UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

FELONY

INDICTMENT FOR CONSPIRACY TO COMMIT HEALTH CARE FRAUD, HEALTH CARE FRAUD, CONSPIRACY TO RECEIVE ILLEGAL HEALTH CARE KICKBACKS AND BRIBES, RECEIVING ILLEGAL HEALTH CARE KICKBACKS AND BRIBES, AND FORFEITURE ALLEGATION

18-32

UNITED STATES OF AMERICA	*	**CRIMINAL NO.**
VERSUS	*	**SECTION:** SECT. E MAG. 3
MUHAMMAD KALEEM ARSHAD, M.D., PADMINI NAGARAJ, M.D., JOSEPH A. HAYNES	*	**VIOLATIONS: 18 U.S.C. § 1349 18 U.S.C. § 371 18 U.S.C. § 1347 42 U.S.C. § 1320a-7b 18 U.S.C. § 2 18 U.S.C. § 982**
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The Grand Jury charges that:

COUNT 1
Conspiracy to Commit Health Care Fraud

A. AT ALL TIMES RELEVANT 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"). Individuals who received benefits under Medicare where referred to as Medicare "beneficiaries."

2. Medicare was a "health care benefit program" as defined by Title 18, United States Code, Section 24(b). Medicare was also a "Federal health care program" as defined by Title 42, United States Code, Section 1320a-7b(f).

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 were 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 qualified 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 preformed, the date and charge for the services, and the names and identification number of the physician or other health care provider who ordered the services.

Reimbursement 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 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 a need for home health care and established the Plan of Care ("POC"); and

c. the determining physician signed a certification statement specifying
   i. that the beneficiary needed intermittent skilled nursing services, physical therapy, or speech therapy,
   ii. the beneficiary was confined to the home,
   iii. that a POC for furnishing services was established and periodically reviewed, and
   iv. 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 the PPS, Medicare paid HHAs a pre-determined base payment for each medically necessary 60-day "episode of care." Medicare adjusted the base payment according to 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. Health Insurance Prospective Payment System ("HIPPS") rate codes represented specific sets of patient characteristics on which payment determinations were made under the home health PPS.

8. 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.

9. For beneficiaries for whom skilled nursing, occupational and physical therapy, speech pathology, and psychotherapy services were medically necessary, Medicare paid for such

services provided by a HHA. The basic requirement that a physician certify that a beneficiary was confined to the home or was homebound was a continuing requirement for a Medicare beneficiary to receive home health care benefits.

Record Keeping Requirements

10. Medicare Part A regulations required HHAs to maintain complete and accurate medical records reflecting the medical assessment and diagnoses of their Medicare patients and records documenting actual treatment of the patients to whom services were provided and for whom claims for reimbursement were submitted by the HHA. The medical records and documentation were required to be sufficient to permit a Medicare contractor or auditor to review the appropriateness of Medicare payments made to the HHA.

11. 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 series/ 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.

12. Medicare Part A regulations required 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, and treatment and drugs administered, and reactions by the patient, any teaching and the understanding of the patient, and any change 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.

Federal Anti-Kickback Statute Compliance

13. As a requirement to enroll as a Medicare service provider, Medicare required services providers to agree to abide by Medicare laws, regulations, and program instructions. Medicare further required service providers to affirm that they understood that a payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions, including the Federal anti-kickback statute. Accordingly, Medicare would not pay claims procured through kickbacks and bribes.

The Defendants and Related Individuals and Entities

14. Company A owned and operated numerous behavioral healthcare facilities in Louisiana, including two outpatient facilities in the Eastern District of Louisiana (individually, "Outpatient Facility," or collectively, "Outpatient Facilities"). These Outpatient Facilities provided behavioral health services, including psychiatric treatment services, group therapy, and substance rehabilitation to individuals, including Medicare beneficiaries.

15. **MUHAMMAD KALEEM ARSHAD, M.D. ("ARSHAD")**, a resident of New Orleans, Louisiana, was a medical doctor, specializing in geriatric and addiction psychiatry. **ARSHAD** was a resident psychiatrist at an Outpatient Facility and, upon completing a Medicare provider enrollment form, was enrolled as a Medicare provider.

