UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

UNITED STATES OF AMERICA *ex rel.* ROXANNE KLINE, and ROXANNE KLINE, individually, Plaintiffs, v. DOCS AT THE DOOR, P.C., AJIBOLA AYENI, BANIO KOROMA, FIRAS ZAHWE, GATEWAY HEALTH SYSTEMS, INC., and JOY H. TURNER-AYENI, Defendants.	)	No. 13 C 7837 Judge Pallmeyer
UNITED STATES OF AMERICA, Plaintiff-Intervenor, v. DOCS AT THE DOOR, P.C., AJIBOLA AYENI, GATEWAY HEALTH SYSTEMS, INC., and JOY H. TURNER-AYENI, Defendants.	)	

COMPLAINT IN INTERVENTION OF THE UNITED STATES OF AMERICA

The United States of America, by Joel R. Levin, Acting United States Attorney for the Northern District of Illinois, having filed a notice of intervention against Docs at the Door, P.C., Ajibola Ayeni, Gateway Health Systems, Inc., and Joy H. Turner-Ayeni, pursuant to 31 U.S.C. § 3730(b)(4), alleges as follows:

Introduction

1. This is a civil fraud action brought by the United States against Docs at the Door, P.C. (a home visiting physician company), Gateway Health Systems, Inc. (a home health services

company), Ajibola Ayeni (who owns both companies and oversaw day-to-day operation of Docs at the Door), and Joy Turner-Ayeni (a registered nurse who co-owns Gateway and oversees its day to day operations), seeking treble damages and civil penalties under the False Claims Act, 31 U.S.C. §§ 3729-3733.

2. Ajibola Ayeni and Joy Turner-Ayeni (the Ayenis), individually and through Docs at the Door and Gateway, have defrauded—and, with respect to Gateway, may still be defrauding—the United States by knowingly submitting false claims to Medicare for home visiting physician and home health services, and making false statements or causing false statements to be made, material to those false claims. Docs at the Door and Gateway each claimed and were paid millions of dollars for services purportedly provided to Medicare beneficiaries, while they were in fact making false documentation to cover up the fact that they were submitting claims for services not rendered, as well as claiming services that were unnecessary because the beneficiaries were not confined to the home or otherwise unable to visit a doctor's office. The Ayenis' fraudulent scheme, perpetrated through their companies, garnered them millions of dollars in federal health care funds to which they were not entitled.

3. Docs at the Door, at the direction of Ajibola Ayeni, defrauded Medicare by knowingly submitting false claims for home visiting physician services through the following schemes: (1) falsely certifying non-homebound individuals for medically unnecessary home health services, in contravention of Medicare rules; (2) falsely billing for home physician visits to individuals who were not eligible; (3) fraudulently upcoding every home physician visit, regardless of the nature of the visit, in order to increase compensation; and (4) falsely billing Medicare for physicians' "care plan oversight" under CPT code G0181, as a matter of course for every patient visited every month, although those services were not provided.

4. Gateway Health Systems defrauded Medicare through knowingly and falsely claiming Medicare payments for home health services for individuals who were not homebound and certifying home health services for those non-homebound individuals. Joy Ayeni, as the co-owner and operator of Gateway, oversaw this fraudulent practice. As a registered nurse, she personally signed false statements on critical assessment documents, which allowed home health services to be fraudulently claimed. The individuals that doctors from Docs at the Door and Joy Ayeni for Gateway certified for home health services included beneficiaries who went camping, regularly drove themselves to their own in-office doctors' appointments, and went shopping on their own at local retailers.

5. In addition, after responding to two civil investigative demands issued by the Department of Justice to Docs at the Door in September 2015, and the month after receiving and responding to an inquiry about whether Docs at the Door's investigation counsel also represented Gateway, the Ayenis transferred their interests in five real properties into two trusts on August 16, 2016. Those transfers were either intentionally or constructively fraudulent and are void as to the rights of the United States in the Ayenis' properties and assets.

Jurisdiction and Venue

6. This court has jurisdiction over the claims, pursuant to 31 U.S.C. § 3730(a), and 28 U.S.C §§ 1331, 1345.

7. Venue lies in this district pursuant to 31 U.S.C. § 3732(a), and 28 U.S.C. § 1391(b), because the defendants reside in this district, and the acts set out herein occurred in this district.

Parties

8. Plaintiff is the United States of America on behalf of its agency, the United States Department of Health and Human Services.

9. Defendant Docs at the Door, P.C., was a home visiting physician services provider, which is not believed to be in business any longer but whose primary place of business was in Matteson, Illinois.

10. Defendant Ajibola Ayeni is the owner of both defendants Docs at the Door, P.C., and Gateway Health Systems, Inc., and managed the day to day operations of Docs at the Door. Upon information and belief, he resides in Flossmoor, Illinois. He is also the husband of defendant Joy Turner-Ayeni.

11. Defendant Gateway Health Systems, Inc. is a home health services provider whose primary place of business is in Matteson, Illinois.

12. Defendant Joy Turner-Ayeni is a registered nurse and the co-owner and manager of day-to-day operations of defendant Gateway Health Systems, Inc. She is also known as Joy Ayeni, and she is the wife of defendant Ajibola Ayeni.

Facts

I. Medicare Requirements for Home Visiting Physician and Home Health Services

13. The Medicare program was enacted in 1965 under Title XVIII of the Social Security Act to pay for certain healthcare services for older Americans. The Department of Health and Human Services ("HHS") administers the Medicare Program through the Center for Medicare and Medicaid Services ("CMS"). Physicians, clinics, and other health care providers that provide services to Medicare beneficiaries are able to apply for and obtain a Medicare provider number. A health care provider issued a Medicare provider number can file claims with Medicare to provide reimbursement for services provided to beneficiaries. A Medicare contractor processes the claims submitted for services provided to beneficiaries.

