

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

FELONY

**FIRST SUPERSEDING INDICTMENT FOR CONSPIRACY TO COMMIT HEALTH
CARE FRAUD, CONSPIRACY TO DEFRAUD THE UNITED STATES AND TO
RECEIVE AND PAY HEALTH CARE KICKBACKS, HEALTH CARE FRAUD,
OBSTRUCTION OF A FEDERAL AUDIT, AND FORFEITURE**

UNITED STATES OF AMERICA

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CRIMINAL NO. 15-61

VERSUS

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SECTION: "E"

HENRY EVANS, M.D.

*

VIOLETIONS:

MICHAEL JONES, M.D.

18 U.S.C. § 1349

SHELTON BARNES, M.D.

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18 U.S.C. § 371

GREGORY MOLDEN, M.D.

18 U.S.C. § 1347

PAULA JONES

*

18 U.S.C. § 1516

JONATHON NORA

18 U.S.C. § 2

SUPRENIA WASHINGTON

*

ERICA EDWARDS

ZELLISHA DEJEAN

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CAREN BATTAGLIA

SHEILA HOPKINS

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JEFF KOON

LARRY TAYLOR

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VERINESE SUTTON

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The Grand Jury charges that:

COUNT 1 - Conspiracy to Commit Health Care Fraud

A. AT ALL TIMES HEREIN:

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 through its agency, the Centers for Medicare & Medicaid Services. Individuals who received 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 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 Part A home health care medical services were typically made directly to an HHA provider based on claims submitted to the Medicare program for qualifying services that had been 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 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 with a Medicare provider number could file claims with Medicare to obtain reimbursement for services it provided to beneficiaries. A Medicare claim was required to set forth, among other things, the beneficiary’s name and Medicare number, the services performed, 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 and a physician certified or recertified the patient's need for home health services. As of April 1, 2011, for an initial certification for home health services, a physician was required to document a face-to-face patient encounter related to the primary reason the patient required home health services. The face-to-face encounter had to be personally performed by the certifying physician or a qualified non-physician practitioner (NPP) working in collaboration with the certifying physician. If the certifying physician did not personally perform the face-to-face encounter, the NPP or other physician who cared for the patient in an acute or post-acute facility was required to communicate the clinical findings of the face-to-face patient encounter to the certifying physician. Then, the certifying physician was required to explain on the home health certification form that the condition for which the patient was being treated in the face-to-face patient encounter was related to the primary reason the patient required home health services and why the clinical findings of the encounter supported that the patient was homebound.

7. In order for a physician to recertify a patient for home health services for an underlying condition or complication requiring the services of an RN, the certifying physician was required to include a brief narrative describing the clinical justification for continued services.

8. If a physician had a financial relationship with the home health agency, the physician could not certify or recertify the need for home health services provided by that home health agency, establish or review a plan of care for such services, or conduct the face-to-face encounter required for home health services unless the financial relationship fell within an exception provided by law. Also, a NPP who had a financial relationship with the home health agency could not perform the face-to-face encounter required for home health services unless the financial relationship fell within an exception provided by law.

9. 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 that 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.

10. HHAs were reimbursed under the Home Health Prospective Payment System ("PPS"). Under 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. 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.

11. The ICD-9 was an acronym for "International Statistical Classification of Diseases and Related Health Problems 9th Revision." The ICD-9 is a publication from the World Health Organization comprising a set of codes that are used worldwide to classify diseases and injuries. Medical facilities and providers use ICD-9 codes any time they receive patients. When physicians make their diagnoses, medical coders and billers assign the appropriate ICD-9 diagnosis code. The ICD-9 code is used with the Current Procedural Terminology (CPT) code, which is for procedures performed in medical facilities. These codes are used to generate bills for provider reimbursement in cases where patients have health insurance.

12. The Case-Mix Group was a list of ICD-9 diagnosis codes reflecting utilization patterns among various provider types. Under the home health PPS, a Case-Mix diagnosis on a POC increased the payment the HHA received from Medicare.

13. Clinical assessment data was the basic input used to determine which Case-Mix Group applied to a particular patient. The data was gathered in an Outcome and Assessment Information Set (OASIS), an assessment tool used to measure and detail the patient's condition. The OASIS form was completed by a Registered Nurse affiliated with a HHA at the beginning of an episode of home health. The OASIS scoring generates a Home Health Resource Group (HRRG) score which is translated to a HIPPS code to be filed on the claim.

14. The first six ICD-9 diagnosis codes input into the OASIS are weighted into the HIPPS score that determines the amount of reimbursement an agency receives. Some diagnosis codes fall into the 153 Case-Mix adjustments. Case-Mix diagnoses are weighted more heavily in the scoring and result in a higher HIPPS code. A higher HIPPS code results in a higher reimbursement for the agency. The HIPPS code was entered on the claim made by the HHA to Medicare.

15. 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.

16. For beneficiaries for whom skilled nursing was medically necessary, Medicare paid for such skilled nursing 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

17. 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 receiving services 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.

18. Medicare required the following written records to document the appropriateness of Medicare home health care claims:

a. A POC that included

- the physician order for home health care
- medical 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

b. a signed certification statement by an attending physician certifying that the patient was homebound and need the planned home health services, and

c. An OASIS assessment.

19. 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,

any treatment and drugs administered, any 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.

Medicare Part B Physician Services for Home Health

20. The Healthcare Common Procedure Coding System (HCPCS) was established to provide a standardized coding system for describing the specific items and services provided in the delivery of health care. Such coding was necessary for Medicare and other health insurance programs to ensure that insurance claims were processed in an orderly and consistent manner.

21. Medicare established a usual, customary and reasonable fee for each service rendered, as described by its corresponding HCPCS code. Codes were based upon the complexity of the service, the severity of the illness or injury and the average amount of time generally required to perform the service, and the fees paid were commensurate with the amount of work required.

22. HCPCS G0180 and G0179 were codes for physician certification and recertifications, respectively, for Medicare-covered home health services that included contacts with the home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the POC that meets a patient's needs, per the certification or recertification period.

23. HCPCS G0181 was physician supervision of a patient receiving Medicare-covered services provided by a home health agency that required complex and multidisciplinary care modalities involving regular physician development and/or revision of POCs, review of subsequent reports of patient status, review of laboratory and other studies, communication,

including telephone calls with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, lasting 30 or more minutes.

24. Abide Home Care Services, Inc. (Abide), was a Medicare provider eligible to receive reimbursement from Medicare for services that Abide claimed to have provided to eligible beneficiaries, assuming that such services were medically necessary and had been properly ordered by a physician. Abide was in the business of providing home health care to Medicare beneficiaries and beneficiaries of other health care benefit plans. Lisa Crinel (Crinel) owned, operated, and managed Abide.

The Defendants

25. **SHELTON BARNES (BARNES), HENRY EVANS (EVANS), MICHAEL JONES, and GREGORY MOLDEN (MOLDEN)** (collectively referred to as "**THE DOCTORS**") were medical doctors licensed by the State of Louisiana who operated medical practices in New Orleans, Louisiana. **BARNES** employed a Registered Nurse Practitioner, also known as a non-physician practitioner (NPP), licensed by the State of Louisiana who operated under his supervision in his practice. **BARNES, EVANS, MICHAEL JONES, and MOLDEN** each applied for and were assigned Provider Numbers by Medicare that enabled them to file Part B claims for services they claimed they rendered to Medicare beneficiaries.