16. **PADMINI NAGARAJ, M.D. ("NAGARAJ")**, a resident of Kenner, Louisiana, was a medical doctor, specializing in forensic psychiatry. **NAGARAJ** was a resident psychiatrist at an Outpatient Facility and, upon completing a Medicare provider enrollment form, was enrolled as a Medicare provider.

17. Joseph A. Haynes ("Haynes"), a resident of New Orleans, Louisiana, was employed by Company A as a marketer, tasked with marketing the Outpatient Facilities' services in the community in order to populate its census with individuals, including Medicare beneficiaries, so that Company A could provide psychiatric and psychosocial care services to those individuals. He also occasionally worked as a driver to transport these patients between their residences and the Outpatient Facilities to receive behavior health services.

18. Progressive Home Health Care, Inc. ("Progressive") was an HHA, based in Eastern District of Louisiana, that provided home health care services to individuals, including Medicare beneficiaries.

19. Milton Diaz ("Diaz"), a resident of Harvey, Louisiana, co-owned and operated Progressive.

20. Kim Ricard ("Ricard"), a resident of New Orleans, Louisiana, was an associate of Haynes, who recruited and referred individuals, including Medicare beneficiaries, to receive home health care services provided by Progressive and other HHAs.

B. THE CONSPIRACY:

21. Beginning in or around September 2010, and continuing through in or around April 2015, in the Eastern District of Louisiana and elsewhere, defendants **MUHAMMAD KALEEM ARSHAD, M.D., PADMINI NAGARAJ, M.D.**, and others known and unknown to the Grand Jury, did knowingly and willfully combine, conspire, confederate, and agree together with each other to commit certain offenses against the United States, that is: to knowingly and willfully 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 material 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 and services, in violation of Title 18, United States Code, Section 1347.

C. PURPOSE OF THE CONSPIRACY:

22. The purpose of the conspiracy was for defendants **ARSHAD, NAGARAJ**, and their co-conspirators to unlawfully enrich themselves and others by, among other things: (a) referring home health care that was not medically necessary for psychiatric patients who were not homebound so that HHAs, including Progressive, could submit false and fraudulent claims to Medicare; (b) receiving kickbacks and bribes to refer such services to HHAs, including Progressive; (c) concealing the receipt of kickbacks and bribes, and the submission of false and fraudulent claims to Medicare; and (d) diverting proceeds of the fraud for the personal use and benefits of the defendants and their co-conspirators.

D. MANNER AND MEANS OF THE CONSPIRACY:

23. The manner and means by which the defendants sought to accomplish the object of the scheme included, among others, the following:

a. **ARSHAD** and **NAGARAJ** treated psychiatric patients at the Outpatient Facilities. As attending physicians, **ARSHAD** and **NAGARAJ** were permitted to refer these patients, including Medicare beneficiaries, to home health agencies, as medically necessary, and could sign certification and recertification forms for that purpose;

b. Haynes, as an employee of Company A and frequently at the Outpatient Facilities, had access to patient information, including Medicare beneficiaries, and interacted with patients, as well as with **ARSHAD** and **NAGARAJ**;

c. In an effort to unlawfully enrich themselves and others through this referral process, **ARSHAD, NAGARAJ,** Haynes, and their co-conspirators, entered into kickback and

bribe arrangements with HHAs, wherein the HHAs would pay kickbacks and bribes to **ARSHAD, NAGARAJ**, and Ricard, in exchange for referring Medicare beneficiaries to the HHAs, so that the HHAs could, in turn, provide medically unnecessary home health care services to these Medicare beneficiaries and ultimately submit claims for reimbursement to Medicare;

d. Haynes, on behalf of **ARSHAD, NAGARAJ**, and Ricard, assisted in negotiating kickback and bribe arrangements with various HHAs, including Progressive, in exchange for **ARSHAD** and **NAGARAJ** referring and certifying Medicare beneficiaries from the Outpatient Facilities to HHAs for home health care services;

