA GANJI, M.D.,** and **GODWIN OGBUOKIRI, M.D.** and others known and unknown to the grand jury, knowingly and willfully did combine, conspire, confederate, and agree with each other and with others to knowingly and willfully execute and attempt to 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, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money and property 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, in violation of Title 18, United States Code, Section 1347.

C. PURPOSE OF THE CONSPIRACY:

21. It was a purpose of the conspiracy for **DAVIS, GANJI, OGBUOKIRI,** and co-conspirators known and unknown to the Grand Jury, to unlawfully enrich themselves by, among other things, (a) obtaining and arranging for the use of Medicare beneficiary numbers as the bases of fraudulent claims filed for home health care services that were not medically necessary, and in some instances not provided; (b) causing the submission and concealment of false and fraudulent claims to Medicare, the receipt and transfer of the proceeds from the fraud, and the

payment of illegal kickbacks; and (c) causing the diversion of the proceeds of the fraud for the personal use and benefit of the defendants and their co-conspirators.

D. MANNER AND MEANS OF THE CONSPIRACY:

The manner and means by which the defendants and other co-conspirators sought to accomplish the object and purpose of the conspiracy included, among others, the following:

22. As owner and operator of Christian, **DAVIS** obtained and maintained signature authority for corporate bank accounts of Christian, including First Bank and Trust Account No. xxxxx4457.

23. **DAVIS** obtained Medicare beneficiaries' Medicare numbers by, among other means, (1) paying patient recruiters, directly or indirectly, in exchange for their provision of Medicare beneficiary numbers that would be used at Christian to bill Medicare for home health care and related services; (2) paying employees and other agents of Christian, directly or indirectly, in exchange for their provision of Medicare beneficiary numbers that would be used at Christian to bill Medicare for home health care and related services; and/or (3) agreeing to hire as employees at Christian nurses, aides, and other persons in exchange for their provision of Medicare beneficiary numbers that would be used at Christian to bill Medicare for home health care and related services.

24. **DRS. GANJI** and **OGBUOKIRI** and other co-conspirators known and unknown to the Grand Jury, (1) referred beneficiaries to Christian for home health services and (2) signed POCs and other documents so that Christian could bill Medicare for home health care and related services that were not medically necessary and, in some instances, were not rendered.

25. **DAVIS, GANJI** and **OGBUOKIRI** submitted and caused the submission of fraudulent claims to Medicare for home health care and related services when such services were not medically necessary and/or not provided.

26. Medicare payments based upon fraudulent claims submitted by Christian were deposited into bank accounts established by **DAVIS** on behalf of Christian, and proceeds were paid out to co-conspirators known and unknown to the Grand Jury.

27. **DAVIS** benefitted from the scheme because, among other reasons, she owned Christian, and paid, or caused to be paid, hundreds of thousands of dollars to herself and members of her family from the proceeds of the fraud.

28. **OGBOUKIRI** benefitted from the scheme because, among other reasons, he billed or caused Medicare Part B to be billed approximately $663,448.00 for services that he claimed to provide to Medicare beneficiaries whom Christian also claimed to serve. Medicare Part B paid approximately $166,083.53 to **OGBOUKIRI** in response to his claims.

29. **GANJI** benefitted from the scheme because, among other reasons, she billed or caused Medicare Part B to be billed approximately $351,788.36 for services that she claimed to provide to Medicare beneficiaries whom Christian also claimed to serve. Medicare Part B paid approximately $110,010.51 to **GANJI**, in response to her claims.

All in violation of Title 18, United States Code, Section 1349.

COUNTS TWO THROUGH FIVE
Health Care Fraud (18 U.S.C. § 1347)

A. AT ALL TIMES MATERIAL HEREIN:

30. Paragraphs 1 through 19 above, of this Indictment are re-alleged and incorporated as though fully set forth herein.

B. THE OFFENSES:

31. On or about the dates enumerated below, in the Eastern District of Louisiana, and elsewhere, the defendants, **ELAINE DAVIS, PRAMELA GANJI, M.D.,** and **GODWIN OGBUOKIRI, M.D.,** and/or others known and unknown to the Grand Jury, did knowingly and willfully cause to be submitted to Medicare the following false and fraudulent claims for payment:

Count	Beneficiary	ICN	Claim Dates of Service	Amount Billed	Defendants
2	S.J.	211137027 71005LAR	03/09/11 – 05/07/11	$2,947.49	**ELAINE DAVIS; GODWIN OGBUOKIRI, M.D.**
3	L.P.	214134043 92907LAR	03/05/14 – 05/03/14	$2,838.00	**ELAINE DAVIS; GODWIN OGBUOKIRI, M.D.**
4	C.S.	213351032 9807LAR	10/11/13 - 12/09/13	$1,388.00	**ELAINE DAVIS; PRAMELA GANJI, M.D.**
5	J.W.	214170051 0207LAR	04/05/14 – 06/03/14	$3,150.01	**ELAINE DAVIS; PRAMELA GANJI, M.D.**

All in violation of Title 18, United States Code, Sections 1347 and 2.

NOTICE OF HEALTH CARE FRAUD FORFEITURE

1. The allegations contained in Counts One through Five of this Indictment are hereby re-alleged and incorporated by reference for the purpose of alleging forfeitures to the United States pursuant to the provisions of Title 18, United States Code, Section 982(a)(7).

2. As a result of the offenses alleged in Counts One through Five, defendants **ELAINE DAVIS, PRAMELA GANJI, M.D.,** and **GODWIN OGBUOKIRI, M.D.** shall forfeit to the United States, pursuant to Title 18, United States Code, Section 982(a)(7), any and all property, real and personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense as a result of the violations of Title 18, United States Code, Sections 1347 and 1349, which are Federal health care offenses within the meaning of Title 18, United States Code, Section 24.

3. If any of the property described above as being subject to forfeiture, as a result of any act or omission of the defendants:

a. cannot be located upon the exercise of due diligence;

b. has been transferred, sold to, or deposited with, a third person;

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 subdivided without difficulty;

it is the intent of the United States, pursuant to Title 18, United States Code, Section 982(b) to seek forfeiture of any other property of said defendants up to the value of the above forfeitable property;

All in violation of Title 18, United States Code, Section 982(a)(7).

FOREPERSON'S SIGNATURE
HAS BEEN REDACTED

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New Orleans, Louisiana
June 12, 2015