14. By becoming a participating provider in Medicare, enrolled providers agree to abide by the policies and procedures, rules, and regulations governing reimbursement. Providers of health care services to Medicare beneficiaries seeking reimbursement under the program must submit a CMS 1500 claim form, which contains information required to obtain reimbursement. Among other things, this includes the beneficiary's name, health insurance claim number, dates of service, locations of service, type of services, number of services, the HCPCS or CPT procedure codes, diagnostic codes, charges, and the provider's Provider Transaction Access Number. The form also requires a certification that, among other things, the provider is familiar with, and the claim complies with, all applicable laws, regulations, and program instructions for payment, the services were medically necessary, and the services were rendered personally by the referenced provider.

15. Medicare benefits include medically necessary physician visits to patients' homes and in-home health care services for persons who are confined to their homes. Medicare Part A provides coverage for inpatient hospital services, skilled nursing care, and home health and hospice care. Medicare Part B provides supplemental insurance for physician services, outpatient services, and certain home health and preventive services. Medicare Part B typically provides home health and home visiting physician services, although Part A pays for those services when they are provided within the first 100 days after a beneficiary's eligible hospital stay.

A. Home Physician Visits

16. Medicare authorizes payment for home visits and physician services only if those services were actually provided and were medically necessary because of disease, infirmity, or impairment. Medicare does not authorize payment for services and treatment that were not

actually provided or for which that patient does not meet the criteria necessary to justify the claimed service or treatment.

17. Medicare will reimburse for physician home visits where they are medically necessary. Therefore, the patient must be unable to visit a physician's office on an outpatient basis. A home doctor visit is not medically necessary if it is done for the convenience of the patient, the patient's family, or the physician.

18. Physician home visits are billed generally on three criteria: the extent of the patient's history taken during the visit, the extent of the examination performed during the visit, and the complexity of the diagnosis or treatment options.

19. A physician visit to a new patient's home is billed by using one of the HCPCS/CPT codes 99341 through 99345. A physician visit to an established patient's home is billed using one of the HCPCS/CPT codes 99347 through 99350. For each of these series of codes, a higher code number corresponds to a more in-depth and time-consuming level of service, with a correspondingly higher reimbursement amount.

20. For a home visit to an established patient to be claimed properly using code 99347, it must have at least two of the following key components: a problem-focused history, a problem-focused examination, and/or straightforward medical decision making. The visit would involve a minor problem, and a physician typically would spend 15 minutes face to face with the patient. In 2013, Medicare paid approximately $58.94 for a claim under this code for services in the Chicago area.

21. For a home visit to an established patient to be claimed properly using code 99348, it must have at least two of the following key components: an expanded problem-focused history, an expanded problem-focused examination, and/or medical decision making of low complexity.

The visit would involve a problem or problems of low-to-moderate severity, and a physician typically would spend 25 minutes face to face with the patient and/or family. In 2013, Medicare paid approximately $88.91 for a claim under this code for services in the Chicago area.

22. For a home visit to an established patient to be claimed properly using code 99349, it must have at least two of the following key components: a detailed history, a detailed examination, and/or medical decision making of moderate complexity. The visit would involve a problem or problems of moderate to high severity, and a physician typically would spend 40 minutes face to face with the patient. In 2013, Medicare paid approximately $134.45 for a claim under this code for services in the Chicago area.

23. For a home visit to an established patient to be claimed properly using code 99350, it must have at least two of the following key components: a comprehensive history, a comprehensive examination, and/or medical decision making of moderate-to-high complexity. The visit would involve a problem or problems of moderate-to-high severity, and a physician typically would spend 60 minutes face to face with the patient. In 2013, Medicare paid approximately $187.70 for a claim under this code for services in the Chicago area.

24. Medicare pays even higher reimbursement rates for a home physician visit to a new patient. Those visits are claimed under HCPCS/CPT codes 99341 through 99345, from least-to-greatest complexity and length-of-visit time. In 2013, for example, the range of reimbursement for those codes ranged from approximately $58.58 to $231.43. A physician typically would spent 60 minutes face to face with the patient where a visit is claimed under 99344 and 75 minutes face to face where a visit is claimed under 99350.

B. Home Health Services

25. To be eligible for the home health benefit and as a condition of payment, a physician must certify that the patient meets the following requirements: is confined to the home (also known as homebound); is under the care of a physician; receives services under a plan of care established and periodically reviewed by a physician; is in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; and had a face-to-face encounter related to the primary reason the patient requires home health services with a physician or an allowed non-physician practitioner ("NPP") no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care. 42 C.F.R. § 424.22(a).

26. Home health services are certified and billed for in 60-day increments known as "episodes." When there is a continuous need for home health care after an initial 60-day episode of care, a physician must recertify the patient's eligibility for the home health benefit. 42 C.F.R. § 424.22(b). A recertification is required at least every 60 days, preferably at the time the plan is reviewed, and must be signed and dated by the physician who reviews the plan of care. *Id*. In recertifying the patient's eligibility for the home health benefit, the recertification must indicate the continuing need for skilled services and estimate how much longer the skilled services will be required. *Id*.

27. For each 60-day episode of care that a beneficiary receives from a home health agency, Medicare makes a standardized payment. For the home health agency to receive that payment, a physician must certify the beneficiary's initial need for home health services and homebound status and must recertify the need at least every 60 days. 42 C.F.R. § 424.22.

28. For certifications after January 1, 2010, the certifying physician must also—prior to certifying a patient's eligibility for the home health benefit—document that the physician, or a

qualified non-physician practitioner, has had a face-to-face encounter with the patient. The face-to-face encounter requirement is a condition of payment and ensures that the orders and certification for home health services are based on a physician's current knowledge of the patient's clinical condition. Without a valid and complete initial certification, claims for subsequent episodes will not be covered by Medicare.