e. In an effort to conceal these illegal kickbacks and bribes arrangements, the HHAs, including Progressive, created illegal kickback arrangements disguised as medical directorships for the HHAs, irrespective of whether the HHAs already had "medical directors," and illegally paid **ARSHAD** and **NAGARAJ** monthly kickbacks and bribes disguised as "medical director" fees. For their part, **ARSHAD** and **NAGARAJ** entered into sham contracts with the HHAs wherein **ARSHAD** and **NAGRAJ** agreed to act as "medical directors" of the HHAs and provide certain services, when, in reality, **ARSHAD's** and **NAGARAJ's** primary services to the HHAs was falsely and fraudulently referring, certifying, and recertifying Medicare beneficiaries, who were patients of the Outpatient Facilities, for medically unnecessary home health care services. These purported medical director fees were concealed kickbacks and bribes;

f. For her part in referring Medicare beneficiaries to HHAs, including Progressive, Ricard accepted kickbacks and bribes from the HHAs in the form of "marketing" fees, when in reality, Ricard provided no services to the HHAs other than in referring, and aiding and abetting **ARSHAD**, **NAGARAJ**, and Haynes in referring, and falsely certifying and

recertifying Medicare beneficiaries from the Outpatient Facilities to HHAs for home health care services irrespective of whether the Medicare beneficiaries qualified for home health care services;

g. Despite knowing that certain Medicare beneficiaries did not qualify for home health care services, did not have the functional limitations certified, or were already receiving the same care and services at the Outpatient Facilities, **ARSHAD** and **NAGARAJ**, in exchange for illegal kickbacks and bribes, referred, and falsely certified and recertified Medicare beneficiaries from the Outpatient Facilities to HHAs, including Progressive, for medically unnecessary home health care services, which they knew often duplicated the care and services received at the Outpatient Facilities, knowing that Medicare would reimburse the HHAs for the medically unnecessary home health care services;

h. **ARSHAD** and **NAGARAJ** fraudulently certified and recertified the Medicare beneficiaries regardless of the beneficiaries' needs, homebound status, functional limitations or diagnoses;

i. In an effort to increase the kickbacks and bribes paid to Ricard by the HHAs, including Progressive, Haynes and Ricard threatened the HHAs with transferring the Medicare beneficiaries, to other HHAs to receive home health care services, unless the HHAs agreed to pay increased kickbacks and bribes to Ricard. On at least one occasion, **NAGARAJ** demanded that an HHA discharge the individuals referred to the HHA, and thereafter referred those individuals to another HHA that paid **NAGARAJ** a "medical director" fee; and

j. Despite inducing the referrals of Medicare beneficiaries from **ARSHAD, NAGRAJ,** Haynes, and Ricard with kickbacks and bribes, and upon providing home health care services to the Medicare beneficiaries referred, the HHAs, including Progressive, in turn,

submitted false and fraudulent claims to Medicare seeking reimbursement for the medically unnecessary services purportedly provided.

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

COUNTS 2 THROUGH 6
Health Care Fraud

A. AT ALL TIMES MATERIAL HEREIN:

24. The allegations in Paragraphs 1 through 20 and 23 of Count 1 of this Indictment are realleged and incorporated by reference as if fully set forth herein.

B. HEALTH CARE FRAUD:

25. On or about the dates specified below, in the Eastern District of Louisiana, and elsewhere, the defendants **MUHAMMAD KALEEM ARSHAD, M.D.** and **PADMINI NAGARAJ, M.D.**, while aiding and abetting one another and others known and unknown to the grand jury, did knowingly and willfully execute, and attempt to execute, a scheme or 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 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, that is, the defendants caused the following false and fraudulent claims to be submitted to Medicare, with each submission described approximately below constituting a separate count:

Count	Defendant	Bene-ficiary	Date Certified	Claim Number	Claim Date	Paid Amount	Date Paid
2	NAGARAJ	T.M.	12/07/2012	21304402497207LAR	02/13/2013	$1,456.16	02/28/2013
3	NAGARAJ	K.T.	12/12/2012	21304601837507LAR	02/15/2013	$1,456.16	03/07/2013

