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U.S. DISTRICT COURT
EASTERN DISTRICT OF LA.
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CAROL L. MICHEL
CLERK

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

FELONY

INDICTMENT FOR
HEALTH CARE FRAUD AND NOTICE OF FORFEITURE

UNITED STATES OF AMERICA	*	**CRIMINAL NO.** 21-98
v.	*	**SECTION:** SECT. I MAG. 4
SHIVA AKULA	*	**VIOLATION: 18 U.S.C. § 1347**
	*	

* * *

The Grand Jury charges that:

COUNTS 1-23
(Health Care Fraud)

A. AT ALL TIMES MATERIAL HEREIN:

1. Canon Healthcare, LLC provided hospice care to patients in Louisiana and elsewhere. **SHIVA AKULA** owned and oversaw the day-to-day operations of Canon Healthcare ("Canon").

2. Medicare is a "health care benefit program," as defined by Title 18, United States Code, Section 24(b).

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3. To participate in Medicare, providers are required to submit an enrollment application. By becoming a participating provider in Medicare, enrolled providers agree to abide by the policies and procedures, rules, and regulations governing reimbursement. To receive Medicare funds, enrolled providers, together with their authorized agents, employees, and contractors, are required to abide by all provisions of the Social Security Act, the regulations promulgated under the Act, and applicable policies, procedures, rules, and regulations issued by the Centers for Medicare and Medicaid Services (CMS) and its authorized agents and contractors.

4. Health care providers can only submit claims to Medicare for medically necessary services they render. Medicare regulations require health care providers to maintain complete and accurate patient medical records to verify that the services were provided as described in the claim. These records are required to be sufficient to permit Medicare, through its contractors, to review the appropriateness of Medicare payments made to the health care provider.

5. Common Procedural Terminology (CPT) codes are written by the American Medical Association (AMA) and are published yearly. The AMA codebook is a listing of descriptive items and identifying codes for reporting medical services and procedures performed by medical providers.

6. Title XVIII of the Social Security Act, Section 1861(dd), established the Medicare provision of hospice care. Section 1861(dd)(1) defines "hospice care" to include services and items provided to a terminally-ill individual by, or by others under arrangements made by, a hospice program under a written plan (for providing such care to such individual) established and periodically reviewed by the individual's attending physician, the medical director and the interdisciplinary group (IDG) coordinating the care.

7. Most hospice care is considered routine care and is provided to the beneficiary in their home. However, there are times while under hospice care, that the beneficiary needs

additional services, and the Medicare hospice benefit allows for these needs by providing additional levels of care. When a beneficiary needs additional services, or another level of care, it should be clear in the documentation what precipitated the change, and any attempts to maintain the beneficiary in routine care prior to the change. There are three additional levels of care: continuous home care, general inpatient (GIP), and respite care.

8. Continuous home care is to be provided only during periods of crisis to maintain a beneficiary at their home. GIP is available to all hospice beneficiaries who are in need of pain control or symptom management that cannot be provided in any other setting. Inpatient respite care is provided to the beneficiary only when necessary to relieve the family members or other caregivers that are caring for the beneficiary at home. Coverage for respite care does not require a worsening of the beneficiary's condition. Respite care is short-term inpatient care and is reimbursed for no more than five consecutive days per respite period.

9. To be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. An individual is considered to be terminally ill if the medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

10. Section 1814(a)(7) of the Social Security Act specifies that certification of a terminal illness for hospice benefits must be based on the clinical judgment of the hospice medical director or physician member of the interdisciplinary group (IDG) coordinating care and the individual's attending physician, if he/she has one, regarding the normal course of the individual's illness. No one other than a medical doctor or doctor of osteopathy can certify or re-certify a terminal illness.

11. For an individual to receive covered hospice services, a certification of the individual's terminal illness must have been completed, and a plan of care ("POC") established

before services are provided. Services must be consistent with the POC and reasonable and necessary for the palliation or management of the terminal illness and related conditions.

12. An individual (or his/her authorized representative) must elect to receive hospice care. The first election is for a 90-day period. An individual may elect to receive Medicare coverage for two 90-day periods and an unlimited number of subsequent 60-day periods. If the individual (or his authorized representative) elects to receive hospice care, he or she must file an election statement with a particular hospice.

13. The election statement includes the following information:

a. Identification of the particular hospice that will furnish care to the individual;

b. The individual's or representative's (if applicable) acknowledgment that, based on the education received, the patient has a full understanding of the palliative rather than curative nature of hospice services;

c. The individual's or representative's (if applicable) acknowledgment that, he or she understands that certain Medicare services are waived by the election;

d. Effective date of the election;

e. Signature of the individual or representative.

14. The election statement must include the individual's choice of attending physician. The information identifying the attending physician should be recorded on the election statement in enough detail so that it is clear which physician or nurse practitioner was designated as the attending physician.

15. An individual must waive all rights to Medicare Part B payments for the duration of the election of hospice care for services that are related to the treatment of the terminal illness and related conditions.