29. The home health agency also prepares documentation in conjunction with certifications and recertifications of home health. Among other things, a nurse assesses the patient's capacity with respect to activities of daily living, and states the bases for the patient's homebound status. The form the nurse prepares includes "outcome and assessment information set" ("OASIS") data elements, which provide objective information about the patient's functionality.

30. The medical record documentation generated by home health agencies, such as an admit summary, the OASIS assessments, therapy evaluation and/or therapy notes, and/or nurse's notes supporting the certification, may be incorporated into the physician's medical record to help support the certification. Documentation must correspond to the dates of service being billed and must corroborate the certifying physician's own documentation or medical record entries.

31. Physicians may submit a claim for the certification or recertification under Part B. The HCPCS code to bill for the initial certification is G0180. The HCPCS code to bill for recertification is G0179.

32. In certain limited circumstances, the physician who certifies a patient to receive home health benefits can bill Medicare for the time the physician spends supervising the home health care provided to the patient by others. This is referred to as "care plan oversight," or "CPO," and it is billed under HCPCS code G0181.

33. For a physician to bill Medicare for care plan oversight, the patient must have needed complex care that required on-going physician involvement, and the oversight must have been provided during a time when the patient was receiving home health care or hospice. The physician billing for care plan oversight must be the same physician who certified that patient's need for home health services and created the plan of care.

34. The physician must have spent a minimum of 30 minutes in that month on services distinct from the home visits and certification or recertification of the plan of care. Those minimum 30 minutes cannot include administrative- or claim-related work, travel time, initial reviews of lab results with the patient, or telephone calls with the patient, among other excluded activities. Instead, care plan oversight under G0181 can be billed only where the physician has spent a minimum of 30 minutes that month in additional professional services, such as conferencing with the patient's providers in other practices.

II. The Health Care Fraud Scheme

A. Defendants' False Certifications and Medically Unnecessary Home Visits and Home Health Services

35. Ajibola Ayeni primarily oversaw day-to-day operations of Docs at the Door, while his wife, Joy Turner-Ayeni, a registered nurse, primarily oversaw day-to-day operations of Gateway. They both, however, were involved in the operations of both entities.

36. Docs at the Door contracted with physicians to conduct home visits. Those physicians were paid a set fee per home visit. For example, in late 2012 through the summer of 2013, Ayeni paid the home visiting physician contractors approximately $43 for each visit to an established patient and $51 for each visit to a new patient. Gateway employed nurses and nursing assistants to visit beneficiaries purportedly to provide home health services and paid them a modest hourly wage.

37. At both companies, home visits and home health services were claimed and paid for individual beneficiaries who did not meet the eligibility requirements for those visits and services, and for whom the services were not necessary. In particular, the individuals were not homebound, as required for Medicare to pay for home health services, and they were not unable to attend physician office visits, as required for Medicare to pay for home visiting physician services.

38. Docs at the Door used the Form CMS-485, "Home Health Certification and Plan of Care," which is sometimes referred to as a "485" or "Plan of Care," to authorize and certify patients for home health services.

39. The 485s state: "I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan." Thereunder, the forms state: "Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws."

40. The 485 or certification form has entries for both a home health nurse's signature, and the attending physician's signature. A significant amount of the certifications signed for Docs at the Door were signed by Banio Koroma, as the physician, and Joy Ayeni, as the home health nurse.

41. In the normal and proper course, a home visiting physician who was determining the need for home health services for a patient would visit and examine a patient and then certify (or re-certify when 60 days had passed) that patient's homebound status and need for home health services. However, at Docs at the Door, Ayeni paid various contractor physicians to see patients

for home visits but primarily had Banio Koroma, who at the time was a physician, sign certifications for home health for those patients, although he had not visited them.

42. During much of the relevant period, Banio Koroma worked full time, weekdays, at another home visiting physician company, Mobile Doctors. In August 2013, Koroma was charged with health care fraud in connection with his work at Mobile Doctors, and—in January 2016—a federal jury convicted him, specifically, on two counts of healthcare fraud and two counts of making false statements related to health care matters. At Mobile Doctors, like here, Koroma certified patients as confined to their homes when they were not actually homebound and did not need the home skilled nursing services that he had authorized.

43. On certain nights and weekends when he was not working for Mobile Doctors, Koroma would come to the Docs at the Door office. Ayeni regularly provided stacks of "485" certification forms to Banio Koroma to sign despite knowing that Koroma had not seen or examined the patients whose forms he was to sign and despite the fact that many of the individuals were not homebound and did not qualify for home health services under Medicare rules. He did so knowing that Koroma would sign certifications regardless of whether they were true or false, and regardless of whether a patient was appropriate for home physician visits or home health services. Koroma would sign those "485s" without having had a face-to-face visit with the patients in the prior 30 days, in most or all instances, and without even reviewing the medical charts.

44. On at least one occasion, Ayeni even brought a stack of unsigned 485s to a party in order to give them to Koroma so that Koroma could sign and return them. At least one other physician who worked as a contractor for Docs at the Door confronted Ayeni about Koroma signing documents for patients that Koroma had not seen. Ayeni was dismissive and told that complaining doctor, in words or in substance, "that's the way it works."

45. Gateway also prepared false assessments in connection with certifications and recertifications of home health services. Nurses including Turner-Ayeni documented falsely that patients required assistance to walk and with activities of daily living, and were unable to safely leave the home unassisted when those statements on many occasions were obviously and objectively false.

46. Docs at the Door falsely submitted claims to Medicare based on false statements for certification and re-certification for home health services of individuals who were not homebound and did not qualify for those services. Gateway then falsely submitted claims to Medicare for home health services for those same individuals, based on false statements by Docs at the Door physicians like Banio Koroma, and Gateway nurses including its owner Joy Turner-Ayeni. In addition, Docs at the Door submitted false claims to Medicare for home physician visits to individuals who were not eligible to receive those services because they were fully able to leave their homes to attend physician office visits.