26. **PAULA JONES** was a biller for Abide and was married to **MICHAEL JONES**.

27. **JONATHAN NORA (NORA)** was an office manager at Abide.

28. **SUPRENIA WASHINGTON (WASHINGTON), ERICA EDWARDS (EDWARDS), ZELLISHA DEJEAN (DEJEAN), SHEILA HOPKINS (HOPKINS), and JEFF KOON (KOON)** were Registered Nurses (RNs) at Abide. **DEJEAN** also, at times, held the position of Director of Nursing.

29. **CAREN BATTAGLIA (BATTAGLIA)** was a Licensed Practical Nurses (LPN) at Abide.

B. CONSPIRACY TO COMMIT HEALTH CARE FRAUD:

30. Beginning in or about November 1, 2008, and continuing until about May 2015, in the Eastern District of Louisiana and elsewhere, defendants **HENRY EVANS, MICHAEL JONES, PAULA JONES, SHELTON BARNES, GREGORY MOLDEN, JONATHAN NORA, CAREN BATTAGLIA, SUPRENIA WASHINGTON, ERICA EDWARDS, ZELLISHA DEJEAN, SHEILA HOPKINS, and JEFF KOON** (collectively referred to as **"THE DEFENDANTS"** in this Count) and others known and unknown to the Grand Jury, willfully and knowingly did combine, conspire, confederate and agree together and with each other to knowingly and willfully execute and attempt to execute a scheme and 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 to obtain by means of materially 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:

31. The purpose of the conspiracy was for **THE DEFENDANTS** to cause the fraudulent certifications and recertifications of medically unnecessary home health services for ineligible Medicare beneficiaries, the production of fraudulent documentation to support medically unnecessary home health services, and the submission and concealment of false and fraudulent claims to Medicare. The purpose of the conspiracy for **THE DOCTORS** was also to bill Medicare Part B for performing care plan oversight for patients for whom they fraudulently certified and recertified for medically unnecessary home health services.

D. MANNER AND MEANS OF THE CONSPIRACY:

32. Abide hired "House Doctors" to sign POCs for Medicare beneficiaries who had no legitimate medical necessity for home health services. The House Doctors, including **BARNES, EVANS, MICHAEL JONES**, and **MOLDEN**, and other physicians known and unknown to the Grand Jury, falsely signed POCs regardless of the beneficiaries' needs, homebound status, or diagnoses. In return, **BARNES, EVANS**, and **MOLDEN** received monthly payments falsely characterized as medical consultant or director fees for which they provided no services to Abide other than fraudulently certifying Medicare beneficiaries for unnecessary home health services.

33. Instead of receiving monthly payments from Abide like the other House Doctors, **MICHAEL JONES** required Abide to almost double the salary of his wife, **PAULA JONES**, and to pay the salary of Larry Taylor, **MICHAEL JONES'** driver/patient recruiter. The inflated salary payments to **PAULA JONES** and the driver/patient recruiter represented **MICHAEL JONES'** kickbacks for fraudulently certifying POCs for Medicare beneficiaries.

34. Abide recruiters contacted **NORA** to confirm that the person fraudulently referred for home health was a Medicare beneficiary. Once **NORA** determined the referred individual was a Medicare beneficiary, **NORA** scheduled a physician visit irrespective of medical necessity or homebound status, usually with an Abide House Doctor, well knowing that the individual referral to Abide was by a marketer instead of the beneficiary's own health care professional.

35. Because **THE DOCTORS** routinely and fraudulently certified and recertified ineligible Medicare beneficiaries for home health, indicted and unindicted co-conspirator employees of Abide were instructed to begin home health services for Medicare beneficiaries regardless of whether a physician certification, order, or face-to-face evaluation had been obtained.

36. RNs, including but not limited to, **EDWARDS, WASHINGTON, DEJEAN, HOPKINS,** and **KOON** were assigned to go to the homes of Medicare beneficiaries to complete the OASIS assessments that determined the necessary level of care required for the beneficiary and the reimbursement rate for the claims made by Abide. When **EDWARDS, WASHINGTON, DEJEAN, HOPKINS,** and **KOON** completed these OASIS assessments, they routinely and fraudulently included a group of diagnoses that were unrelated to the needs of the beneficiaries and included items suggesting the need for assistance with different activities of daily living in order to falsely inflate the reimbursement rates paid by Medicare to Abide. **EDWARDS, WASHINGTON, HOPKINS, KOON,** and **DEJEAN** also fraudulently included other items in the OASIS assessment to falsely document the beneficiary's homebound status.

37. After OASIS assessments were completed, Case Managers at Abide generated POCs reflecting falsely created assessments. Abide gave the POCs to **THE DOCTORS** to falsely certify/recertify medically unnecessary episodes of home health. LPNs, including **BATTAGLIA**, were assigned to beneficiaries. Skilled nursing visits by the LPNs were usually made at least once per week and **BATTAGLIA** routinely falsified documentation of visits to support the ongoing fraudulent billing of unnecessary home health services by **PAULA JONES** and another biller on behalf of Abide.

38. From about January 1, 2009, through on or about October 1, 2014, Abide fraudulently billed Medicare approximately \$22,578,454.75 for home health services Abide falsely claimed to have provided to eligible Medicare beneficiaries, and Medicare paid Abide approximately \$30,052,264.82.

39. From about January 1, 2009, through on or about October, 2012, **BARNES** submitted fraudulent claims to Medicare Part B for care plan oversight as follows:

HCPCS Code	Amount Billed	Amount Paid
G0180	\$13,150	\$7,791
G0181	\$284,802	\$154,993
Totals	\$297,952	\$162,784

40. From about January 1, 2009, through on or about June 20, 2014, **EVANS** submitted fraudulent claims to Medicare Part B for care plan oversight as follows:

HCPCS Code	Amount Billed	Amount Paid
G0179	\$49,950	\$18,932.69
G0180	\$12,400	\$4,904.80
G0181	\$5,400	\$2,871
Totals	\$67,750.00	\$26,708.49

41. From about January 2013, through on or about April 2014, **MICHAEL JONES** submitted fraudulent claims to Medicare Part B for care plan oversight as follows:

HCPCS Code	Amount Billed	Amount Paid
G0179	\$75	\$32.01
G0180	\$840	\$262.90
G0181	\$9,720	\$2,362.65
Totals	\$10,635	\$2,657.56

42. From about January 1, 2009, through on or about November 27, 2013, **MOLDEN** submitted fraudulent claims to Medicare Part B for care plan oversight as follows:

HCPCS Code	Amount Billed	Amount Paid
G0179	\$3,459.84	\$2,767.68
G0180	\$2,083.90	\$1,111.24
G0181	\$8,806.50	\$4,612.85
Totals	\$14,350.24	\$8,491.77

43. In about November 2009, an audit by a Medicare contractor required that **BARNES** provide additional documentation supporting his billing of approximately 96 claims of HCPCS G0181 to Medicare Part B. After **BARNES** provided the documentation Medicare required for only 5 of the 96 claims, which claims were approved by Medicare, **BARNES** was placed on 100% pre-payment review because of his failure to provide the requested

documentation of the remaining 91 claims. Thereafter, Medicare's contractor notified **BARNES** that he would be receiving Additional Documentation Requests (ADRs) for G0181 claims and, between about January 26, 2011 and April 27, 2011, **BARNES** was sent approximately 259 ADR requests. In response to the ADR requests, well knowing that he had no such documentation in his possession as required by Medicare, **BARNES** tasked his NPP and other employees to respond to the audit requests knowing that falsified documentation would be created to fraudulently reflect that he had rendered claims he caused to be filed under HCPCS G0181. **BARNES** caused the falsified documentation to be submitted and, on April 25, 2011, the Medicare contractor informed **BARNES** that the documentation he provided supported his G0181 billing and that he was no longer on pre-payment review. **BARNES** was, however, instructed by the auditor to continue to respond to ADR requests which he well knew were being falsely created and fraudulently submitted by his employees on his behalf to Medicare's auditor.

