United States Courts
Southern District of Texas
FILED
JUL 06 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**
ANH DO, M.D.,	§	
	§	
Defendant.	§	**H 17 417**

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 over the age of 65 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. "Part B" of the Medicare program covers eligible physician and outpatient medical services provided by a participating Part B service provider and provided to Medicare beneficiaries with a medical need for the provided service. Claims for qualifying Part B services are typically reimbursed in part to the Part B provider based on contract rates determined by Medicare. For Part B services, Medicare beneficiaries are required to bear financial responsibility for a portion of the Medicare contract rate, typically a twenty percent co-payment, which is paid directly by the Medicare beneficiary to the Part B provider.

5. Physicians, clinics, and other healthcare providers, including HHAs that provided services to Medicare beneficiaries, were able to apply for and obtain a Medicare "provider number." 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-healthcare benefits. A patient qualified for home-healthcare 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 (or "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. The Medicaid program was a state administered health insurance program funded by the United States government and by the State of Texas. The Medicaid program helped pay for reasonable and necessary medical procedures and services, such as physician services, provided to individuals who were deemed eligible under state low-income programs.

8. The State of Texas contracted with Texas Medicaid & Healthcare Partnership to process and pay claims submitted by healthcare providers.

9. The Medicaid program in Texas could pay a portion of a claim originally submitted to Medicare in the event the patient had both Medicare and Medicaid coverage. This portion was generally a percentage of the amount Medicare allows for the billed charge. Such claims were automatically sent to Medicaid once processed by Medicare. Medicaid would pay its portion if Medicare originally allowed the claim.

DEFENDANT

10. **ANH DO**, a physician licensed by the State of Texas, is a resident of Harris County, Texas.

11. **ANH DO** represented to Medicare that he was the President and owner of 7111 Medical Clinic, Inc. ("7111 Medical Clinic"), a purported medical clinic that was purportedly located at 2470 Gray Falls Drive, Suite 215, Houston, Texas 77077.

COUNT 1

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

12. Paragraphs 1 through 11 are re-alleged and incorporated by reference as if fully set forth herein.

13. From in or around November 2012 to in or around February 2015, the exact dates being unknown to the Grand Jury, in the Houston Division of the Southern District of Texas, and elsewhere, Defendant

ANH DO

did knowingly and willfully combine, conspire, confederate and agree with 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 Medicaid, 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

14. It was a purpose of the conspiracy for **ANH DO**, and others known and unknown to the Grand Jury, to unlawfully enrich themselves by (a) signing false and fraudulent POCs, and other medical documents, for Medicare and Medicaid beneficiaries, (b) causing the submission and concealment of false and fraudulent claims to Medicare and Medicaid, and the receipt and transfer of proceeds from the fraud, and (c) causing the diversion of the proceeds of the fraud for the personal use and benefit of Defendant and his co-conspirators.

Manner and Means of the Conspiracy

The manner and means by which Defendant sought to accomplish the purpose of the conspiracy included, among other things:

15. Co-conspirators at HHAs in and around Houston referred Medicare and Medicaid beneficiaries or patients to **ANH DO** and his co-conspirators at 7111 Medical Clinic.

16. In exchange for these patient referrals from HHAs, **ANH DO** signed false and fraudulent Plans of Care, and other home-health documents, certifying and recertifying these HHA-referred patients for home-health services.

17. **ANH DO**, and his co-conspirators, made it appear as if patients qualified for and received home-health services under Medicare when those services were not medically necessary, not provided or both.

18. **ANH DO** fraudulently certified and recertified patients for home-health services by falsely stating in POCs, and other medical documents, that patients qualified for home-health services under Medicare.

19. **ANH DO** specifically falsely certified and recertified that patients were confined to the home, had a medical need for home-health services, and were under his care.

20. **ANH DO**, and his co-conspirators at 7111 Medical Clinic, then purportedly performed medical diagnostic tests, and other services, on some of the HHA-referred patients.

21. **ANH DO**, and his co-conspirators at 7111 Medical Clinic, signed false medical documents to make it appear as if the HHA-referred patients both received diagnostic tests, and other medical services, and had a medical need for these tests and services.

