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United States Courts
Southern District of Texas
FILED

JUN 07 2017

David J. Bradley, Clerk of Court

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

UNITED STATES OF AMERICA	§	
	§	**Criminal No.**
v.	§	
	§	**UNDER SEAL**
ELEKWACHI KALU,	§	
PRISCA KALU, a/k/a Prisca Kalu Henley, and	§	
VERINUS KALU,	§	
Defendants.	§	

17-326

INDICTMENT

The Grand Jury charges:

General Allegations

At all times material to this Indictment, unless otherwise specified:

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

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

3. "Part A" of the Medicare program covered certain eligible home healthcare costs for medical services provided by a home healthcare agency ("HHA") to beneficiaries requiring home health services because of an illness or disability causing them to be homebound. Payments for home healthcare services were typically made directly to a HHA based on claims submitted to the

Medicare program for qualifying services that had been provided to eligible beneficiaries, rather than to the beneficiaries.

4. Physicians, clinics, and other healthcare providers, including HHAs that provided services to Medicare beneficiaries, were required to apply for and obtain a Medicare "provider number." Part of this application process required that the healthcare providers certify that they understand and will abide by the federal laws and regulations governing their participation in Medicare. This application specifically named the Federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7(b).

5. A healthcare 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 identification number, 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 healthcare provider that ordered the services.

6. The Medicare program paid for home health services only if the patient qualified for home health care benefits. A patient qualified for home health care benefits 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 there was a need for home healthcare and established the Plan of Care ("POC"); and

c. the determining physician signed a certification statement specifying that:

i. the beneficiary needed intermittent skilled nursing services, physical therapy, or speech therapy;

ii. the beneficiary was confined to the home;

iii. a POC for furnishing services was established and periodically reviewed; and

iv. the services were furnished while the beneficiary was under the care of the physician who established the POC.

7. Medicare 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 payment were submitted by the HHA.

8. These medical records were required to be sufficient to permit Medicare, through its contractors, to review the appropriateness of Medicare payments made to the HHA.

9. Among the written records required to document the appropriateness of home health care claims submitted under Part A of Medicare was a POC, which 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. A POC signed and dated by the physician, or a signed and dated written prescription, or a verbal order recorded in the POC were required in advance of rendering services. Also required was a signed certification statement by an attending physician certifying that the beneficiary was confined to his or her home and was in need of the planned home health services,

10. Medicare also required that HHAs conduct an assessment of the beneficiary's condition and eligibility for home health services, called an Outcome and Assessment Information Set ("OASIS"). The OASIS set the basis by which a HHA was paid. The more severe a beneficiary's medical conditions, as reflected by the OASIS, the more money Medicare would pay the HHA for providing care.

11. Medicare Part A regulations required provider HHAs to maintain medical records of each visit made by a nurse, therapist, or home health care 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 beneficiary, any teaching and the understanding of the beneficiary, and any changes in the beneficiary's physical or emotional condition. The home health care nurse, therapist, or aide was required to document the hands-on personal care provided to the beneficiary if the services were deemed necessary to maintain the beneficiary's health or to facilitate treatment of the beneficiary's primary illness or injury. These written medical records were generally created and maintained in the form of "visit notes" and "home health aide notes/observations."

12. Rhythmic Home Health Services, Inc. ("Rhythmic") was a Texas corporation doing business at 9226 S. Dairy Ashford Road, Suite 2601, Houston, Texas. Rhythmic submitted claims to Medicare and Medicaid for home health services.

13. Defendant **ELEKWACHI KALU**, a resident of Harris County, Texas, was the owner and administrator of Rhythmic.

14. Defendant **PRISCA KALU**, a resident of Harris County, Texas, was the manager and a licensed vocational nurse for Rhythmic, and was the wife of **ELEKWACHI KALU**.

15. Defendant **VERINUS KALU**, a resident of Harris County, Texas, was a registered nurse, who worked as the Director of Nursing at Rhythmic, and was the daughter of **ELEKWACHI KALU** and **PRISCA KALU**.

16. Doctor 1 was a licensed Medical Doctor who certified Rhythmic patients for home healthcare.

17. Doctor 2 was a licensed Medical Doctor who certified Rhythmic patients for home health care.

COUNT 1
Conspiracy to Commit Healthcare Fraud
(Violation of 18 U.S.C. § 1349)

18. Paragraphs 1 through 17 are re-alleged and incorporated by reference as if fully set forth herein.

19. From in or around August 2012 through in or around January 2017, the exact dates being unknown to the Grand Jury, in the Houston Division of the Southern District of Texas, and elsewhere, defendants **ELEKWACHI KALU, PRISCA KALU**, and **VERINUS KALU** did knowingly and willfully combine, conspire, confederate and agree with each other, and others known and unknown to the Grand Jury, to violate Title 18, United States Code, Section 1347, that is, to execute a scheme and artifice to defraud a healthcare 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, said healthcare benefit program, in connection with the delivery of and payment for healthcare benefits, items and services.

Purpose of the Conspiracy

20. It was a purpose of the conspiracy for defendants **ELEKWACHI KALU, PRISCA KALU**, and **VERINUS KALU** and their co-conspirators to unlawfully enrich themselves by (a) submitting false and fraudulent claims to Medicare for services that were medically unnecessary, were not eligible for Medicare reimbursement, were not provided, and that were based upon false or fraudulent documentation, (b) concealing the submission of false and fraudulent claims to Medicare

and the receipt and transfer of proceeds from the fraud, and (c) diverting proceeds of the fraud for the personal use and benefit of defendants and their co-conspirators.