B. Fraudulently Upcoded Home Visits

47. In addition to falsely claiming home visits for patients who did not meet the Medicare eligibility requirements for payment of those claims, Docs at the Door also fraudulently upcoded home visits to the second highest paying code in order to maximize reimbursement while still avoiding the red flag of using the highest paying code.

48. Despite the fact that most visits to Docs at the Door patients were "easy," to use the term of one of its physicians, and varied from approximately 10 to 20 minutes in duration, Docs at the Door claimed the second highest complexity code, CPT 99344, for 95 percent of the claimed home visits to new patients, and CPT 99349, for 99 percent of its visits to established patients. This was no accident. Doctors did not select the CPT code used for a visit. Ayeni did. Ayeni

instructed medical assistants to document the code 99344 on the patient encounter form for every new patient visit, and 99349 for every established patient visit.

49. Docs at the Door contractors or staff sometimes claimed visits to the homes of as many as 16 or more patients in a workday that typically lasted, from beginning to end, starting and ending in the Docs at the Door office, eight hours or less. A time-and-distance analysis of the codes billed for patients, including the driving time, shows doctors would have needed all 24 hours in a day, or more, just to provide the amount of services claimed on some days, not including the driving time required.

50. For example, Docs at the Door submitted claims to Medicare reflecting that a particular physician visited 16 patients on April 19, 2012, all claimed through CPT codes 99344 and 99349, as well as conducted two certifications and two recertifications, three EKGs, and five smoking-cessation treatments. An analysis of the average service times for each of those CPT codes totals to 24 hours just to provide the services billed for, not including the travel time between the 16 home visits. Each of the claims submitted by Docs at the Door for those 16 home visits was fraudulent and constituted a false claim under the False Claims Act.

C. Fraudulent Claims for Care Plan Oversight

51. Docs at the Door, at the direction of Ayeni, submitted false claims to Medicare for care plan oversight, using G0181. Ayeni directed the company's biller to submit care plan oversight/G0181 claims for each patient, every month, so long as that patient had been visited by a doctor that month. Ayeni gave this instruction, although he knew that none of his contractor physicians, who made a flat fee per patient visit, actually provided an additional 30 minutes per patient per month of complex care coordination.

52. In order to create false supporting documentation for these false claims, Ayeni instructed several staff members at Docs at the Door to fill out "CPO Logs," based upon a model he provided them. These logs had a space for the patient's name and birth date, the log's date, the "oversight month," and the doctor. The log form then had a list of various activities. Next to each potential activity, there was a "time spent" area with options for 5, 10, and 15. Most or all of the potential activity selections on the log form were not activities for which a physician can bill for care plan oversight, including activities handled by office staff or medical assistants, not physicians, including "initiate and schedule patient visit" and "check availability before visit."

53. The following is an excerpt from one of Docs at the Door's CPO Logs.

CERT/485: START DATE:		END DATE:			
	COMMUNICATION WITH PHYSICIANS				
DATE	TOPIC	TIME SPENT			NOTES/COMMENTS
	INITIATE AND SCHEDULE PATIENT VISIT	5	(10)	15	
	CHECK AVAILABILITY BEFORE VISIT	(5)	10	15	
	DISCUSSED WITH MD WHEN TO ARRIVE AT PATIENTS HOME	5	10	15	
	CALL TO PHARMACY TO ORDER MEDICATION	5	10	15	
	MEDICATION REFILL REQUEST PER PATIENT	5	10	15	
	RECEIVE CALL FROM HHA FOR CONFIRMATION OF MD ORDERS	5	10	15	
	HHA CALLED TO INFORM THAT PATIENT HAS AN	5	10	15	
	OCCUPATIONAL/PHYSICAL THERAPY EVALUATION	5	10	15	
	PHONE CALL TO PHYSICIAN	5	10	15	
	PLAN OF CARE	5	10	15	
	RECERTIFICATION ORDER RECEIVED	5	10	15	
	RELAYED LAB RESULTS	5	10	15	
	ROC ORDERED RECEIVED	5	10	15	
	SOC ORDER RECEIVED	5	10	15	
	NEW ORDER FROM MD REGARDING NEW MEDS	5	10	15	
	PHONE CALL TO MD TO CHANGE MEDICATION	5	10	15	
	TALKED TO NURSE REGARDING PATIENT & HEALTH	5	10	(15)	
	REVIEW WITH MD PATIENT'S PROGRSS	5	10	15	
	RCVD CALL FROM HH CLIENT NEEDS BLOOD WORK	5	10	15	
	D/C ORDER RECEIVED	5	10	15	
	DISCUSSED CHANGE IN PATIENT CONDITION	5	10	15	
	MISSED VISITS	5	10	15	
	NEW ORDERS RECEIVED	5	10	15	
	PATIENT TRANSFERRED TO HOSPITAL/FACILITY	5	10	15	

54. Ayeni instructed office staff members to fill out and mark the CPO logs. The staff members selected activities and time amounts based upon what those non-physician staff members thought was likely to have occurred, not based upon any information provided by the physician. These logs were often filled out long after the oversight month in question. One staff member ultimately created a variety of templates that were blank as to the patient involved but had pre-marked activity and "time spent" selections, and then used those templates for preparing the CPO Logs to maintain in the file.

55. Although the CPO logs ostensibly regarded a provider's professional services, they were not dictated nor prepared by providers. They were often not signed by the providers whose time was being accounted for. A biller who prepared many of the CPO logs, at the direction of Ayeni, regularly signed doctors' names herself, followed by a slash mark and her initials. Koroma pre-signed CPO log forms that had activity- and time-spent selections, but did not have any patient information.