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

COUNT 2 - Conspiracy to Pay and Receive Illegal Health Care Kickbacks

A. AT ALL TIMES MATERIAL HEREIN:

44. The allegations in Paragraphs 1 – 29, 32, and 33 of Count 1 of this Superseding Indictment are realleged and incorporated by reference as though fully set forth herein.

45. **VERINESE SUTTON (SUTTON)** operated two unlicensed group homes that served as residences to several Medicare beneficiaries with psychiatric diagnoses.

46. **LARRY TAYLOR (TAYLOR)** was a driver and patient recruiter in the New Orleans area who transported patients on behalf of **MICHAEL JONES**.

B. THE OFFENSE:

47. From in or around November 1, 2008, and continuing through March, 2014, in the Eastern District of Louisiana, and elsewhere, defendants **SHELTON BARNES, HENRY**

EVANS, MICHAEL JONES, GREGORY MOLDEN, PAULA JONES, JONATHAN NORA, LARRY TAYLOR, VERINESE SUTTON, and others known and unknown to the Grand Jury did knowingly and willfully combine, conspire, confederate and agree with each other to commit certain offenses against the United States, that is:

a. to knowingly and willfully solicit and receive remuneration, specifically, kickbacks and bribes, directly and indirectly, to 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 Medicare; and for 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, Section 1320a-7b(b)(1); and

b. to knowingly and willfully offer and pay 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 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 or in part by a Federal health care program, that is, Medicare; in violation of Title 42, United States Code, Section 1320a-7b(b)(2).

C. PURPOSE OF THE CONSPIRACY:

48. The purpose of the conspiracy was for **BARNES, EVANS, MICHAEL JONES, MOLDEN, PAULA JONES, TAYLOR, NORA, SUTTON,** and their co-conspirators to unlawfully enrich themselves by paying and receiving illegal kickbacks and bribes, in the form of monthly payments disguised as compensation for services performed as a Medical Director

or Consultant, and salary payments paid to **PAULA JONES** and **LARRY TAYLOR** by Abide as instructed and required by **MICHAEL JONES**, in exchange for providing false, fraudulent, and medically unsupported documentation used by Abide to submit fraudulent claims to Medicare.

D. MANNER AND MEANS OF THE CONSPIRACY:

49. **BARNES, EVANS, MICHAEL JONES, MOLDEN, PAULA JONES, NORA, TAYLOR, SUTTON**, and other co-conspirators sought to accomplish the object and purpose of the conspiracy including, among other things, the following:

50. Abide maintained the following corporate bank accounts: (1) Capital One Account XXXXXX7903 (7903) (CapOnexxx7903), and (2) State Bank and Trust Account XXXX1057 (StateBankxxx1057). From April 21, 2008, until August 27, 2013, CapOnexxx7903 was the account into which claim reimbursement payments to Abide from Medicare were deposited. From September 6, 2013, until January 31, 2014, StateBankxxx1057 was the account into which claim reimbursement payments to Abide from Medicare were deposited.

51. Abide referred Medicare beneficiaries to **BARNES, EVANS, MICHAEL JONES**, and **MOLDEN** so that they would falsely and fraudulently certify and recertify the beneficiaries for home health services purportedly to be provided by Abide. **BARNES, EVANS, MICHAEL JONES**, and **MOLDEN** fraudulently signed home health POC's for ineligible beneficiaries so that Abide could falsely bill Medicare for home health services that were medically unnecessary. In return, Abide fraudulently paid and caused payments to be made to **BARNES, EVANS, MOLDEN**, and **MICHAEL JONES**, disguised as payments to **PAULA JONES** and **TAYLOR**, his wife and driver/patient recruiter, respectively, in exchange for

Physician's Orders, medical assessments, and home and office visits purportedly conducted by these physicians and the NPP associated with **BARNES**.

52. In addition to physicians, Abide paid RNs, LPNs, Aides, recruiters, and marketers between about \$150 and \$500 for each referral of a Medicare beneficiary who Abide fraudulently qualified for home health services. **PAULA JONES** and another biller fraudulently submitted billing to Medicare on behalf of Abide for the medically unnecessary home health services.

53. **NORA** and others at Abide checked eligibility for **SUTTON'S** referrals to home health and arranged for **SUTTON** to be paid for each individual Medicare beneficiary or resident she referred to Abide. **NORA** also instructed **SUTTON** which House Doctor she should contact so that **SUTTON** could make an appointment for the Medicare beneficiary to be certified for home health to be provided by Abide.

E. OVERT ACTS:

54. In furtherance of the conspiracy, and to accomplish its object and purpose, the conspirators committed and caused to be committed, in the Eastern District of Louisiana, and elsewhere, the following overt acts:

55. On about each of the following dates, Abide paid and caused to be paid, \$2,000 to **EVANS** for the referral of Medicare beneficiaries and for fraudulently signing Physician Orders and falsified 485/POC certifications and recertifications for Medicare beneficiaries, in whose names Abide submitted fraudulent claims to Medicare:
- a. December 29, 2011;
 - b. January 26, 2012;
 - c. February 23, 2012;
 - d. March 30, 2012;
 - e. December 31, 2012; and
 - f. January 31, 2013.

56. Between February 2011 and February 2014, Abide paid **EVANS** approximately \$56,000 even though **EVANS** provided no services other than referring patients to Abide.
57. On about each of the following dates, Abide paid and caused to be paid, \$3,500 to **BARNES** for the referral of Medicare beneficiaries and for fraudulently signing Physician Orders and falsified 485/POC certifications and recertifications for Medicare beneficiaries, in whose names Abide submitted fraudulent claims to Medicare:
- a. October 20, 2011;
 - b. November 17, 2011;
 - c. December 29, 2011;
 - d. January 26, 2012;
 - e. February 23, 2012;
 - f. March 30, 2012;
 - g. April 30, 2012;
 - h. May 31, 2012; and
 - i. June 30, 2012.
58. Abide paid **BARNES** approximately \$42,500, in 2011, and approximately \$38,500 in 2012, pursuant to annual Medical Director agreements even though the contracts explicitly restricted **BARNES'** payment to \$25,000 annually.
59. Between about April 2008 and March 2014, Abide paid **BARNES** approximately \$209,000 even though **BARNES** provided no services other than referring patients to Abide.
60. On about each of the following dates, Abide paid and caused to be paid, \$5,000 to **MOLDEN** for the referral of Medicare beneficiaries and for fraudulently signing physician orders and falsified 485/POC certifications and recertifications for Medicare beneficiaries, in whose name Abide submitted fraudulent claims to Medicare:
- a. July 11, 2011;
 - b. August 11, 2011;
 - c. September 1, 2011;
 - d. September 29, 2011; and
 - e. December 8, 2011.
61. Between about July 11, 2011 and November 6, 2012, Abide paid **MOLDEN** approximately \$42,500 even though **MOLDEN** provided no services other than referring patients to Abide.
62. On about May 29, 2013, **MICHAEL JONES** required Abide to raise **PAULA JONES'** salary to reflect a net increase of \$3,500 per month. In

return, **MICHAEL JONES** agreed to refer Medicare beneficiaries to Abide for home health and to sign Physician Orders and 485 certifications/recertifications for Medicare beneficiaries in whose names Abide submitted fraudulent claims to Medicare.