16. For the first 90-day period of hospice coverage, the hospice must obtain, no later than two calendar days after hospice care is initiated, (that is, by the end of the third day), oral or

written certification of the terminal illness by the medical director of the hospice or the physician member of the hospice IDG, and the individual's attending physician if the individual has an attending physician.

17. Initial certifications may be completed up to 15 days before hospice care is elected. For any subsequent periods, recertification may be completed up to 15 days before the next benefit period begins. The hospice must obtain, no later than two calendar days after the first day of each period, a written certification statement from the medical director of the hospice or the physician member of the hospice's IDG. Subsequent certifications must be written and on file in the hospice patient's record prior to submission of a claim to the Medicare contractor.

18. A hospice physician or hospice nurse practitioner was required to have a face-to-face encounter with each hospice patient prior to the beginning of the patient's third benefit period, and prior to each subsequent benefit period. Failure to meet the face-to-face encounter requirements results in a failure by the hospice to meet the patient's recertification of terminal illness eligibility requirement. The patient would cease to be eligible for the benefit.

19. Written certification of the terminal illness must be on file in the hospice patient's record prior to the submission of a claim to the Medicare contractor. The written certification must include:

a. The statement that the individual's medical prognosis is such that their life expectancy is six months or less if the terminal illness runs its normal course;

b. Specific clinical findings and other documentation supporting a life expectancy of six months or less; and

c. The signature(s) of the physician(s), the date signed, and the benefit period dates that the certification or recertification covers.

20. A hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient prior to the beginning of the patient's third benefit period, and

prior to each subsequent benefit period. Failure to meet the face-to-face encounter requirements results in a failure by the hospice to meet the patient's recertification of terminal illness eligibility requirement. The patient would cease to be eligible for the benefit.

21. The hospice benefit is available only to individuals who are terminally ill; therefore, a hospice is unable to recertify a beneficiary who is no longer considered terminally ill. The hospice will notify the Medicare contractor of any discharge so that hospice services and billings are terminated as of that date. Discharge from hospice will occur as a result of one of the following if and/or when:

a. The beneficiary decides to revoke the hospice benefits;

b. The beneficiary moves away from the geographic area of the hospice;

c. The beneficiary transfers to another hospice;

d. The beneficiary's condition improves and is no longer considered terminally ill;

e. The beneficiary is discharged for cause. There may be extraordinary circumstances in which a hospice would be unable to continue to provide hospice care to a patient. These situations would include issues where patient safety or hospice staff safety is compromised; or

f. The beneficiary dies.

22. Hospices are paid a per diem rate based on the number of days and level of care provided during the election period. The daily payments are made regardless of the amount of services furnished on a given day and are intended to cover costs that the hospice incurs in furnishing services identified in the patient's POC, including services provided directly or arranged by the hospice. Payments are made based on the level of care required to meet the patient and family needs.

23. The following services performed by hospice physicians and NPs are included in the rates described in hospice payments:

a. General supervisory services of the medical director.

b. Participation in the establishment in the plan of care, supervision of care and services, periodic review and updating the plan of care, and establishment of governing policies by the physician member of the IDG.

24. The daily reimbursement rate for respite care from 2015 to 2017 was between $164.81 and $170.97. GIP for that same time period ranged from $708.77 to $734.94 per day.

25. CPT Code 99233 is an evaluation and management code, which requires two of the three following components: (1) detailed interval history; (2) detailed examination; or (3) medical decision making of a high complexity. Usually, the beneficiary is unstable or has developed a significant complication or a significant new problem.

26. CPT Code 99236 should only be billed when a patient is admitted to inpatient hospital care for a minimum of 8 hours, but less than 24 hours and discharged on the same calendar day. In addition, when billing for CPT Code 99236, the physician shall identify that he or she was physically present and that he or she performed the initial hospital care service. The physician shall personally document the admission and discharge notes and include the number of hours the beneficiary remained in inpatient hospital status.

27. CPT code 99350 is used to bill a home visit for the evaluation and management of an established beneficiary and requires two of these three components: (1) a comprehensive interval history; (2) a comprehensive examination; and (3) medical decision making of moderate to high complexity. Importantly, a home visit cannot be billed by a physician unless that physician was actually present in the beneficiary's home performing the examination.

B. THE SCHEME AND ARTIFICE TO DEFRAUD:

It was part of the scheme and artifice to defraud that **AKULA** unlawfully enriched himself by submitting and causing the submission of false and fraudulent claims to health care benefit programs, to include Medicare.

It was further part of the scheme and artifice to defraud that **AKULA** instructed Canon employees to improperly bill for GIP to maximize reimbursement from health care benefit programs, knowing that those services were not medically necessary.

It was further part of the scheme and artifice to defraud that **AKULA** instructed Canon employees to admit the beneficiary, and then billed automatically that beneficiary at the GIP rates.

