

SEALED

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

<p align="center">U.S. DISTRICT COURT NORTHERN DISTRICT OF TEXAS FILED</p> <p align="center">OCT - 2 2012</p> <p align="center">CLERK, U.S. DISTRICT COURT</p> <p>By _____ Deputy </p>
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UNITED STATES OF AMERICA

v.

JOSEPH MEGWA, M.D. (01) §
 FERGUSON IKHILE, R.N. (02) §
 EBOLOSE EGHOBOR, R.N. (03) §
 a.k.a "EBOLOSE FRIDAY EGHOBOR" §
 "FRIDAY EBOLOSE EGHOBOR" §
 "FRED EGHOBOR" §

UNDER SEAL

Criminal No.

8-12CR-312-K

INDICTMENT

The Grand Jury charges:

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

General Allegations

1. The Medicare Program ("Medicare") was a federal healthcare 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 receiving benefits under Medicare were referred to as Medicare "beneficiaries."

2. Medicare was a "health care benefit program," as defined by 18 U.S.C. § 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 healthcare services because of an illness or disability causing them to be homebound. Payments for home healthcare medical services under Medicare Part A 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 beneficiary.

4. CMS did not directly pay Medicare Part A claims submitted by Medicare-certified HHAs. CMS contracted with different companies to administer the Medicare Part A program throughout different parts of the United States. In the State of Texas, CMS contracted with Palmetto GBA (“Palmetto”) to administer Part A HHA claims. As administrator, Palmetto received, adjudicated and paid claims submitted by HHA providers under the Part A program for home healthcare claims.

5. “Part B” of the Medicare program covered physician services and other ancillary services not covered by Part A. Under certain circumstances, Medicare Part B covered the cost of “home visits” for evaluation and management services provided to a beneficiary by a physician or, in some circumstances, a nurse practitioner or physician’s assistant, in a private residence. To reimburse for home visits, Medicare required that the medical record document the medical necessity of making a home visit in lieu of an office or outpatient visit.

6. As with Part A claims, CMS did not pay Medicare Part B claims directly to the Medicare-certified physicians that submitted them. CMS contracted in Texas with Trailblazer Health Enterprises (Trailblazer) to administer Part B claims. As administrator, Trailblazer received, adjudicated and paid claims submitted by physicians under the Part B program for, among other things, home visits.

7. 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.

8. Medicare Part A and Part B regulations required HHAs and physicians 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 providers.

9. These medical records were required to be sufficient to permit Medicare, through Palmetto and Trailblazer, to review the appropriateness of Medicare payments made to providers under the Part A and Part B programs.

10. The Medicare program paid 100% of the allowable charges for participating HHAs providing home healthcare services only if the patient qualified for home healthcare benefits. A patient qualified for home healthcare benefits only if the patient:

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

11. Among the written records required to document the appropriateness of home healthcare claims submitted under Part A of Medicare was a POC that included the physician order for home healthcare, 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 healthcare services, and an assessment of the beneficiary's condition and eligibility for home health services, called an Outcome and Assessment Information Set ("OASIS").

12. Medicare Part A regulations required provider HHAs to maintain medical records of each visit made by a nurse, therapist, and home healthcare 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 healthcare nurse, therapist and aide were 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."

13. Among the written records required to document the appropriateness of home visit services claimed under Part B of Medicare were documentation supporting the medical necessity for the service and verifying that the service was performed on the date billed, by the identified performing provider or incident to that provider, as listed on the date noted on the claim.

The Defendants

14. **Joseph Megwa, M.D.**, a resident of Fresno, California, was a medical doctor licensed by the State of Texas. **Joseph Megwa, M.D.** owned and operated Raphem Medical Practice, P.A. (“Raphem”).

15. Raphem was a Texas corporation located in Arlington, Texas, incorporated in or about 2005. In connection with Raphem, **Joseph Megwa, M.D.** employed a few medical professionals with varying levels of professional expertise.

16. **Joseph Megwa, M.D.** provided home health certifications so that HHAs were able to bill Medicare for home health services that were not medically necessary and not rendered.

17. **Joseph Megwa, M.D.** and, at his direction, Raphem medical professionals, performed unnecessary home visits and ordered unnecessary medical services for the Medicare beneficiaries certified for home health services by **Joseph Megwa, M.D.**

18. From January 1, 2006, through November 30, 2011, **Joseph Megwa, M.D.** certified more than 2,000 unique Medicare beneficiaries for home health services provided by over 230 HHAs. Raphem and the HHAs billed Medicare for approximately \$100,500,000 for these beneficiaries.