63. Between May 31, 2013, and March 25, 2014, Abide paid **PAULA JONES** bimonthly checks the amounts of between about \$3,274 and \$3,304. Approximately \$35,000 of those payments were compensation to **MICHAEL JONES** for patient referrals he made to Abide disguised as a raise in **PAULA JONES'** salary.
64. In about August 2013, **MICHAEL JONES** instructed the owner of Abide to begin paying a salary to **TAYLOR**. In return, **MICHAEL JONES** agreed to refer patients to Abide for home health services. On about August 9, 2013, Abide began paying **TAYLOR** a salary and, in return, **MICHAEL JONES** fraudulently referred Medicare beneficiaries to Abide and fraudulently signed Physician Orders and falsified 485 certifications/recertifications for Medicare beneficiaries in whose names Abide submitted fraudulent claims to Medicare.
65. Between about August 9, 2013 and January 15, 2014, Abide paid **TAYLOR** a total salary of about \$12,150.06, all of which represented kickbacks to **MICHAEL JONES** for falsified 485 certifications/recertifications and physician orders. While Abide was paying the salary on behalf of **MICHAEL JONES**, **TAYLOR** performed no tasks on behalf of Abide.
66. On about April 30, 2013, Abide paid and caused to be paid, check number 35853 in the amount of \$400 from Abide's Capital One Account No. 7903 to **SUTTON** in exchange for her referral to Abide of a Medicare beneficiary for home health services.
67. On about January 23, 2014, after **SUTTON** took Medicare beneficiary EvLa into her group home, she called **NORA** to check EvLa's Medicare eligibility. After **NORA** confirmed EvLa's eligibility, **NORA** instructed **SUTTON** to send EvLa to **MICHAEL JONES** to have her certified for Abide home health. **SUTTON** arranged a visit with **MICHAEL JONES** for EvLa and **TAYLOR** picked up EvLa from **SUTTON'S** group home and transported her to **MICHAEL JONES'** medical offices.
68. On about March 17, 2014, Abide paid and caused to be paid, check number 50510 in the amount of \$600 from Abide's State Bank Account No. 1057 to **SUTTON** in exchange for her referral of EvLa and SaHa, another group home resident, to Abide for home health services.

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

COUNTS 3 THROUGH 30 - Health Care Fraud

A. AT ALL TIMES MATERIAL HEREIN:

69. The allegations in Paragraphs 1 through 29 of Count 1 of this Superseding Indictment are realleged and incorporated by reference as though fully set forth herein.

B. HEALTH CARE FRAUD:

70. Beginning on or about January 1, 2009, and continuing through on or about October 1, 2014, in the Eastern District of Louisiana and elsewhere, the defendants, **HENRY EVANS, SHELTON BARNES, MICHAEL JONES, GREGORY MOLDEN, JONATHAN NORA, ERICA EDWARDS, ZELLISHA DEJEAN, SUPRENIA WASHINGTON, CAREN BATTAGLIA, SHEILA HOPKINS, JEFF KOON** and others known and unknown to the Grand Jury, did knowingly and willfully execute and attempt to execute a scheme and artifice to defraud Medicare and to obtain, by means of false and fraudulent pretenses, representations, and promises, money owned by, and under the custody and control of, the Medicare program.

71. It was part of the scheme and artifice to defraud that when information on a Medicare beneficiary was brought to Abide by a recruiter, an Abide office employee assigned a House Doctor affiliated with Abide or an NPP employed by Abide to see the beneficiary. If the beneficiary was new to Abide, a Client Profile/Referral containing the beneficiary's contact information was sent to the House Doctor or NPP. If a beneficiary had a primary care physician who would not recertify home health, the House Doctor or NPP was instructed to see the beneficiary to ensure a recertification would be done. If the beneficiary was already receiving home health from Abide, a Form 485 was often provided to the House Doctor or NPP from an earlier home health episode so that the House Doctor or NPP would have the beneficiary's contact information and medical demographics. Office staff assigned beneficiaries to Abide House Doctors and NPPs well knowing that Abide paid referral fees to marketers and recruiters

in return for providing Medicare beneficiaries and that the home health referrals did not originate with a medical necessity for home health services for the referred beneficiaries.

72. It was further part of the scheme and artifice to defraud that, in addition to certifying Abide patients for medically unnecessary home health services, **THE DOCTORS** assigned Case Mix diagnoses to patients on the 485s that were medically unsupported and fraudulently inflated Medicare's reimbursement to Abide.

73. It was further part of the scheme and artifice to defraud that **BARNES** purported to use his NPP to perform Medicare required face-to-face encounters in order for **BARNES** to certify Medicare beneficiaries to home health. **BARNES** then used the face-to-face encounter to certify home health services well knowing that his NPP was also employed by Abide and that face-to-face encounters performed by the NPP, who had a financial relationship with Abide, could not be used to support a home health certification and that any subsequent home health episodes would be disqualified and non-reimbursable.

74. It was further part of the scheme and artifice to defraud that Abide nurses, including **WASHINGTON, EDWARDS, and KOON**, fraudulently recertified patients for home health by recording false changes in medications and exacerbations of medical conditions that did not occur and did not require skilled nursing, but which would justify recertification if the changes had been legitimate. The nurses also falsely documented that beneficiaries were homebound when they well knew that the patients were not homebound.

Patient JoBi

75. It was further part of the scheme and artifice to defraud that JoBi, a group home resident, was a Medicare beneficiary with mental health diagnoses who received treatment at a psychiatric partial hospitalization day program. Abide fraudulently billed for providing eleven

episodes of home health for JoBi based upon falsely created OASIS assessments prepared by **HOPKINS**.

76. It was further part of the scheme and artifice to defraud that **HOPKINS** falsely and fraudulently documented performing skilled nursing visits on behalf of Abide for JoBi during the periods JoBi was certified for home health with Abide.

77. It was further part of the scheme and artifice to defraud that, after the execution of federal search warrants on Abide on March 25, 2014, Abide abruptly discharged JoBi to home/self-care on about April 8, 2014, despite JoBi having been certified for home health for eleven episodes at Abide between approximately April 10, 2012 and March 21, 2014, and even though the last skilled visit indicated minimal progress toward JoBi's goals. Neither Abide, nor a House Doctor, nor **HOPKINS** provided JoBi or his group home caregiver with any discharge instructions or documentation.