22. **ANH DO** maintained a Medicare provided number, which was used to submit false and fraudulent claims to Medicare for diagnostic tests, and other medical services, that were not medically necessary, not provided or both.

23. **ANH DO** knew that these diagnostic tests, and other medical services, billed to Medicare on behalf of HHA-referred patients were not medically necessary, not provided or both.

24. From in or around November 2012 to in or around January 2015, co-conspirators at HHAs, known and unknown, submitted, and caused the submission of, approximately $9 million to Medicare in claims for home-health services where **ANH DO** was listed as the attending physician. Medicare paid co-conspirators at these HHAs approximately $10 million on these claims.

25. From in or around November 2012 to in or around January 2015, **ANH DO** submitted, and caused the submission of, approximately $4.3 million in claims to Medicare for diagnostic tests and other medical services. Medicare paid approximately $2 million on these claims.

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

COUNTS 2-7
Healthcare Fraud
(Violation of 18 U.S.C. §§ 1347 and 2)

26. Paragraphs 1 through 11 and 15 through 25 are re-alleged and incorporated by reference as if fully set forth herein.

27. On or about the date specified below, in the Houston Division of the Southern District of Texas, and elsewhere, Defendant

ANH DO

aided and abetted by, and aiding and abetting, 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, as set forth below:

Count	Medicare Beneficiary	Medical Test	On or About Date of Services	Approximate Medicare Payment
2.	G.M.	Allergy Test	January 18, 2013	$418.26
3.	E.R.	Heart Ultrasound	March 5, 2013	$152.05
4.	L.D.	Allergy Test	July 22, 2013	$409.89
5.	M.M.	Heart Ultrasound	May 7, 2014	$117.13
6.	M.M.	Allergy Test	May 7, 2014	$396.39
7.	A.B.	Heart Ultrasound	July 9, 2014	$177.13

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

<u>COUNTS 8-12</u>
False Statements Relating to Health Care Matters
(Violation of 18 U.S.C. § 1035)

28. Paragraphs 1 through 11 and 15 through 25 of this Indictment are realleged and incorporated by reference as if fully set forth herein.

29. On or about the dates set forth below, in Harris County, in the Southern District of Texas, and elsewhere, Defendant

ANH DO

did knowingly and willfully make materially false, fictitious, and fraudulent statements and representations, and make and use materially false writings and documents, as set forth below, knowing the same to contain materially false, fictitious, and fraudulent statements and entries, in connection with the delivery of and payment for health care benefits, items, and services, and in a matter involving a health care benefit program, specifically Medicare:

Count	Medicare Beneficiary	HHA	Approximate Certification Period	Description	Approximate Medicare Payment
8.	G.M.	Awford Home Healthcare Services	Jan. 21, 2013 to Mar. 21, 2013	Certification	$4,331.90
9.	E.R.	Caring Angel Healthcare Services	March 6, 2013 to May 4, 2013	Certification	$4,337.84
10.	L.D.	A-1 Advantage Home Health Services	Aug. 24, 2013 to Oct. 22, 2013	Recertification	$1,957.34
11.	M.M.	Awford Home Health Services	May 8, 2014 to July 6, 2014	Certification	$1,023.37
12.	A.B.	Able Healthcare Solutions	July 10, 2014 to Sept. 7, 2014	Certification	$3,739.08

All in violation of Title 18, United States Code, Section 1035.

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

Pursuant to Title 18, United States Code, Section 982(a)(7), the United States of America gives notice to Defendant **ANH DO** that upon conviction, all property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of such offense is subject to forfeiture.

Money Judgment

30. Defendant **ANH DO** is notified that, upon conviction, a money judgment may be imposed equal to the total value of the property subject to forfeiture, which is approximately $12,000,000.

Substitute Assets

31. Defendant **ANH DO** is notified that if any of the forfeitable property, or any portion thereof, as a result of any act or omission of Defendant or his 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 Defendant 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

Scott P. Armstrong
TRIAL ATTORNEY
CRIMINAL DIVISION
FRAUD SECTION
U.S. DEPARTMENT OF JUSTICE