56. These CPO logs were not actually used to determine billing for care plan oversight/G0181, but were created after the fact. CPO/G0181 billing was automatic at Docs at the Door for all patients seen in a particular month.

57. Ajibola Ayeni instructed staff to create this false documentation and submit the false claims despite the fact that he knew that he could not claim G0181 for office staff administrative work. Indeed, Ayeni received and forwarded an email chain in June 2013, which included the statements of other providers, making clear that care plan oversight/G0181 could not be billed for staff administrative work or even in-office provider communications with staff but instead must be based upon the physician's own time spent, for example, in complex care coordination with a patient's other providers (from other offices/specialties).

58. Docs at the Door, at the direction of Ajibola Ayeni, even submitted to Medicare months' worth of claims for care plan oversight/G0181 services purportedly provided to hundreds of patients by a physician who had resigned months before.

59. Docs at the Door, at the direction of Ajibola Ayeni, submitted thousands of false G0181 claims to Medicare, 5,730 of which were paid at approximately $90 per claim, for a total reimbursement by Medicare of more than half a million dollars.

60. On August 3, 2017, a federal grand jury in this district returned a criminal indictment against Ajibola Ayeni on twelve counts of health care fraud under 18 U.S.C. §1347 for his knowing and willful execution of a scheme in which he caused to be submitted to the Medicare program claims seeking payment for care-plan oversight services, when those services had not been rendered. No plea has been entered, and no trial date has been set.

D. Examples of Fraudulent Claims

61. **Patient A**

a. Both Docs at the Door and Gateway submitted false and fraudulent claims to Medicare for home visiting physician services and home health services for Patient A, who was not confined to the home or unable to attend office visits with a primary care physician. On the contrary, during the time each of the defendant companies was providing him with services, Patient A regularly left his home safely, including to go camping on numerous occasions with his spouse (who is Patient B), and drove long distances to see his preferred physician for in-office visits.

b. After Koroma was charged with fraud in connection with Mobile Doctors in August 2013 and no longer working full time for them, he had more time to perform home visits for Docs at the Door, and even he—in March 2014—documented that Patient A was fully ambulatory, not homebound, and "not now a candidate for our services." In June 2014,

he again noted that Patient A was "still fully ambulatory" and wrote in the notes, "please ask another provider to continue to see this patient." Regardless, Koroma and Turner-Ayeni signed certifications for home health services for Patient A on June 1 and July 31, 2014.

c. Docs at the Door physicians falsely certified Patient A for home health services beginning on December 3, 2010, under CPT code G0180 and then recertified his eligibility for those services under G0179 on February 1, 2011, April 2, 2011, June 1, 2011, and then discharged him. Docs at the Door then certified Patient A anew for home health services on September 2, 2011, under G0180 and recertified him on November 1, 2011, December 31, 2011, February 29, 2012, April 29, 2012, and June 28, 2012. Patient A was subsequently discharged, then later recertified on June 1, July 31, and September 29, 2014, each time with the 485 form signed by Koroma and Turner-Ayeni. All of these certifications and re-certifications of homebound status for home health services were performed and claimed by Docs at the Door despite Patient A not qualifying for these services because he was not confined to his home.

d. In addition, Docs at the Door submitted claims to Medicare for numerous home physician visits to Patient A, beginning in August 2010 and ending in September 2014. These were falsely claimed and upcoded using codes 99344 or 99349. Docs at the Door also submitted claims for other add-on services for Patient A.

e. In that same period, from 2010 through September 2014, Patient A attended 35 in-office physician visits that were claimed to Medicare. In some months that Docs at the Door physicians visited Patient A at home, he also made an office visit to his regular physician. As an example, a claim was submitted to Medicare for an office physician visit by Patient A on September 17, 2012, and then Docs at the Door submitted a claim under 99349 for a home visit on October 13,

2012, followed shortly by another claim for an in-office physician visit on October 26, 2012, and then another Docs at the Door home visit, claimed under 99349, on November 9, 2012.

f. Docs at the Door also submitted at least 16 care plan oversight/G0181 claims to Medicare for services not provided to Patient A. Medicare paid more than $1,431 for those false G0181 claims. In all, Medicare paid Docs at the Door approximately $4,433 on its false or fraudulent claims submitted for home physician services purportedly provided to Patient A.

g. Gateway likewise submitted false claims to Medicare for medically unnecessary home health services for Patient A. Joy Turner-Ayeni personally signed Patient A's certifications and recertifications for home health services on October 4, 2013 (for start of care), November 29, 2013, January 31, 2014, March 29, 2014, June 1, 2014, July 31, 2014, and September 29, 2014, and signed Patient A's discharge on November 25, 2014, because he had achieved "max potential." Turner-Ayeni then signed off on Patient A's December 4, 2015 start of care, and then his January 29, 2016 discharge, and then once again his March 26, 2016 start of care, which falsely stated that Patient A was unable to safely leave home unassisted. Turner-Ayeni again signed off on Patient A's discharge from Gateway again in May 2016, because he lacked a physician order for home health services. Gateway was paid $46,480 by Medicare for false or fraudulent home health services purportedly provided to Patient A.