78. It was further part of the scheme to defraud that Abide fraudulently billed Medicare \$10,375.05 and was paid \$9,834.27 for seven episodes of home health for JoBi based upon falsified OASIS assessments performed by **HOPKINS**, POCs fraudulently certified by a House Doctor, and purported skilled nursing visits **HOPKINS** falsely claimed she performed, when Abide well knew and should have known that the services billed were medically unnecessary and for a patient who was not homebound.

Patient GePr

79. It was further part of the scheme and artifice to defraud that GePr, a group home resident, was a Medicare beneficiary with mental health diagnoses who received treatment at a psychiatric partial hospitalization day program. Abide fraudulently billed for providing twenty-six episodes of home health for GePr based upon falsely created OASIS assessments prepared by

HOPKINS, twenty-four of which were falsely certified as medically necessary by a House Doctor.

80. It was further part of the scheme and artifice to defraud that **HOPKINS** falsely and fraudulently documented performing skilled nursing visits on behalf of Abide for Medicare beneficiary GePr during the periods GePr was certified for home health with Abide.

81. It was further part of the scheme and artifice to defraud that on about August 21, 2013, **HOPKINS** and **DEJEAN** created a false and fraudulent case conference and 60-day summary for GePr containing falsified diagnoses, medical conditions and exacerbations that were based upon no objective medical data or history and was created solely to falsely recertify GePr for home health.

82. It was further part of the scheme and artifice to defraud that, after the execution of federal search warrants on Abide on March 25, 2014, Abide abruptly discharged GePr to home/self-care on about April 8, 2014, despite GePr having been certified for home health for twenty-six episodes at Abide between approximately January 28, 2010 and March 8, 2014, and even though the last skilled visit indicated fair progress toward GePr's goals. Neither Abide, nor a certifying House Doctor, nor **HOPKINS** provided GePr or his group home caregiver with any discharge instructions or documentation.

83. It was further part of the scheme to defraud that Abide fraudulently billed Medicare \$35,925.05 and was paid \$41,528.47 for twenty-four episodes of home health for GePr based upon falsified OASIS assessments performed by **HOPKINS**, purported skilled nursing visits **HOPKINS** falsely claimed she performed, and 60-day conferences falsely documenting fabricated exacerbations and complications of GePr's medical condition by **HOPKINS** and **DEJEAN**, when Abide owners and operators well knew and should have known that the services billed were medically unnecessary and for a patient who was not homebound.

Patient ArGi

84. It was further part of the scheme and artifice to defraud that ArGi was a Medicare beneficiary who resided alone in a senior living community. Abide fraudulently billed for providing thirty episodes of home health for ArGi based upon falsely created OASIS assessments prepared by **WASHINGTON, DEJEAN, EDWARDS**, and others, sixteen of which were falsely certified as medically necessary by **BARNES** and seven of which were falsely certified as medically necessary by **MICHAEL JONES. WASHINGTON, DEJEAN, EDWARDS**, and others, falsely documented homebound status when they well knew and should have known that ArGi was not homebound, did not suffer from all of the diagnosed illnesses they listed on documentation, and did not need home health services.

85. It was further part of the scheme and artifice to defraud that from about May 24, 2009, through March of 2014, **WASHINGTON, DEJEAN, EDWARDS**, and others created false and fraudulent OASIS and POCs including diagnoses of illnesses that ArGi did not have. An unindicted physician known to the grand jury, **BARNES** and **JONES** falsely and fraudulently recertified ArGi for home health episodes by diagnosing ArGi with Case Mix ICD-9 diagnoses 281.0 (pernicious anemia), 330.1 (cerebral lipidosis), 369.20 (low vision), 536.9 (stomach function disorder NOS), 401.9 (hypertension NOS), 358.1 (myasthenic syndromes in diseases classified elsewhere), 714.0 (rheumatoid arthritis), 357.1 (polyneuropathy in collagen vascular disease), among other diagnoses, and by certifying that ArGi was homebound.

86. It was further part of the scheme and artifice to defraud that through thirty episodes of home health, hypertension was identified as the primary diagnosis for eleven episodes even though ArGi's blood pressure was habitually within normal limits and, on the rare occasion when ArGi's blood pressure was not within normal limits, no notification was made to a physician even though the plan of care required such a notification.

87. It was further part of the scheme and artifice to defraud that despite two previous home health episodes wherein ArGi's blood pressure was within normal limits, on about September 11, 2010, **EDWARDS** fraudulently initiated the recertification of ArGi based upon a falsified exacerbation of hypertension.

88. It was further part of the scheme and artifice to defraud that **BARNES** recertified ArGi for sixteen episodes of home health between May 19, 2010 and January 2, 2013, without ever seeing ArGi, without having any knowledge of ArGi's medical condition, and without ever having conducted a face-to-face with ArGi.

89. It was further part of the scheme and artifice to defraud that **BARNES** billed Medicare Part B for performing CPT Code G0181(home health care plan oversight) for ArGi on ten occasions between November 22, 2010 and October 22, 2012, even though he never saw or treated ArGi, never maintained a patient file for ArGi, and never performed the elements of CPT Code G0181 for ArGi.

90. It was further part of the scheme and artifice to defraud that **MICHAEL JONES** recertified ArGi for seven episodes of home health between January 3, 2013 and April 27, 2014. For the initial recertification on January 3, 2013, **MICHAEL JONES** signed a 485 for ArGi before **MICHAEL JONES** ever saw or treated ArGi as a patient.

91. It was further part of the scheme and artifice to defraud that **MICHAEL JONES** billed Medicare Part B for performing HCPCS G0181 for ArGi on at least one occasion even though he never performed the elements of that procedure code.

92. It was further part of the scheme and artifice to defraud that **MICHAEL JONES** assigned diagnoses on ArGi's 485s that were not medically supported in **MICHAEL JONES'** treatment or documentation of treatment of ArGi.

93. It was further part of the scheme to defraud that Abide fraudulently billed Medicare \$17,420, and was paid \$35,122.03, for sixteen episodes of home health based upon falsified OASIS assessments performed by **WASHINGTON, DEJEAN, EDWARDS**, and others, and POCs fraudulently certified by **BARNES**. Abide also fraudulently billed Medicare \$8,863.46 and was paid \$14,501.63 for seven episodes of home health based upon falsified OASIS assessments performed by **WASHINGTON, DEJEAN, EDWARDS**, and others, and POCs fraudulently certified by **MICHAEL JONES**. Abide owners and operators well knew and should have known that the services billed were medically unnecessary and for a patient who was not homebound.

Patient KiSt

94. It was further part of the scheme and artifice to defraud that KiSt, a Medicare beneficiary, resided with her minor child and received home health from Abide from July 23, 2011 until January 13, 2013. KiSt was discharged on March 13, 2013. Abide fraudulently billed for providing ten episodes of home health for KiSt based upon falsely created OASIS assessments and POCs, all of which were falsely certified as medically necessary by **BARNES**.

95. It was further part of the scheme and artifice to defraud that the NPP employed with **BARNES** made a home visit with KiSt in July 2011. The NPP documented a blood pressure of 120/70 on a copy of the first page of a POC already signed by **BARNES** and **DEJEAN**.

96. It was further part of the scheme and artifice to defraud that **BARNES** never submitted a face-to-face evaluation to Abide, a document required by Medicare in order for Medicare to reimburse for the home health episode.