Manner and Means of the Conspiracy

21. The manner and means by which defendants **ELEKWACHI KALU, PRISCA KALU,** and **VERINUS KALU** and their co-conspirators, sought to accomplish the object and purpose of the conspiracy included, among other things, the following:

22. Defendant **ELEKWACHI KALU** applied for and received a Medicare provider number for Rhythmic from Medicare, which he used to submit claims to Medicare for home health services.

23. Defendant **ELEKWACHI KALU** signed Rhythmic's Medicare provider application stating that Rhythmic would comply with the Federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7(b).

24. Defendants **ELEKWACHI KALU, PRISCA KALU, VERINUS KALU,** and their co-conspirators, recruited Medicare beneficiaries to Rhythmic for medically unnecessary home health services so that they could bill, and direct others to bill, Medicare for those services.

25. Defendants **ELEKWACHI KALU, PRISCA KALU, VERINUS KALU** and their co-conspirators, paid $150 to $500 in kickbacks to Medicare beneficiaries in exchange for the beneficiaries agreeing to be certified for home health services by Doctor 1 and Doctor 2, for home health services that were often medically unnecessary, and in exchange for the Medicare beneficiaries' agreement to receive home health services from Rhythmic.

26. Defendants **ELEKWACHI KALU, PRISCA KALU, VERINUS KALU** and their co-conspirators, accompanied Medicare beneficiaries to the clinics of Doctor 1 and Doctor 2, so that Doctor 1 and Doctor 2 would certify the Medicare beneficiaries for home health services that were

often medically unnecessary, not eligible for Medicare reimbursement, not provided, and/or based upon false or fraudulent documentation.

27. Doctor 1 and Doctor 2 required a kickback, disguised as a copayment and document fee, before they would certify Medicare beneficiaries for home health care.

28. Defendants **ELEKWACHI KALU, PRISCA KALU, VERINUS KALU** and their co-conspirators, would pay kickbacks, disguised as copayments, to Doctor 1 and Doctor 2, to induce Doctor 1 and Doctor 2 to certify Medicare beneficiaries for home health services.

29. Defendants **PRISCA KALU, VERINUS KALU**, and their co-conspirators, would falsify and cause to be falsified OASIS forms, POCs, and other home health documentation, to make it appear that the services for which Rhythmic billed Medicare for were medically necessary and eligible for Medicare reimbursement.

30. Defendants **PRISCA KALU, VERINUS KALU** and their co-conspirators, represented to Medicare, and caused others to represent to Medicare, that they provided home health services on POCs, OASIS forms, nurse's notes, and other home health documentation, when they did not provide the services as claimed.

31. From in or around August 2012 through in or around January 2017, defendants **ELEKWACHI KALU** and **PRISCA KALU** billed Medicare, and directed others to bill Medicare, approximately $3.2 million for services that were often medically unnecessary, not eligible for Medicare reimbursement, not provided, based upon false or fraudulent documentation, and/or based upon illegal kickbacks. Medicare paid Rhythmic approximately $2.9 million on those claims.

32. After Medicare deposited payments into Rhythmic's bank account, defendants **ELEKWACHI KALU, PRISCA KALU,** and **VERINUS KALU** transferred proceeds of the fraud to themselves, and their co-conspirators.

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

COUNTS 2-5
Healthcare Fraud
(Violation of 18 U.S.C. §§ 1347 and 2)

33. Paragraphs 1 through 17 and 19 through 32 are re-alleged and incorporated by reference as if fully set forth herein.

34. On or about the dates specified below, in the Houston Division of the Southern District of Texas, and elsewhere, defendants **PRISCA KALU**, and **VERINUS KALU**, aiding and abetting and aided and abetted by others known and unknown to the Grand Jury, in connection with the delivery of and payment for healthcare benefits, items, and services, did knowingly and willfully execute and attempt to execute, a scheme and artifice to defraud a healthcare 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, by submitting or causing the submission of false and fraudulent claims to Medicare for home health services, including the following claims:

Count	Medicare Beneficiary	On or About Dates of Purported Home Health Services	On or About Date of Payment	Approximate Medicare Payment
2	P.S.	02/02/2015 through 04/02/2015	05/22/2015	$1,824.13
3	P.S.	09/30/2015 through 11/28/2015	12/25/2015	$1,467.79

4	K.M.	02/07/16 through 04/06/16	04/29/16	$1,405.01
5	J.I.	01/21/2015 through 03/21/2015	04/24/15	$1,824.13

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

CRIMINAL FORFEITURE
(18 U.S.C. § 982(a)(7))

35. Pursuant to Title 18, United States Code, Section 982(a)(7), the United States of America gives notice to defendants **ELEKWACHI KALU, PRISCA KALU,** and **VERINUS KALU** that upon conviction of any Counts in this Indictment, all property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of such offenses—approximately $3,191,997.04—is subject to forfeiture.

36. Defendants **ELEKWACHI KALU, PRISCA KALU,** and **VERINUS KALU** are notified that upon conviction, a money judgment may be imposed equal to the total value of the property subject to forfeiture.

37. Defendants **ELEKWACHI KALU, PRISCA KALU,** and **VERINUS KALU** are notified that if any of the forfeitable property, or any portion thereof, as a result of any act or omission of defendants or their co-conspirators:

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;

it is the intent of the United States to seek forfeiture of any other property of defendants up to the total value of the property subject to forfeiture, pursuant to Title 21, United States Code, Section 853(p), incorporated by reference in Title 18, United States Code, Section 982(b)(1).

A TRUE BILL

ORIGINAL SIGNATURE ON FILE

FOREPERSON

ABE MARTINEZ
ACTING UNITED STATES ATTORNEY

Jason R. Knutson
TRIAL ATTORNEY
CRIMINAL DIVISION, FRAUD SECTION
U.S. DEPARTMENT OF JUSTICE