/s/

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

January 2014 Grand Jury

UNITED STATES OF AMERICA, Plaintiff, v. EUCHARIA OKEKE, aka "UK," Defendant.	CR No. CR14-0234 I N D I C T M E N T [18 U.S.C. § 1349: Conspiracy to Commit Health Care Fraud; 18 U.S.C. § 1347: Health Care Fraud; 18 U.S.C. § 2(b): Causing an Act to be Done]

The Grand Jury charges:

COUNT ONE

[18 U.S.C. § 1349]

A. INTRODUCTORY ALLEGATIONS

At all times relevant to this Indictment:

The Conspirators

1. Defendant EUCHARIA OKEKE ("OKEKE"), also known as ("aka") "UK," owned and operated Esteem Medical Supply, Inc. ("Esteem"), a durable medical equipment ("DME") supply company located in Inglewood, California, within the Central District of California.

2. Co-conspirator Jason C. Ling was a physician licensed to practice medicine in the State of California. Jason C. Ling wrote fraudulent prescriptions for power wheelchairs ("PWCs") and other DME, which defendant OKEKE used as the basis to submit fraudulent claims to Medicare.

3. Co-conspirator J.C.H.C. was a marketer who recruited Medicare beneficiaries to receive medically unnecessary PWCs and other DME from, among other DME supply companies, Esteem.

4. On or about April 27, 2007, OKEKE opened a business bank account for Esteem at Bank of America, account number xxxxxx7443.

5. On or about August 23, 2007, defendant OKEKE submitted an application and other paperwork to the Medicare Program ("Medicare") to obtain and maintain a Medicare provider number for Esteem.

6. Between in or around March 2010 and in or around November 2010, Esteem submitted to Medicare claims totaling approximately $496,794 for purported PWCs and other DME based on fraudulent prescriptions written by co-conspirator Jason C. Ling, and Medicare paid Esteem approximately $311,145 on those claims.

The Medicare Program

7. Medicare was a federal health care benefit program, affecting commerce, that provided benefits to individuals who were over the age of 65 or disabled. 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 ("HHS").

8. CMS contracted with private insurance companies to (a) certify DME providers for participation in Medicare and monitor their compliance with Medicare standards; (b) process and pay claims; and (c) perform program safeguard functions, such as identifying and reviewing suspect claims.

9. Individuals who qualified for Medicare benefits were referred to as Medicare beneficiaries. Each Medicare beneficiary was given a Health Identification Card containing a unique identification number ("HICN").

10. DME companies, physicians, and other health care providers that provided medical services that were reimbursed by Medicare were referred to as Medicare "providers."

11. To obtain payment from Medicare, a DME company first had to apply for and obtain a provider number. By signing the provider application, the DME company agreed to abide by Medicare rules and regulations, including the Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b)), which, among other things, prohibited the payment of kickbacks or bribes for the referral of Medicare beneficiaries for any item or service for which payment may be made by the Medicare program.

12. If Medicare approved a provider's application, Medicare assigned the provider a Medicare provider number, enabling the provider (such as a DME company or physician) to submit claims to Medicare for services and supplies provided to Medicare beneficiaries.

13. To obtain and maintain their Medicare provider numbers and billing privileges, DME suppliers had to meet Medicare standards for participation. The Medicare contractor responsible

for evaluating and certifying DME suppliers' compliance with these standards was Palmetto GBA ("Palmetto").

14. From in or about October 2006 through the date of this Indictment, Noridian Administrative Services ("Noridian") processed and paid Medicare DME claims in Southern California.

15. Most Medicare providers, including Esteem, submitted their claims electronically pursuant to an agreement with Medicare that they would submit claims that were accurate, complete, and truthful.

16. Medicare paid DME providers only for DME that was medically necessary to the treatment of a beneficiary's illness or injury, was prescribed by a beneficiary's physician, and was provided in accordance with Medicare regulations and guidelines that governed whether a particular item or service would be paid by Medicare.

17. To bill Medicare for DME provided to a beneficiary, a DME supplier was required to submit a claim (Form 1500). Medicare required claims to be truthful, complete, and not misleading. In addition, when a claim was submitted, the DME provider was required to certify that the DME or services covered by the claim were medically necessary.