97. It was further part of the scheme and artifice to defraud that **DEJEAN** completed an OASIS for KiSt falsely reflecting a primary diagnosis of 401.9 (hypertension NOS), a Case-

Mix ICD-9 diagnosis, when **DEJEAN** had taken only one blood pressure reading, and other Case-Mix ICD-9 diagnoses of 369.2 (low vision 2 eyes NOS), 250.6 (DMII neuropathy uncontrolled), and 281.1 (Vitamin B12 deficiency anemia NEC), that KiSt's safety was compromised because of vision, that KiSt's physician was notified of the patient's risk of falls, that KiSt was confused at times, that KiSt needed assistance with oral medications, and that a caregiver provided assistance with activities of daily living.

98. It was further part of the scheme and artifice to defraud that **DEJEAN** and **BARNES** fraudulently signed the POC on about July 25, 2011, for the start of care for home health services at Abide well knowing that there was no physician orders and no acceptable face-to-face evaluation performed by **BARNES**.

99. It was further part of the scheme and artifice to defraud that **DEJEAN**, and other nursing staff, **BARNES**, and Abide, never possessed or were aware of medical documentation supporting the diagnoses listed in the OASISs and the POCs prepared for KiSt.

100. It was further part of the scheme and artifice to defraud that **BARNES** never maintained a patient file for KiSt, nor did **BARNES** ever bill Medicare Part B for any office visits made with KiSt or any POCs he oversaw, signed and certified.

101. It was further part of the scheme and artifice to defraud that on April 3, 2013, **BARNES** ordered medication used to treat major depressive, anxiety and panic disorders that had a common side effect of elevated blood pressure even though KiSt was diagnosed with hypertension for every episode of home health at Abide, KiSt was never seen by **BARNES**, **BARNES'** NPP only saw KiSt once on June 27, 2012, and KiSt had been discharged from Abide on March 13, 2013.

102. It was further part of the scheme to defraud that Abide fraudulently billed Medicare \$8,879.86, and was paid \$19,666.24, for ten episodes of home health based upon

falsified OASIS assessments performed by **DEJEAN** and others and POCs fraudulently certified by **BARNES**, when Abide owners and operators well knew and should have known that the services billed were medically unnecessary and for a patient who was not homebound.

Patient JeJo

103. It was further part of the scheme and artifice to defraud that JeJo was a developmentally delayed Medicare beneficiary diagnosed with Downs Syndrome who resided with his sister and received home health from Abide from March 13, 2013, until January 9, 2014.

104. It was further part of the scheme and artifice to defraud that RNs completed OASIS assessments for JeJo falsely reflecting Case-Mix ICD-9 diagnoses of 369.20 (low vision 2 eyes NOS) and 716.89 (arthropathy).

105. It was further part of the scheme and artifice to defraud that on about March 13, 2013, **EVANS** discharged JeJo from Touro Infirmary after treatment of an abdominally related, non-surgical condition. **EVANS** specifically identified Abide for post hospitalization care, instead of permitting JeJo's caretaker the choice of home health providers, to monitor vital signs, assist with dietary oversight, and to have physical therapy. Because JeJo could not be located, Abide was not able to evaluate JeJo for services until about March 20, 2013.

106. It was further part of the scheme and artifice to defraud that Abide fraudulently billed for providing five episodes of home health for JeJo based upon physician orders and falsely created OASIS assessments prepared by Abide RNs that did not support home health.

107. It was further part of the scheme and artifice to defraud that on about May 22, 2013, despite repeatedly certifying that JeJo was homebound, **EVANS** medically cleared JeJo to participate in an adult non-medical day care program with no restrictions.

108. It was further part of the scheme and artifice to defraud that on about August 28, 2013, **EVANS** completed a Request for Medical Eligibility Determination and prescribed and

certified Medicaid services for intermediate institutional and developmental care for JeJo. On the documentation completed by **EVANS**, he certified that Home/Community Based Services adequately met the needs of JeJo, including most activities of daily living, and indicated that JeJo had a normal physical examination and no visual impairment.

109. It was further part of the scheme and artifice to defraud that **BATTAGLIA** falsely documented skilled nursing visits by “teaching on disease processes” that JeJo did not have. **BATTAGLIA** falsely stated in a 60-day conference that JeJo’s homebound status was evident even though **BATTAGLIA** knew and should have known that JeJo left home each day for a day program, had frequent outings with his caregivers, and continually witnessed him returning home from these outings. **BATTAGLIA** also falsely documented that JeJo had complications with arthritis, a condition from which JeJo did not suffer, representations fraudulently used to recertify JeJo for medically unnecessary home health services.

110. It was further part of the scheme and artifice to defraud that, despite justifying the need for skilled nursing home health services for JeJo for five episodes, Abide abruptly discharged JeJo from home health on about January 9, 2014, because JeJo was receiving daily personal care services that assisted JeJo with activities of daily living.

111. It was further part of the scheme and artifice to defraud that for two home health episodes, **EVANS’** Physician Orders reflected a need for recertification based upon a change of medication when the only medication change was to add Tylenol as needed, a change that does not require skilled nursing provided by a home health agency.

112. It was further part of the scheme and artifice to defraud that between about March 20, 2013, and about November 13, 2013, OASIS assessments prepared by Abide RNs, skilled nursing visits documented by **BATTAGLIA** and others, and 485 POCs certified by **EVANS** were all fraudulently completed for JeJo by documenting false diagnoses, the need for skilled

nursing, and the need for assistance with activities of daily living, and JeJo's homebound status when **EVANS, BATTAGLIA** and other Abide employees, including skilled nurses and aides, well knew that JeJo had full time personal care services provided by Medicaid, lived with a family member, was not homebound, and did not need skilled and aide home health services.

113. It was further part of the scheme to defraud that Abide fraudulently billed Medicare \$12,880.03, and was paid \$9,634.93, for five episodes of home health provided to JeJo based upon the above-described falsified documentation, when Abide owners and operators well knew and should have known that the services billed were medically unnecessary and for a patient who was not homebound.

Patient LiSc

114. It was further part of the scheme and artifice to defraud that LiSc was a Medicare beneficiary who resided with her daughter and a roommate. Abide fraudulently billed for providing sixteen (16) episodes of home health for LiSc based upon falsely created OASIS assessments prepared by **KOON**, six of which **MICHAEL JONES** falsely certified as medically necessary. **KOON** falsely documented homebound status when he well knew and should have known LiSc was not homebound, did not suffer from all the diagnosed illnesses he listed on documentation, and did not need home health services.

115. It was further part of the scheme and artifice to defraud that from about October 7, 2011, through May 20, 2014, **KOON** created false and fraudulent OASIS assessments and POCs including diagnoses of illnesses that LiSc did not have. An unindicted physician and **MICHAEL JONES** falsely and fraudulently recertified LiSc for home health episodes by diagnosing LiSc with Case Mix ICD-9 diagnoses 714.0 (rheumatoid arthritis), 536.9 (stomach function disorder, 281.0 (pernicious anemia), 401.9 (hypertension NOS), and 369.20 (low vision), among other diagnoses, and by certifying that LiSc was homebound.