62. **Patient B**

a. Both Docs at the Door and Gateway submitted false and fraudulent claims to Medicare for home visiting physician services and home health services for Patient B, who was not confined to the home or unable to attend office visits with a primary care physician. On the contrary, during the period when she was receiving services from both defendant companies, Patient B regularly left her home safely, including to go camping with her spouse (who is Patient

A), approximately two hours away from her primary residence. She also drove significant distances to see her preferred physician for in-office visits.

b. Despite this, Docs at the Door physicians certified or recertified Patient B for home health services 18 times, beginning in August 2010 and continuing through July 2015. All but two of the claims reflect Koroma as the certifying physician. All of those certifications and re-certifications of homebound status for home health services were carried out and claimed by Docs at the Door despite Patient B not qualifying for those services, because she did not need them and was not homebound.

c. In addition, Docs at the Door submitted claims to Medicare for 29 home physician visits to Patient B, beginning in August 2010 and continuing through September 2015. Docs at the Door falsely claimed codes 99344 or 99349 for those visits. Docs at the Door also submitted claims for other add-on services for Patient B.

d. In that same period, from August 2010 through September 2015, Patient B attended 69 in-office physician visits. In many months that Docs at the Door physicians visited Patient B at home, Patient B had made an office visit to her regular physician within weeks or even days of that home visit. Docs at the Door also was paid by Medicare for at least 26 care plan oversight/G0181 claims for services not provided to Patient B. Medicare paid more than $2,320 for those false G0181 claims. The total paid by Medicare to Docs at the Door for all of the false or fraudulent claims submitted for services purportedly provided to Patient B was approximately $6,613.

e. Gateway likewise submitted false claims to Medicare for unnecessary home health services for Patient B. Joy Turner-Ayeni personally signed Patient B's certifications and recertifications for those services on October 4, 2013 (for start of care), November 29, 2013,

January 31, 2014, March 29, 2014, and July 30, 2014, and signed her discharge on November 25, 2014, because purportedly she then had achieved "max potential" like her spouse, Patient A, on the same date. Turner-Ayeni then signed off on Patient A's January 9, 2015 start of care, and falsely assessed Patient A as needing assistance with all activities. Turner-Ayeni then signed off on six more recertifications in support of home health services until discharging Patient A on March 3, 2016. Two weeks later, on March 19, 2016, Turner-Ayeni began home health care again for Patient A, again falsely stating that she needed assistance with all activities. She then recertified home health services for Patient B on May 13, 2016, but discharged her again a few days later, stating that the discharge was due to failure to have a physician order for home health services.

f. Medicare paid Gateway a total of approximately $85,325 for the false or fraudulent claims submitted for home health services purportedly provided to Patient B.

63. **Patient C**

a. Both Docs at the Door and Gateway submitted false and fraudulent claims to Medicare for home visiting physician services and home health services for Patient C, who was not confined to the home or unable to attend office visits with a primary care physician. On the contrary, while receiving services from each of the defendant companies, Patient C regularly left his home safely unassisted, including to drive around his neighborhood for social reasons, and drove to see his primary physician once every three months. He also climbed the stairs in his home daily.

b. Patient C was referred to Docs at the Door by Joy Turner-Ayeni. He did not have home visiting physician or home health services before or after he was serviced by Docs

at the Door and Gateway. Patient C ultimately asked for the visits to stop because he found them unnecessary.

c. Despite this, Docs at the Door physicians certified or recertified Patient C for home health services 22 times, beginning in May 2011 and continuing through April 2015. All but one of the claims submitted to Medicare reflect Koroma as the certifying physician. All of these certifications and re-certifications of homebound status for home health services were carried out and claimed by Docs at the Door despite Patient C not qualifying for these services because he did not need them and was not homebound.

d. In addition, Docs at the Door submitted claims to Medicare for 40 home physician visits to Patient C beginning in May 2011 and continuing through April 2015. Docs at the Door falsely claimed codes 99344 or 99349 for those visits. Docs at the Door also submitted claims for other add-on services for Patient C.

e. Patient C has identified Ayeni as the only physician who visited his home from Docs at the Door. Ayeni is not a licensed physician in Illinois, thus all those claims are false because they were not provided by a licensed physician and not provided by the physician stated on the claim.

f. In that same period, from May 2011 through April 2015, Patient C attended 123 in-office physician visits. In many months that Docs at the Door physicians visited Patient C at home, Patient C had made an office visit to his regular physician within weeks or even days of that home visit. Docs at the Door also was paid by Medicare for 41 care plan oversight/G0181 claims for services not provided to Patient C. Medicare paid more than $3,663 for those false G0181 claims. The total paid by Medicare to Docs at the Door for all of the false or fraudulent claims submitted for services purportedly provided to Patient C was approximately $11,160.

g. Gateway likewise submitted false claims to Medicare for unnecessary home health services for Patient C, who was not confined to the home. Joy Turner-Ayeni personally signed Patient C's certifications and recertifications for those services on October 14, 2013 (for start of care), December 12, 2013, and February 2, 2014, stating falsely on each that Patient C was unable to leave his home safely. On October 23, 2014, Turner-Ayeni noted Patient C's discharge because he refused further care. On February 27, 2015, she again falsely documented, in connection with starting care again, that Patient C was unable to leave the home unassisted and required assistance to walk. On October 5, 2015, Turner-Ayeni discharged Patient C for "failure to maintain service of a doctor."

h. The total paid by Medicare for the false or fraudulent claims submitted for home health services purportedly provided to Patient C by Gateway was approximately $84,197.

64. **Patient D**

a. Both Docs at the Door and Gateway submitted false and fraudulent claims to Medicare for home visiting physician services and home health services for Patient D, who was not confined to the home or unable to attend office visits with a primary care physician. On the contrary, while receiving services from each of the defendant companies, Patient D regularly left her home safely unassisted, including traveling on public transit and shopping at Walmart.

b. Despite this, Docs at the Door physicians certified or recertified Patient D for home health services seven times, beginning in April 2012 through October 2013. Five of those sevens claims submitted to Medicare reflect Koroma as the certifying physician. All of these certifications and re-certifications of homebound status for home health services were carried out and claimed by Docs at the Door despite Patient D not qualifying for these services, because she did not need them and was not homebound.

c. In addition, Docs at the Door submitted claims to Medicare for 15 home physician visits to Patient D, beginning in February 2012 and continuing until January 2014. Docs at the Door falsely claimed codes 99344 or 99349 for those visits. Docs at the Door also submitted claims for other add-on services for Patient D.