18. Medicare required a claim for payment to set forth, among other things, the beneficiary's name and HICN, the type of DME provided to the beneficiary, the date the DME was provided, and the name and unique physician identification number ("UPIN") of the physician who prescribed or ordered the DME.

19. Medicare had a co-payment requirement for DME. Medicare reimbursed providers 80% of the allowed amount of a DME

claim and the beneficiary was ordinarily obligated to pay the remaining 20%.

B. THE OBJECT OF THE CONSPIRACY

20. Beginning in or around March 2010, and continuing through in or around November 2010, in Los Angeles County, within the Central District of California, and elsewhere, defendant OKEKE, together with others known and unknown to the Grand Jury, including Jason C. Ling and J.C.H.C., knowingly combined, conspired, and agreed to commit health care fraud, in violation of Title 18, United States Code, Section 1347.

C. THE MANNER AND MEANS OF THE CONSPIRACY

21. The object of the conspiracy was carried out, and to be carried out, in substance, as follows:

a. Defendant OKEKE would use marketers, including co-conspirator J.C.H.C., to recruit Medicare beneficiaries for PWCs and other DME that the beneficiaries did not need.

b. The marketers, including co-conspirator J.C.H.C., would take the Medicare beneficiaries to visit doctors, including co-conspirator Jason C. Ling, who were not the beneficiaries' regular primary care physicians. The doctors would write prescriptions for medically unnecessary PWCs and other DME.

c. Defendant OKEKE would pay the marketers, including co-conspirator J.C.H.C., kickbacks for recruiting the Medicare beneficiaries to receive PWCs and other DME.

d. After acquiring the false and fraudulent prescriptions and supporting documents, defendant OKEKE would submit, and cause the submission of, false and fraudulent claims to Medicare for medically unnecessary PWCs and other DME.

e. Defendant OKEKE would also submit, and cause the submission of, claims to Medicare before Esteem actually provided or delivered PWCs and other DME to the Medicare beneficiariee. In an attempt to conceal these facts, OKEKE backdated and caused to be backdated, delivery tickets and other delivery documentation for PWCs.

f. As a result of defendant OKEKE's submission of false and fraudulent claims at Esteem, Medicare made payments to Esteem's business bank account at Bank of America. Defendant OKEKE then transferred and disbursed, and caused the transfer and disbursement of, monies from Esteem's business bank account to herself and others.

COUNTS TWO THROUGH EIGHT

[18 U.S.C. §§ 1347 and 2(b)]

A. INTRODUCTORY ALLEGATIONS

22. The Grand Jury incorporates by reference and re-alleges paragraphs 1 through 19 and 21 above of this Indictment as though set forth in their entirety herein.

B. THE SCHEME TO DEFRAUD

23. Beginning in or around August 2007, and continuing through in or around February 2011, in Los Angeles County, within the Central District of California, and elsewhere, defendant OKEKE, together with others known and unknown to the Grand Jury, knowingly, willfully, and with intent to defraud, executed, and attempted to execute, a scheme and artifice: (a) to defraud a health care benefit program, namely Medicare, as to material matters in connection with the delivery of and payment for health care benefits, items, and services; and (b) to obtain money from Medicare by means of material false and fraudulent pretenses and representations and the concealment of material facts in connection with the delivery of and payment for health care benefits, items, and services.

C. MEANS TO ACCOMPLISH THE SCHEME TO DEFRAUD

24. The fraudulent scheme operated, in substance, as described in paragraph 21 above of this Indictment, which is incorporated by reference as though set forth in its entirety herein.

25. In addition, as part of the fraudulent scheme, defendant OKEKE would submit, and cause the submission of, claims to Medicare for PWCs and other DME that were never provided to

COUNT	BENE-FICIARY	CLAIM NUMBER	APPROX. DATE BILLED TO MEDICARE	APPROX. AMOUNT BILLED TO MEDICARE
SEVEN	M.G.	1020482907600	7/21/10	$5,350
EIGHT	G.M.	10258849839000	9/15/10	$5,915

A TRUE BILL

/s/
Foreperson

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