116. It was further part of the scheme and artifice to defraud that on about November, 2013, after **KOON** told LiSc that her physician no longer worked with Abide, **KOON** scheduled an appointment for LiSc to see **MICHAEL JONES**. Larry Taylor transported LiSc to **MICHAEL JONES'** office. Verbal orders signed on April 30, 2013, by an Abide RN indicated that "pt request to change MD from Dr. Wiley to Dr. Jones."

117. It was further part of the scheme and artifice to defraud that, despite the previous episode wherein LiSc's blood pressure was within normal limits, on about June 20, 2013, **KOON** fraudulently initiated the recertification of LiSc based upon a false statement of abnormal blood pressure. **KOON** also falsely reported that LiSc required recertification for psychotic behavior despite no previous reports or mentions of or treatment for psychosis.

118. It was further part of the scheme and artifice to defraud that, despite two previous episodes wherein LiSc's blood pressure was within normal limits, on about October 18, 2013, **KOON** fraudulently initiated the recertification of LiSc based upon a false statement of abnormal blood pressure. **KOON** also falsely stated that LiSc required recertification for psychotic behavior despite no previous reports or mentions of or treatment for psychosis.

119. It was further part of the scheme and artifice to defraud that, despite no indications of abnormal findings noted during the previous episode, on about December 17, 2013, **KOON** falsely initiated the recertification of LiSc for abnormal findings and/or assessment.

120. It was further part of the scheme and artifice to defraud that **MICHAEL JONES** billed three claims to Medicare Part B for performing CPT Code G0181, home health care oversight, for LiSc between June 25, 2013, and February 20, 2014, when documentation required by Medicare indicates that he never performed the elements of that code for LiSc.

121. It was further part of the scheme and artifice to defraud that **MICHAEL JONES** fraudulently recertified LiSc for five episodes of home health between April 26, 2013, and February 20, 2014. For the first three recertifications, **MICHAEL JONES** recertified LiSc before he ever saw or treated LiSc as a patient.

122. It was further part of the scheme and artifice to defraud that **MICHAEL JONES** falsely assigned ICD-9 diagnoses on LiSc's POCs/485s that were not medically supported in his treatment and the documentation of his treatment of LiSc.

123. It was further part of the scheme and artifice to defraud that **KOON** falsely and fraudulently documented skilled nursing visits he made to LiSc beginning on October 7, 2011, and continuing until about May 20, 2014. **KOON** fraudulently reported that he educated LiSc on the false diagnoses supporting home health.

124. It was further part of the scheme and artifice to defraud that during each home health episode, **KOON** participated in 60-day conferences with Abide staff to discuss the need for ongoing home health services for LiSc, and falsely supported the need for ongoing home health services well knowing that LiSc had no medical necessity for home health and was not homebound.

125. It was further part of the scheme and artifice to defraud that Abide fraudulently billed Medicare approximately \$31,641.34 and was paid about \$21,237.53 for ten (10) episodes of medically unnecessary home health purportedly provided to LiSc based upon falsified OASIS assessments performed by **KOON** and POCs fraudulently certified by an unindicted physician. Abide fraudulently billed Medicare approximately \$17,800.05 and was paid about \$14,709.75 for six (6) episodes of medically unnecessary home health based upon falsified OASIS assessments performed by **KOON** and POCs fraudulently certified by **MICHAEL JONES**.

Patient KeTr

126. It was further part of the scheme and artifice to defraud that KeTr was a Medicare beneficiary who resided alone, owned a car and drove himself, and had been seeing **MOLDEN** since May 25, 2010. On August 4, 2011, approximately three weeks after **MOLDEN** received his first "Consultant" check from Abide, **MOLDEN** completed a face-to-face note citing the variations in blood glucose levels and the considerable taxing effort KeTr required when absent from home as justification for skilled nursing services provided by home health and wrote a prescription for KeTr to be admitted specifically to Abide. Despite **MOLDEN** having documented on the face-to-face encounter the need for home health services for the above-stated reasons, Abide did not admit KeTr for over six weeks and, during that delay, KeTr again visited **MOLDEN**. The 485/POC on which **MOLDEN** certified the medical necessity for home health indicated that KeTr was incontinent, had impaired vision, was unable to safely leave home unassisted, had shortness of breath upon exertion, and was dependent upon adaptive devices although KeTr consistently denied shortness of breath when he visited **MOLDEN**. When KeTr was gone from his home with family on two occasions during the home health episode, **MOLDEN** was informed. Yet, on November 18, 2011, **MOLDEN** again fraudulently certified KeTr for medically unnecessary home health.

127. It was further part of the scheme and artifice to defraud that on the last episode **MOLDEN** certified KeTr for home health, from May 16, 2012 through July 14, 2012, **MOLDEN'S** certification was based upon falsified diagnoses that KeTr did not have and for which **MOLDEN'S** own records did not support. Instead, the recertification was based upon Case Mix diagnoses.

128. It was further part of the scheme and artifice to defraud that Abide fraudulently billed for providing five (5) episodes of home health for KeTr from September 19, 2011 through

July 14, 2012, based upon falsely created OASIS assessments and 485/POCs **MOLDEN** fraudulently certified well knowing the KeTr did not qualify because he was not homebound and did not require skilled nursing.

129. It was further part of the scheme and artifice to defraud that between about January 1, 2009, and October, 2012, **BARNES** fraudulently billed Medicare approximately \$297,952 for providing Medicare Part B services for CPT Codes G0180 and G0181 and was paid approximately \$162,783.

130. It was further part of the scheme and artifice to defraud that between about January 1, 2009, and July, 2014, Abide billed Medicare \$7,325,092 and was paid \$10,687,445 because **BARNES** fraudulently referred patients to Abide for home health services in return for payments from Abide and fraudulently signed POCs for beneficiaries so that Abide could bill Medicare for home health services that were medically unnecessary, and in some cases not rendered.

131. It was further part of the scheme and artifice to defraud that between about January 1, 2009, and October, 2012, **EVANS** fraudulently billed Medicare approximately \$67,750 for providing Medicare Part B services for CPT Codes G0179, G0180, and G0181 and was paid approximately \$26,708.

132. It was further part of the scheme and artifice to defraud that between about January 1, 2009, and May, 2014, Abide billed Medicare approximately \$1,160,744 and was paid approximately \$1,546,320 because **EVANS** fraudulently referred patients to Abide for home health services in return for payments from Abide and fraudulently signed POCs for beneficiaries so that Abide could bill Medicare for home health services that were medically unnecessary, and in some cases not rendered.

133. It was further part of the scheme and artifice to defraud that between January 2013, and May, 2014, **MICHAEL JONES** fraudulently billed Medicare approximately \$10,635 for providing Medicare Part B services for CPT Codes G0180 and G0181 and was paid approximately \$2,658.

134. It was further part of the scheme and artifice to defraud that between about May 29, 2013, and May, 2014, Abide billed Medicare approximately \$237,155 and was paid approximately \$295,413 because **MICHAEL JONES** fraudulently referred patients to Abide for home health services in return for payments to his wife, Paula Jones, and to his driver/recruiter, Larry Taylor, from Abide, and fraudulently signed POCs for beneficiaries so that Abide could bill Medicare for home health services that were medically unnecessary, and in some cases not rendered.

135. It was further part of the scheme and artifice to defraud that between January 1, 2009, and November 27, 2013, **MOLDEN** fraudulently billed Medicare approximately \$14,350 for providing Medicare Part B services for CPT Codes G0179, G0180, and G0181 and was paid approximately \$8,492.