Count	Defendant	Bene-ficiary	Date Certified	Claim Number	Claim Date	Paid Amount	Date Paid
4	ARSHAD	H.J.	04/05/2013	213017023 91607LAR	01/17/2013	$2,387.78	02/04/2013
5	ARSHAD	E.G.	04/05/2013	213043019 73507LAR	02/12/2013	$1,791.04	02/26/2013
6	ARSHAD	S.M.	04/05/2013	213060026 52507LAR	03/01/2013	$1,791.04	03/15/2013

Each of the above is a violation of Title 18, United States Code, Sections 1347 and 2.

COUNT 7
Conspiracy to Receive Illegal Health Care Kickbacks

A. AT ALL TIMES MATERIAL HEREIN:

26. The allegations in Paragraphs 1 through 20 and 23 of Count 1 of this Indictment are realleged and incorporated by reference as if fully set forth herein.

B. THE OFFENSE:

27. Beginning in or around July 2008, and continuing through in or about February 2013, in the Eastern District of Louisiana and elsewhere, defendants **MUHAMMAD KALEEM ARSHAD, M.D., PADMINI NAGARAJ, M.D.,** and **JOSEPH A. HAYNES** did knowingly and willfully combine, conspire, confederate and agree with each other, Milton Diaz, Kim Ricard, and others, known and unknown to the Grand Jury, to commit certain offenses against the United States, that is: to knowingly and willfully solicit and receive remuneration, specifically, kickbacks and bribes, directly and indirectly, overtly and covertly, in return for referring individuals for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole or in part by a Federal health care program, that is, Medicare; and for the purchasing, leasing, ordering, and arranging for and recommending the purchasing, leasing, and ordering of any good, item, and service for which payment may be made in whole and in part by

a Federal health care program, that is, Medicare; in violation of Title 42, United States Code, Sections 1320a-7b(b)(1)(A) and 1320a-7b(b)(1)(B).

C. PURPOSE OF THE CONSPIRACY:

28. It was the purpose of the conspiracy for defendants **ARSHAD**, **NAGARAJ**, **HAYNES**, and their co-conspirators to unlawfully enrich themselves and others by soliciting and receiving illegal kickbacks and bribes in exchange for referring Medicare beneficiaries to HHAs for home health care services paid for by Medicare.

D. MANNER AND MEANS OF CONSPIRACY:

29. The manner and means by which the defendants sought to accomplish the object of the scheme included, among others, the following:

a. **ARSHAD** and **NAGARAJ** treated psychiatric patients at the Outpatient Facilities. As attending physicians, **ARSHAD** and **NAGARAJ** were permitted to refer these patients, including Medicare beneficiaries, to home health agencies, as medically necessary, and could sign certification and recertification forms for that purpose;

b. **HAYNES**, as an employee of Company A and frequently at the Outpatient Facilities, had access to patient information, including Medicare beneficiaries, and interacted with patients, as well as with **ARSHAD** and **NAGARAJ**;

c. In an effort to unlawfully enrich themselves and others through this referral process, **ARSHAD**, **NAGARAJ**, **HAYNES**, and their co-conspirators, entered into illegal kickback and bribe arrangements with HHAs, wherein the HHAs paid kickbacks and bribes to **ARSHAD**, **NAGARAJ**, and Ricard, in exchange for referring Medicare beneficiaries to the HHAs, so that the HHAs could, in turn, provide medically unnecessary home health care services to these Medicare beneficiaries and ultimately submit claims for reimbursement to Medicare;

d. **HAYNES**, on behalf of **ARSHAD**, **NAGARAJ**, and Ricard, helped to negotiate and enforce illegal kickback and bribe arrangements with various HHAs, including Progressive, in exchange for **ARSHAD** and **NAGARAJ** referring Medicare beneficiaries from the Outpatient Facilities to HHAs for home health care services;