19. **Ferguson Ikhile, R.N.** a resident of Irving, Texas, was the owner of PTM Healthcare Services, Inc. (“PTM”). **Ebolose Eghobor, R.N.** was the Director of Nursing for PTM. PTM was a HHA located in Irving, Texas, doing business in and around Dallas

County. Almost twenty-five percent (25%) of PTM's patients were certified for home healthcare services by **Joseph Megwa, M.D.**

20. **Ferguson Ikhile, R.N.**, and others acting at his direction, submitted fraudulent claims to Medicare for home health services that were not medically necessary. From January 1, 2006, through December 31, 2010, PTM submitted claims to Medicare totaling approximately \$4,825,251 for services for Medicare beneficiaries certified by **Joseph Megwa, M.D.**

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

21. Paragraphs 1 through 20 of the General Allegations section of this Indictment are realleged and incorporated by reference as though fully set forth herein.

22. From in or around January 2006, through in or around November 2011, the exact dates being unknown to the Grand Jury, in the Dallas Division of the Northern District of Texas, and elsewhere, the defendants, **Joseph Megwa, M.D., Ferguson Ikhile, R.N., and Ebolose Eghobor, R.N.**, did knowingly and willfully combine, conspire, confederate and agree with others, known and unknown to the Grand Jury, to violate 18 U.S.C. § 1347, that is, to execute a scheme and artifice to defraud a health care benefit program affecting commerce, as defined in 18 U.S.C. § 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

23. It was a purpose of the conspiracy for the defendants to unlawfully enrich themselves by, among other things, (a) submitting and causing the submission of false and fraudulent claims to Medicare for services that were medically unnecessary and not rendered; (b) concealing the submission of false and fraudulent claims to Medicare and

the receipt of and transfer of the proceeds from the fraud; and (c) diverting the proceeds of the fraud for the personal use and benefit of the defendants and their coconspirators.

Manner and Means of the Conspiracy

A. The Scheme to Defraud

24. Coconspirators, known and unknown to the Grand Jury, recruited Medicare beneficiaries to be placed at PTM so that PTM could bill Medicare for unnecessary home health services.

25. **Ferguson Ikhile, R.N. and Ebolose Eghobor, R.N.**, as well as other coconspirators, known and unknown to the Grand Jury, would falsify OASISs to make it appear that the beneficiaries recruited (the “Recruited Beneficiaries”) by coconspirators, also known and unknown to the grand jury, qualified for home health services that were not medically necessary.

26. **Ferguson Ikhile, R.N. and Ebolose Eghobor, R.N.**, as well as other coconspirators, known and unknown to the Grand Jury, prepared POCs that were not medically necessary for the Recruited Beneficiaries.

27. Coconspirators known and unknown to the Grand Jury, would provide these POCs to **Joseph Megwa, M.D.**, who would falsely certify that the Recruited Beneficiaries needed home health care services from PTM.

28. **Ferguson Ikhile, R.N.** and other coconspirators, known and unknown to the Grand Jury, would provide payments to **Joseph Megwa, M.D.** in exchange for falsely certifying that the Recruited Beneficiaries needed home health care services from PTM.

29. **Joseph Megwa, M.D.** would falsely certify that the Recruited Beneficiaries needed home health care services from PTM.

30. **Ferguson Ikhile, R.N. and Ebolose Eghobor, R.N.**, as well as other coconspirators, known and unknown to the Grand Jury, would write visit notes to make it appear that they provided skilled nursing to the Recruited Beneficiaries when no skilled nursing was provided.

31. At the conclusion of the initial 60-day episode of care covered by the POCs, the coconspirators would engage in the same conduct as alleged above so that the Recruited Beneficiaries could receive additional episodes of care.

32. Coconspirators at PTM, known and unknown to the Grand Jury, would submit fraudulent claims to Medicare for unnecessary home health services.

33. **Joseph Megwa, M.D.**, and other coconspirators, known and unknown to the Grand Jury, would perform medically unnecessary home visits and order unnecessary medical services for the Recruited Beneficiaries.

34. Coconspirators at Raphem, known and unknown to the Grand Jury, would submit fraudulent claims to Medicare for certifying and recertifying beneficiaries for unnecessary home health services, for unnecessary home visits, and other unnecessary medical services.

B. Megwa's Fraudulent Business Model

35. **Joseph Megwa, M.D.** received hundreds of POCs and/or requests for physician orders for home health services per day from HHAs. In order to process this volume of paperwork, Megwa signed stacks of documents one after another.

36. Megwa did not review the documents he was signing, let alone the underlying medical charts for the beneficiaries to whom they applied.

37. Employees suggested to Megwa that he review each POC and the underlying medical chart. To that end, an employee attached a medical chart to each POC waiting for Megwa's signature.

38. Megwa told his employees to stop this practice, because he did not want to review the medical charts and signing the POCs with the charts attached made his wrist hurt.

39. With each signature on a POC, **Joseph Megwa, M.D.** certified that the beneficiary was under his care and that the beneficiary was homebound and in need of skilled nursing services. Often **Joseph Megwa, M.D.** made this certification when he had never seen the beneficiary.

40. By processing the paperwork in this manner, **Joseph Megwa, M.D.** was able to bill Medicare for certifying and recertifying beneficiaries for unnecessary home health services, for unnecessary home visits, and other unnecessary medical services.