d. In that same period of time, Patient D attended 10 in-office physician visits. In many months that Docs at the Door physicians visited Patient D at home, Patient D had made an office visit to her regular physician within weeks and even days of that home visit. Docs at the Door also was paid by Medicare for 21 care plan oversight/G0181 claims for services not provided to Patient D. Medicare paid more than $1,873 for those false G0181 claims. Medicare paid Docs at the Door approximately $4,880 for all of the false or fraudulent claims it submitted for services purportedly provided to Patient D.

e. Gateway likewise fraudulently provided and claimed to Medicare for unnecessary home health services for Patient D, who was not confined to the home. Joy Turner-Ayeni falsely stated in assessments on April 6, 2012, May 31, 2012, August 3, 2012, November 30, 2012, January 29, 2013, and May 28, 2013, that Patient D was unable to safely leave home unassisted. On August 26, 2013, Turner-Ayeni documented discharge of Patient D based on "patient/family request" and "geographic relocation for next 4-5 weeks."

f. Medicare paid Gateway approximately $30,153 for the false or fraudulent claims submitted for home health services purportedly provided to Patient D.

65. **Patient E**

a. Both Docs at the Door and Gateway submitted false and fraudulent claims to Medicare for home visiting physician services and home health services for Patient E while she was not confined to the home or unable to attend office visits with a primary care physician. On

the contrary, according to a physician who saw Patient E on behalf of Docs at the Door, Patient E had a driver's license and drove to other provider appointments. Docs at the Door had trouble scheduling visits to Patient E because she was often not at home. At one point, Patient E stated that she did not want to receive home health services. Ayeni asked the contractor physician to convince Patient E to accept home health services. That physician informed Ayeni that Patient E did not need those services and even drove herself around.

b. Despite this, Docs at the Door and Gateway continued to submit false claims for medically unnecessary services for Patient E for years following that conversation. In all, Docs at the Door physicians certified or recertified Patient E for home health services 14 times, beginning in November 2011 through August 2015. All but one of those claims identified Koroma as the certifying physician. All of these certifications and re-certifications of homebound status for home health services were carried out and claimed by Docs at the Door, despite Patient E not qualifying for these services because she was not homebound.

c. In addition, Docs at the Door submitted claims to Medicare for 34 home physician visits to Patient E, beginning in October 2011 and continuing until December 2015. Docs at the Door falsely claims codes 99344 or 99349 for all of those visits. Docs at the Door also submitted claims for other add-on services for Patient E.

d. In that same period of time, Patient E attended 37 in-office physician visits. In many months that Docs at the Door physicians visited Patient E at home, Patient E had made an office visit to her regular physician within weeks and even days of that home visit.

e. Docs at the Door also was paid by Medicare for 37 care plan oversight/G0181 claims for services not provided to Patient E. Medicare paid more than $3,302

for those false G0181 claims. In all, Medicare paid Docs at the Door approximately $8,358 for all of the false or fraudulent claims it submitted for services purportedly provided to Patient E.

f. Gateway likewise fraudulently submitted claims to Medicare for years of medically unnecessary home health services for Patient E, who was not confined to the home. Joy Turner-Ayeni signed numerous false 485s, supporting the false physician's certification for home health services for Patient E. Medicare paid Gateway approximately $35,475 for the false or fraudulent claims submitted for home health services purportedly provided to Patient E.

66. **Patient F**

a. Both Docs at the Door and Gateway submitted false and fraudulent claims to Medicare for home visiting physician services and home health services for Patient F, who was not confined to the home or unable to attend office visits with a primary care physician. On the contrary, during the period she was receiving services from each of the defendant companies, Patient F had no issues walking, did not use a walker or cane, and had no difficulties with the activities of daily living, including feeding, toileting, bathing, or dressing.

b. Despite this, Docs at the Door physicians certified or recertified Patient F for home health services four times, from December 2011 through June 2012, and then four more times, from January through July 2015. All of these certifications and re-certifications of homebound status for home health services were carried out and claimed by Docs at the Door despite Patient F not qualifying for these services because she was not homebound.

c. In addition, Docs at the Door submitted claims to Medicare for 22 home physician visits to Patient F, beginning in December 2011 and continuing through December 2015. Docs at the Door falsely claimed codes 99344 or 99349 for those visits. Docs at the Door also submitted claims for other add-on services for Patient F.

d. In that same period of time, Patient F attended 13 in-office physician visits. In some of the months that Docs at the Door physicians visited Patient F at home, Patient F had made an office visit to her regular physician within weeks or even days of that home visit. Docs at the Door also was paid by Medicare for at least 20 care plan oversight/G0181 claims for services not provided to Patient F. Medicare paid more than $1,777 for those false G0181 claims. The total paid by Medicare to Docs at the Door for all of the false or fraudulent claims submitted for services purportedly provided to Patient F was approximately $7,251.

e. Gateway likewise fraudulently submitted claims to Medicare for medically unnecessary home health services for Patient F. Joy Turner-Ayeni prepared and signed Patient F's assessments associated with certifications or recertifications for those services, including preparing and signing a false assessment on January 8, 2015, in order to restart Patient F's home health services. On that form, Turner-Ayeni false stated that Patient F was unable to leave her home safely unassisted and required assistance to ambulate.

f. In total, Medicare paid Gateway $53,924 for the false or fraudulent claims submitted for home health services purportedly provided to Patient F, who did not qualify for those services.

III. The Fraudulent Transfers

67. The Ayenis own numerous real properties. However, in July 2016, they transferred several of those properties into trusts for no consideration. At that time, Ajibola Ayeni had been aware of the health care fraud investigation into his and Docs at the Door's activities since September 2015. Also, at the time of the transfer, Gateway, owned by Ayeni and Joy Turner-Ayeni, knew that the United States Attorney's Office had inquired as to whether Docs at the Door and Gateway had the same counsel.