e. In an effort to conceal these illegal kickbacks and bribes arrangements, Progressive hired **ARSHAD** and **NAGARAJ** as "medical directors" of the HHAs, irrespective of whether the HHAs already had "medical directors," and paid **ARSHAD** and **NAGARAJ** monthly "medical director" fees. For their part, **ARSHAD** and **NAGARAJ** entered into sham contracts with the HHAs wherein **ARSHAD** and **NAGRAJ** agreed to act as "medical directors" of the HHAs and provide certain services, when, in reality, **ARSHAD's** and **NAGARAJ's** primary services to the HHAs was fraudulently certifying and recertifying Medicare beneficiaries, who were patients of the Outpatient Facilities, for medically unnecessary home health care services, and these purported director fees were nothing more than concealed kickbacks and bribes;

f. For her part in referring Medicare beneficiaries to HHAs, including Progressive, Ricard accepted kickbacks and bribes from the HHAs in the form of "marketing" fees, when in reality, Ricard provided no marketing services to the HHAs other than in referring, and aiding and abetting **ARSHAD, NAGARAJ,** and **HAYNES** in referring, certifying and recertifying Medicare beneficiaries from the Outpatient Facilities to HHAs for home health care services irrespective of whether the Medicare beneficiaries qualified for home health care services;

g. Despite knowing that certain Medicare beneficiaries did not qualify for home health care services or were already receiving the same care and services at the Outpatient Facilities, **ARSHAD** and **NAGARAJ**, in exchange for illegal kickbacks and bribes, referred, certified and recertified Medicare beneficiaries from the Outpatient Facilities to HHAs, including

Progressive, for medically unnecessary home health care services, which they knew often duplicated the care and services received at the Outpatient Facilities, knowing that Medicare would reimburse the HHAs for the medically unnecessary home health care services;

h. **ARSHAD** and **NAGARAJ** fraudulently certified and recertified the Medicare beneficiaries for home health services, regardless of the beneficiaries' needs, homebound status, or diagnoses;

i. In an effort to increase the kickbacks and bribes paid to Ricard by the HHAs, including Progressive, **HAYNES** and Ricard threatened the HHAs with transferring the Medicare beneficiaries, to other HHAs to receive home health care services, unless the HHAs agreed to pay increased kickbacks and bribes to Ricard. On at least one occasion, **NAGARAJ** demanded that an HHA discharge the individuals referred to the HHA, and thereafter referred those individuals to another HHA that paid **NAGARAJ** a "medical director" fee; and

j. Despite inducing the referrals of Medicare beneficiaries from **ARSHAD, NAGRAJ, HAYNES**, and Ricard with illegal kickbacks and bribes, and upon providing medically unnecessary home health care services to the Medicare beneficiaries referred, the HHAs, including Progressive, in turn, submitted claims to Medicare seeking reimbursement for the services purportedly provided.

E. OVERT ACTS:

30. In furtherance of the conspiracy, and to accomplish its purposes and objects, at least one of the conspirators committed, or caused to be committed, in the Eastern District of Louisiana, the following overt acts, among others:

a. Diaz paid and caused to be paid check number 23853, in the amount of $1,500 from Progressive, to **NAGARJ**, which **NAGARAJ** negotiated or caused to be negotiated

on or about February 25, 2013, in exchange for **NAGARAJ** referring Medicare beneficiaries for home health care services;

b. On or about March 13, 2013, **HAYNES** contacted patients of Progressive to tell them that they must change home health agencies or risk being kicked out of the Outpatient Facilities and program at Company A;

c. Diaz paid or caused to be paid check number 23943, in the amount of $1,500 from Progressive, to **ARSHAD**, which **ARSHAD** negotiated or caused to be negotiated on or about April 30, 2013, in exchange for **ARSHAD** referring Medicare beneficiaries for home health care services; and

d. Diaz paid or caused to be paid check number 23942, in the amount of $1,500 from Progressive, to **ARSHAD**, which **ARSHAD** negotiated or caused to be negotiated on or about May 1, 2013, in exchange for **ARSHAD** referring Medicare beneficiaries for home health care services.

All in violation of Title 18, United States Code, Section 371.