136. It was further part of the scheme and artifice to defraud that between about January 2009, and May 20, 2014, Abide billed Medicare approximately \$672,071 and was paid approximately \$1,050,472 because **MOLDEN** fraudulently referred patients to Abide for home health services in return for payments from Abide and fraudulently signed POCs for beneficiaries so that Abide could bill Medicare for home health services that were medically unnecessary, and in some cases not rendered.

137. In order to execute and attempt to execute the scheme, and to accomplish the purposes of the scheme, the defendants **BARNES, EVANS, MICHAEL JONES, MOLDEN, NORA, WASHINGTON, HOPKINS, EDWARDS, DEJEAN, KOON, BATTAGLIA** and

others known and unknown to the Grand Jury, committed and caused others to commit the following acts of fraudulent billing to Medicare for episodes of home health listed below.

COUNT	BENEFICIARY	EPISODE/ PART B BILLING	AMOUNT BILLED	AMOUNT PAID	DEFENDANTS
3	JoBi	03/26/13 – 05/24/13	\$1,375.00	\$1,427.04	HOPKINS
4	JoBi	05/25/13 – 07/23/13	\$1,650.00	\$1,427.04	HOPKINS
5	JoBi	11/21/13 – 01/19/14	\$1,650.01	\$1,249.79	HOPKINS
6	GePr	07/16/12 – 09/13/12	\$1,250.00	\$1,470.35	HOPKINS
7	GePr	03/13/13 – 05/11/13	\$1,250.00	\$1,427.04	HOPKINS
8	GePr	07/11/13 – 09/08/13	\$1,650.01	\$1,803.78	HOPKINS, DEJEAN
9	ArGi	07/18/10 – 09/15/10	\$1,125.00	\$2,324.19	BARNES, WASHINGTON
10	ArGi	11/15/10 – 01/13/11	\$1,000.00	\$2199.28	BARNES, EDWARDS
11	ArGi	11/22/10	\$132.22	\$84.11	BARNES
12	ArGi	03/09/12 – 05/07/12	\$1,125.00	\$2,200.81	BARNES
13	ArGi	05/02/12	\$132.22	\$82.01	BARNES
14	ArGi	08/04/12	\$132.22	0	BARNES
15	ArGi	08/31/13 – 10/29/13	\$1,200.01	\$2,135.82	MICHAEL JONES
16	ArGi	12/29/13 – 02/26/14	\$1,200.01	\$2,055.49	MICHAEL JONES
17	ArGi	01/03/13	\$120.00	0	MICHAEL JONES
18	JeJo	07/18/13 – 09/15/13	\$2,240.01	\$1,759.06	EVANS, BATTAGLIA
19	JeJo	09/16/13 – 11/14/13	\$2,710.01	\$1,427.04	EVANS, BATTAGLIA
20	KiSt	07/23/11 – 09/20/11	\$1,000.00	\$1,690.12	BARNES, DEJEAN
21	KiSt	11/14/12 – 01/12/13	\$625.00	\$2,012.74	BARNES
22	KiSt	01/13/13 – 03/13/13	\$625.00	\$1,657.97	BARNES
23	LiSc	06/25/13	\$120.00	0	MICHAEL JONES
24	LiSc	06/25/13 – 08/23/13	\$3,280.00	\$2,135.00	MICHAEL JONES, KOON
25	LiSc	10/23/13 – 12/21/13	\$2,055.01	\$2,135.82	MICHAEL JONES, KOON

COUNT	BENEFICIARY	EPISODE/ PART B BILLING	AMOUNT BILLED	AMOUNT PAID	DEFENDANTS
26	LiSc	12/22/13	\$120.00	\$81.93	MICHAEL JONES
27	LiSc	12/22/13 – 02/19/14	\$2,710.00	\$2,055.00	MICHAEL JONES, KON
28	LiSc	02/20/14	\$120.00	\$84.31	MICHAEL JONES
29	KeTr	09/19/11 – 11/17/11	\$875.00	\$2,027.94	MOLDEN
30	KeTr	05/16/12 – 07/14/12	\$500.00	\$417.52	MOLDEN

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

COUNT 31 - Obstruction of a Federal Audit

A. AT ALL TIMES MATERIAL HEREIN:

138. The allegations in Paragraphs 1 through 26 and 43 of Count 1 of this Superseding Indictment are realleged and incorporated by reference as though fully set forth herein.

B. OBSTRUCTION

139. Between on or about January 26, 2011, and April 27, 2011, in the Eastern District of Louisiana and elsewhere, the defendant, **SHELTON BARNES**, with the intent to deceive and defraud the United States, endeavored to influence, obstruct, and impede Pinnacle Business Solutions, Inc., a Federal auditor in the performance of official duties relating to Medicare, a federal program receiving in excess of \$100,000, directly and indirectly, from the United States in any one year period under a qualifying contract, subcontract property, or agreement using the words of the statute, in violation of Title 18, United States Code, Section 1516.

NOTICE OF HEALTH CARE FRAUD FORFEITURE

1. The allegations contained in Counts 1 through 30 of this Superseding 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).

2. As a result of the offenses alleged in Counts 1 through 30, defendants, **HENRY EVANS, MICHAEL JONES, GREGORY MOLDEN, PAULA JONES, SHELTON BARNES, JONATHON NORA, SUPRENIA WASHINGTON, ERICA EDWARDS, ZELLISHA DEJEAN, CAREN BATTAGLIA, SHEILA HOPKINS, JEFF KOON, VERINESE SUTTON, and LARRY TAYLOR** 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 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, including but not limited to:

- a. At least \$30,252,906 in United States Currency and all interest and proceeds traceable thereto.
- j. The government specifically provides notice of its intent to seek a personal money judgment against the defendant in the amount of the fraudulently-obtained proceeds.

3. If any of the property described above as being subject to forfeiture, as a result of any act or omission of the defendants:

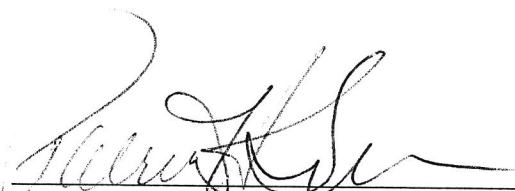
- a. cannot be located upon the exercise of due diligence;
- b. has been transferred, sold to, or deposited with, a third person;
- c. has been placed beyond the jurisdiction of the Court;
- d. has been substantially diminished in value; or
- e. has been commingled with other property which cannot be subdivided without difficulty;

it is the intent of the United States, pursuant to Title 18, United States Code, Section 982(b) to seek forfeiture of any other property of said defendants up to the value of the above forfeitable property;

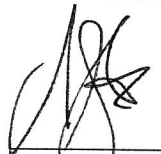
All in violation of Title 18, United States Code, Section 982(a)(7).

A TRUE BILL:

FOREPERSON


PATRICE HARRIS SULLIVAN
ASSISTANT UNITED STATES ATTORNEY
Louisiana Bar No. 14987


SHARAN LIEBERMAN
ASSISTANT UNITED STATES ATTORNEY


ANDRE LAGARDE
ASSISTANT UNITED STATES ATTORNEY
Louisiana Bar No. 28649

New Orleans, Louisiana
April 21, 2016