41. When **Joseph Megwa, M.D.** completed a POC for a beneficiary, that beneficiary became a Raphem patient. Once a beneficiary became a Raphem patient,

Joseph Megwa, M.D. and Raphem medical professionals acting under his direction would make home visits to that beneficiary, provide unnecessary medical services and order unnecessary durable medical equipment for that beneficiary. Raphem would then bill Medicare for those visits and services.

42. The funds paid by Medicare to Raphem for those home visits and medical services were paid into accounts controlled by **Joseph Megwa, M.D.**

43. In total, between January 1, 2006, and November 30, 2011, **Joseph Megwa, M.D.** approved approximately 33,000 POCs for more than 2,000 unique Medicare beneficiaries from more than 230 different HHAs. Many of these Medicare beneficiaries had primary care physicians who never certified home healthcare services for them.

44. By virtue of this fraudulent business model, **Joseph Megwa, M.D.**, through Raphem, was able to bill approximately \$10 million to Medicare for unnecessary home visits and unnecessary medical services from January 1, 2006, through November 30, 2011.

All in violation of 18 U.S.C. § 1349.

Counts 2-4
Healthcare Fraud
(Violation of 18 U.S.C. §§ 1347 and 2)

45. Paragraphs 1 through 20 Indictment are realleged and incorporated by reference as though fully set forth herein.

46. On or about the dates specified below, in the Dallas Division of the Northern District of Texas, and elsewhere, the defendants, **Joseph Megwa, M.D., Ferguson Ikhile, R.N., and Ebolose Eghobor, R.N.**, in connection with the delivery and payment for health care benefits, items, and services, did knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud Medicare, a health care benefit program affecting commerce, as defined by 18 U.S.C. § 24(b), 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, that is, the defendants submitted and aided and abetted in submitting false and fraudulent claims to Medicare, seeking reimbursement for the cost of various unnecessary home health services.

Count	Medicare Beneficiary	Approximate Dates	Conduct	Amount Submitted to Medicare
2	J.R.	June 1, 2010 to July 31, 2010	Home health certification for 60-day episode of care	\$2,574.12
3	J.T.	March 24, 2010 to May 22, 2010	Home health certification for 60-day episode of care	\$2,634.12

Count	Medicare Beneficiary	Approximate Dates	Conduct	Amount Submitted to Medicare
4	H.D.	September 8, 2010 to November 6, 2010	Home health certification for 60-day episode of care	\$1,134.12

All in violation of 18 U.S.C. §§ 1347 and 2.

Counts 5-8
False Statements Relating to Healthcare Matters
(18 U.S.C. § 1035)

47. Paragraphs 1 through 20 of the General Allegations section of this Indictment are realleged and incorporated by reference as though fully set forth herein.

48. On or about the dates enumerated below, in the Dallas Division of the Northern District of Texas, and elsewhere, the defendant, **Joseph Megwa, M.D.**, did knowingly and willfully conceal material facts by scheme, and made materially false, fictitious, and fraudulent statements and representations, in claims submissions for services purportedly rendered to the beneficiaries set forth below, in connection with the delivery of and payment for health care benefits under Medicare, to wit, that those services were rendered by him in the beneficiary's home when he was in fact outside the United States:

Count	Medicare Beneficiary	Date of Service	Amount Submitted to Medicare
5	A.H.	December 5, 2009	\$275
6	E.D.	June 13, 2010	\$275
7	W.H.	June 15, 2010	\$275
8	W.J.	July 1, 2011	\$295

Each in violation of 18 U.S.C. § 1035.

Criminal Forfeiture
(18 U.S.C. § 982)

49. The allegations contained in paragraphs 1 through 20 of this Indictment are realleged and incorporated by reference as though fully set forth herein for the purpose of alleging forfeiture to the United States of America of certain property in which the defendant has an interest.

50. Upon conviction of any federal healthcare offense, the defendants, **Joseph Megwa, M.D., Ferguson Ikhile, R.N., and Ebolose Eghobor, R.N.** shall forfeit to the United States property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense, pursuant to 18 U.S.C. § 982(a)(7).

51. The property which is subject to forfeiture includes but is not limited to a money judgment in the amount of approximately \$6,998,390, which represents the approximate gross proceeds of the fraud.

52. Pursuant to 21 U.S.C. § 853(p), as incorporated by reference by 18 U.S.C. § 982(b), if any of the forfeitable property, or any portion thereof, as a result of any act or omission of the defendant:

- 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 subdivided without difficulty;

53. It is the intent of the United States to seek the forfeiture of other property of the defendant up to the value of the above-described forfeitable properties, including, but not limited to, any identifiable property in the name of **Joseph Megwa, M.D., Ferguson Ikhile, R.N., or Ebolose Eghobor, R.N.**

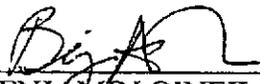
All pursuant to 18 U.S.C. § 982(a)(7), and the procedures set forth at 21 U.S.C. § 853, as made applicable through 18 U.S.C § 982(b)(1).

A TRUE BILL

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