It was further part of the scheme and artifice to defraud that Canon routinely billed physician services with CPT Code 99233 for beneficiaries who were receiving GIP services, in addition to the daily per diem rate.

It was further part of the scheme and artifice to defraud that Canon routinely billed for physician services for CPT Code 99236 for beneficiaries who were admitted into GIP and remained on GIP for more than 24 hours.

It was further part of the scheme and artifice to defraud that from on or about January 1, 2013, to on or about August 25, 2017, Canon submitted approximately 1,053 claims for CPT code 99236 and was paid approximately $223,601 by Medicare. During that same time period, Canon submitted approximately 23,000 claims to Medicare for CPT code 99233 and was paid approximately $2,281,251. These physician services reflected in CPT Codes 99236 and 99233 should not have been billed as a separate line item in addition to the GIP services because they were included within the daily per diem rate that Medicare paid for the GIP services.

It was further part of the scheme and artifice to defraud that from on or about January 1, 2013, through on or about August 25, 2017, Canon submitted claims to Medicare for

approximately 1,949 home visits using CPT code 99350 that were purported to have been performed by a doctor, when a doctor did not perform home visits. As a result of these 1,949 home visits, Medicare reimbursed Canon approximately $316,384.

From January 2013 to December 2019, Canon billed Medicare approximately $62,833,346.28 and was paid approximately $47,106,838.94.

C. THE OFFENSES:

On or about the dates and in the approximate amounts set forth below, in the Eastern District of Louisiana and elsewhere, the defendant **SHIVA AKULA**, for the purpose of executing and attempting to execute the fraudulent scheme described above, knowingly and willfully submitted or caused to be submitted claims for payment for the following false and fraudulent claims:

Counts 1-8

COUNT	BENEFICIARY	GIP DATES	TOTAL AMOUNT PAID
1		6/1/2017 – 6/30/2017	$19,741
2		7/1/2017 – 7/31/2017	$20,399
3		8/1/2017 – 8/31/2017	$12,502
4		4/24/2017 – 4/30/2017	$4,606
5		5/1/2017 – 5/31/2017	$20,399
6		4/8/2017 – 4/30/2017	$15,135
7		5/1/2017 – 5/31/2017	$5,922
8		6/1/2017 – 6/30/2017	$13,819

Counts 9-11

COUNT	BENEFICIARY	PURPORTED DATE OF SERVICE FOR CPT CODE 99236	TOTAL AMOUNT PAID
9	[redacted]	5/26/2017	$215
10	[redacted]	4/24/2017	$214
11	[redacted]	4/8/2017	$218

Counts 12 - 17

COUNT	BENEFICIARY	PURPORTED DATE OF SERVICE FOR CPT CODE 99233	AMOUNT PAID
12	[redacted]	5/27/2017	$102
13	[redacted]	8/18/2017	$102
14	[redacted]	4/25/2017	$102
15	[redacted]	5/30/2017	$102
16	[redacted]	5/10/2017	$104
17	[redacted]	6/7/2017	$104

Counts 18 - 23

COUNT	BENEFICIARY	PURPORTED DATE OF SERVICE FOR CPT CODE 99350	AMOUNT PAID
18	[redacted]	1/2/17	$140
19	[redacted]	1/11/2017	$140
20	[redacted]	1/13/17	$140
21	[redacted]	1/20/17	$140
22	[redacted]	1/13/17	$140
23	[redacted]	1/20/17	$140

All in violation of Title 18, United States Code, Section 1347.

NOTICE OF FORFEITURE

1. The allegations of Counts 1-23 of this Indictment are incorporated by reference as though set forth fully herein for the purpose of alleging forfeiture to the United States.

2. As a result of the offenses alleged in Counts 1-23, the defendant, **SHIVA AKULA**, shall forfeit to the United States pursuant to Title 18, United States Code, Section 982(a)(7), any property, real or personal, involved in said offenses, and any property traceable to such property.

3. If any of the above-described property, as a result of any act or omission of the defendant:

a. cannot be located upon the exercise of due diligence;

b. has been transferred or sold to, or deposited with, a third person;

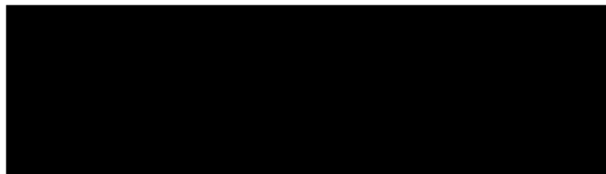
c. has been placed beyond the jurisdiction of the Court;

d. has been substantially diminished in value; or

e. has been commingled with other property which cannot be subdivided without difficulty;

the United States shall seek a money judgment and, pursuant to Title 21, United States Code, Section 853(p), forfeiture of any other property of the defendant up to the value of said property.

A TRUE BILL:



DUANE A. EVANS
UNITED STATES ATTORNEY

KATHRYN MCHUGH
Assistant United States Attorney

New Orleans, Louisiana
August 5, 2021