COUNTS 8 THROUGH 10
Receipt of Illegal Health Care Kickbacks

A. AT ALL TIMES MATERIAL HEREIN:

31. The allegations in Paragraphs 1 through 20 and 23 of Count 1 and Paragraph 28 of Count 7 of this Indictment are realleged and incorporated by reference as if fully set forth herein.

B. RECEIPT OF ILLEGAL HEALTH CARE KICKBACKS:

32. On or about the dates enumerated below, in the Eastern District of Louisiana and elsewhere, defendants **MUHAMMAD KALEEM ARSHAD, M.D.**, **PADMINI NAGARAJ, M.D.**, and **JOSEPH A. HAYNES**, while aiding and abetting each other and others known and unknown to the Grand Jury, did knowingly and willfully solicit and receive remuneration, that is

kickbacks and bribes, directly and indirectly, overtly and covertly, in return for referring an individual to a person for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole and in part under a Federal health care program as defined in Title 42, United States Code, Section 1320a-7b(f), that is, Medicare, as set forth below, with each payment constituting a separate count:

Count	Defendant	Approx. Date of Payment	Payment Amount	Description of Payment
8	**NAGARAJ HAYNES**	02/25/2013	$1,500	Check # 23853 from Progressive (signed by Milton Diaz) to **NAGARAJ**
9	**ARSHAD HAYHNES**	04/30/2013	$1,500	Check # 23943 from Progressive (signed by Milton Diaz) to **ARSHAD**
10	**ARSHAD HAYNES**	05/01/2013	$1,500	Check #23942 from Progressive (signed by Milton Diaz) to **ARSHAD**

All in violation of Title 42, United States Code, Section 1320a-7b(b)(1)(A) and Title 18, United States Code, Section 2.

NOTICE OF HEALTH CARE FRAUD FORFEITURE

33. The allegations contained in Counts 1 through 10 of this Indictment are hereby realleged 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).

34. As a result of the offenses alleged in Counts 1 through 10, defendants upon conviction of any of the offenses set forth above, defendants **MUHAMMAD KALEEM ARSHAD, M.D.**, **PADMINI NAGARAJ, M.D.**, and **JOSEPH A. HAYNES** 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 offenses as a result of the violations of Title 18, United States Code, Sections 371, 1347, and 1349, and Title 42, United States Code, Sections 1320a-7(b)(1); 1320a-

7(b)(2), which are Federal Health Care offenses within the meaning of Title 18, United States Code, Section 24.

35. 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 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, pursuant to 18 U.S.C. 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).

A TRUE BILL:

[redacted]

DUANE A. EVANS
UNITED STATES ATTORNEY

KATHERINE PAYERLE
TRIAL ATTORNEY
CRIMINAL DIVISION, FRAUD SECTION
UNITED STATES DEPARTMENT OF JUSTICE

New Orleans, Louisiana
February 8, 2018

No.

UNITED STATES DISTRICT COURT

Eastern *District of* Louisiana

Criminal *Division*

THE UNITED STATES OF AMERICA

vs.

MUHAMMAD KALEEM ARSHAD, M.D.
PADMINI NAGARAJ, M.D.
JOSEPH A. HAYNES

INDICTMENT

INDICTMENT FOR CONSPIRACY TO COMMIT HEALTH CARE FRAUD, HEALTH CARE FRAUD, CONSPIRACY TO RECEIVE ILLEGAL HEALTH CARE KICKBACKS AND BRIBES, RECEIVING ILLEGAL HEALTH CARE KICKBACKS AND BRIBES, AND FORFEITURE ALLEGATIONS

VIOLATIONS: 18 U.S.C. § 1349, 18 U.S.C. § 371, 18 U.S.C. § 1347, 18 U.S.C. § 1320a-7b, 18 U.S.C. § 2, 18 U.S.C. § 982

A true [redacted]

Foreperson

Filed in open court this _____ *day of* _____ *A.D. 2018.*

Clerk

Bail, $ _____

KATHERINE PAYERLE, U.S. Department of Justice Trial Attorney