68. In particular, the United States served two civil investigative demands on Docs at the Door on September 16, 2015. The CIDs stated on their face that they were issued in connection with an investigation under the False Claims Act regarding whether false claims were being submitted for physician home visit services and home health services. Through counsel, Docs at the Door began responding to the CIDs. On June 29, 2016, in anticipation of serving a CID on Gateway, the United States Attorney's Office inquired of Docs at the Door's counsel as to whether she also represented Gateway. After conferring with her client, she responded on July 6, 2016, that she did not represent Gateway.

69. On August 16, 2016, the Ayenis transferred the following of their properties through deeds in trust to Trust No. BEV-4104, under a trust agreement dated July 12, 2016, with The Chicago Trust Company, N.A. as trustee:

a. 20534 Abbey Drive, Frankfort, Will County, Illinois 60423

b. 22592 Cobble Stone Trl., Frankfort, Will County, Illinois 60423

c. 4178 S Drexel Blvd., Unit 2, Chicago Illinois 60653

d. 5415 N Sheridan Rd., Apt 2701, Chicago, Illinois 60640

70. On August 16, 2016, they also transferred their primary residence, 4 Gianna Ct., Flossmoor, Cook County, Illinois 60422, through a deed in trust to Trust No. BEV-4105, under a trust agreement dated July 12, 2016, with The Chicago Trust Company, N.A. as trustee.

71. Upon information and belief, all of these transfers were done for no consideration.

72. At the time of those transfers, they Ayenis were years into the fraudulent scheme described above. They either intentionally transferred the properties to avoid paying a judgment to the United States for their fraud, or at a minimum, knew that they had incurred debts that they

would not be able to pay, including but not limited to the debts they incurred to the United States, as a result of the fraud schemes alleged in this complaint.

Count I

Violations of the False Claims Act
(31 U.S.C. § 3729(a)(1)(2006), and, as amended, 31 U.S.C. § 3729(a)(1)(A))
Causing False Claims to Be Presented

73. The United States incorporates by reference paragraphs 1 through 72 as if fully set forth in this paragraph.

74. As set forth above, defendants knowingly or with deliberate ignorance or reckless disregard for the truth, presented, or caused to be presented, to an officer, employee, or agent of the United States, or a contractor thereof, false or fraudulent claims that were paid with federal funds. Those claims were false or fraudulent because they were for services not rendered as well as for services and claims in violation of applicable Medicare requirements.

75. Defendants' fraudulent conduct caused false claims to be presented to Medicare contractors for payments of federal funds.

76. The United States made payments to Docs at the Door and Gateway Health Systems, because of the false or fraudulent claims caused by defendants.

77. Pursuant to the False Claims Act, the defendants are liable to the United States under the treble-damage and civil-penalty provisions of the False Claims Act for a civil penalty of not less than $5,500 and not more than $11,000 for each of the false or fraudulent claims herein, plus three times the amount of damages that the United States has sustained because of the defendants' actions.

Count II

Violations of the False Claims Act
(31 U.S.C. § 3729(a)(2)(2006), and, as amended, 31 U.S.C. § 3729(a)(1)(B))
Use of False Statements

78. The United States incorporates by reference paragraphs 1 through 77 as if fully set forth in this paragraph.

79. As set forth above, defendants knowingly or with deliberate ignorance or reckless disregard of the truth, made, used, and caused to be made and used, false records and statements material to false or fraudulent claims in connection with their claims for payment of federal funds for home visiting physician and home health services.

80. Defendants made and/or caused to be made numerous false records and statements, including false statements that individuals were homebound and specific false statements about those patients' conditions. As a result of these false records and statements, false claims for payment were submitted to Medicare contractors by Docs at the Door and Gateway.

81. The United States paid such false or fraudulent claims because of the acts and conduct of defendants.

82. By reason of defendants' false statements and false claims, the United States has been damaged in a substantial amount to be determined at trial.

Count III

Fraudulent Transfers under 28 U.S.C. § 3304(b)(1)(A)

83. The United States incorporates by reference paragraphs 1 through 82 as if fully set forth in this paragraph.

84. The Ayenis transferred their real properties into trusts with actual intent to hinder, delay or defraud the United States inasmuch as the transfers occurred after the Ayenis had become

aware that the United States was investigating them in connection with their fraudulent billing practices (*see* 28 U.S.C. § 3304(b)(2)(D)); upon information and belief, they received no consideration at the time the transfer occurred (*see* 28 U.S.C. § 3304(b)(2)(H)); the Ayenis continue to reside at the 4 Gianna Court property after the transfer (*see* 28 U.S.C. § 3304(b)(2)(B)); the Ayenis placed title to multiple parcels of real estate in land trusts concealing their interest in the real estate (*see* 28 U.S.C. § 3304(b)(2)(G)); and, at the time of the transfers, the Ayenis believed or reasonably should have believed that they would incur debts beyond their ability to pay (*see* 28 U.S.C. § 3304(b)(2)(J),

85. Ajibola Ayeni and Joy Turner-Ayeni committed the above acts and omissions in violation of 28 U.S.C. § 3304(b)(1)(A).

86. Accordingly, the transfers should be voided pursuant to 28 U.S.C. § 3306(a)(1).

WHEREFORE, the United States requests that judgment be entered in its favor, as follows:

a. On Counts One and Two (False Claims Act), judgment for the United States against each of the defendants, jointly and severally, treble the government's damages, and civil penalties for the maximum amount allowed by law;

b. On Count Three (Fraudulent Transfers), voiding the transfers from Ajibola Ayeni and Joy Turner-Ayeni, to the extent necessary to satisfy the debts owing to the United States;

c. For an award of costs pursuant to 31 U.S.C. § 3729(a); and

d. For such further relief as is proper.

Respectfully submitted,

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