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UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
SOUTHERN DIVISION

NO. 7:09-CR-155-1H

UNITED STATES OF AMERICA)
)
) I N F O R M A T I O N
)
JANET JOHNSON-HUNTER)

The United States Attorney charges that:

STATUTORY AND REGULATORY BACKGROUND

At all times material to this Information:

1. Medicare was a federally funded, national health care benefit program administered through the United States Department of Health and Human Services (HHS). Medicare provided benefits for the elderly, certain disabled people, and persons with permanent kidney failure.

2. Medicare had three components, part "A," part "B," and part "C." Part "B" pertained to services rendered to out-patients, and provided payment for medically necessary physician, laboratory, and other provider services. Part "B" funds were distributed through a Medicare carrier, which is a private insurance company under contract with the federal government to process claims for services billed by physicians, laboratories, and other providers. Medicare designated Connecticut General Life Insurance Company, a division of Connecticut Insurance Group of North America (CIGNA),

as the Medicare carrier for North Carolina.

3. Entities that provided services that were reimbursed by Medicare were called Medicare providers. A Medicare provider obtained a unique identification number, called a "provider number," by completing and submitting an application to Medicare. Approved Medicare providers submitted claims for payment to the Medicare carrier either on paper or electronically. If the claim was submitted on paper, it had to be completed on a standardized form called a "HCFA 1500." An electronically submitted claim was submitted through the use of specific billing software and an electronic data interface. Whether submitted on paper or electronically, providers were required to certify that (1) the services provided were medically indicated and necessary, (2) the services were personally provided by the person signing the form, or by one of his/her employees acting under the signer's direction, and (3) the information contained on the form was true, accurate and complete. The provider number was included as a part of each submission.

4. All payments made by Medicare were made to a provider in the form of a United States Treasury check or a pre-arranged direct deposit into the provider's bank account.

5. Medicare reimbursed ambulance transportation services where a beneficiary was bed-confined or the use of other methods of transportation was "contraindicated," or inadvisable, by the

beneficiary's medical condition. Under Medicare regulations, "bed-confined" was defined as relating to a beneficiary who was (1) unable to get out of bed without assistance, (2) unable to "ambulate," or walk, and (3) unable to sit in a chair or wheelchair. The Medicare Manual provided that in any case in which some means of transportation other than an ambulance could be utilized without endangering the patient's health, whether or not such other means of transportation was actually available, no reimbursement may be made by Medicare for the ambulance services. The Manual instructed ambulance service providers to describe on an Ambulance Call Report the clinical conditions which rendered the beneficiary bed-confined or to establish that there was a medical necessity for the use of an ambulance.

6. Medicare did not cover the beneficiary's non-emergency transportation by means other than ambulance. Therefore, transportation by medi-van, taxi, or wheelchair van was not reimbursed to the transportation provider. Medicare regularly issued Bulletins to providers updating them on regulations and guidelines, billing issues, and regulatory reminders, among other things. The Medicare Ambulance Manual specifically stated that, "In most cases, ambulance service is not covered if the patient is ... ambulatory (e.g., If the patient can sit in a chair, he/she can be transported in a private vehicle. If the patient can sit in a wheelchair, he/she can be transported in a medi-van)."

7. Medicaid was a federal-state assistance program providing services to low-income persons of every age. Medicaid was operated by state and local governments within federal guidelines. Medical bills of beneficiaries were paid from federal, state, and local tax funds. Patients generally paid no part of costs for covered medical expenses. The North Carolina Medicaid Program was a federal health care program established under Title XIX of the Social Security Act. Under the Medicaid program, HHS shared with each state and counties the cost of medical and related services to families with dependent children and aged, blind, or disabled individuals whose income and other financial and economic resources were insufficient to allow them to meet the cost of necessary medical services.

8. Under the Medicaid program, each state was required to promulgate a plan for medical assistance and administer its own Medicaid program. North Carolina enacted a statewide medical plan in accordance with the Medicaid Act, and such plan was approved by the Health Care Financing Administration (HCFA), an agency of HHS, as required by law. HHS, through HCFA, administered the Medicaid program at the federal level. The Division of Medical Assistance (DMA) of the North Carolina Department of Health and Human Services was responsible for administering the Medicaid program at the state level. DMA submitted quarterly reports to HHS detailing the amount and nature of Medicaid claims. HHS then reimbursed the federally

qualified Medicaid claims at a set percentage for each dollar paid by North Carolina.

9. Electronic Data Systems (EDS) was employed by DMA as fiscal agent for the purpose of processing Medicaid claims.

10. The Medicaid program provided for the payment of the costs of services to providers, including services provided by ambulance transportation providers, which were reimbursed by DMA for those ambulance transportation services authorized under the Medicaid program by means of claims. Such reimbursement could be made by direct wire deposit to the bank account of the provider or by check mailed to the provider.

11. Under Medicaid, medical necessity requirements had to be met for all non-emergency transports, to include that (1) the patient was bed-confined, and (2) his or her condition must be such that a stretcher is the only safe mode of transportation. Medicaid defines "bed-confined" as the state in which "a patient is unable to get up from bed without assistance, ambulate and sit in a chair, including a wheelchair." It was the ambulance provider's responsibility to assess the patient's medical necessity status and take the necessary and conclusive steps to substantiate the status prior to rendering services, particularly repetitive services, such as dialysis or chemotherapy.

12. Under Medicaid, ambulance technicians were required to complete an Ambulance Call Report (ACR), for each ambulance

transport. According to the Medicaid Manual, "Call reports must support the medical necessity and condition codes billed. A call report must: be legible, include a complete description of recipient at time of transport, include data on how, when, where recipient was found, vital signs, level of consciousness, etc., document all treatments rendered and recipient's response to treatments, [and] describe in sufficient detail recipient's condition to justify transportation could only be made by stretcher."

13. Medicaid did not cover a patient's transportation by means other than ambulance. Therefore, providers were not reimbursed for transportation by medi-van, taxi, or wheelchair van.

FACTUAL BACKGROUND

At all times material to this Information,

14. JANET JOHNSON-HUNTER was a licensed medical doctor who resided in the Eastern District of North Carolina.

15. From at least January of 2002 and continuing through August of 2005, JANET JOHNSON-HUNTER and another owned and operated a private ambulance transportation company referred to herein as "CCI" in the Eastern District of North Carolina.

16. Under the direction of JANET JOHNSON-HUNTER and another, CCI regularly billed Medicare and Medicaid for non-emergency ambulance transportation services.

17. In most instances, the services billed to Medicare and

Medicaid were for the non-emergency ambulance transportation of patients from nursing homes or residences to scheduled appointments at doctors' offices, rehabilitation and physical therapy centers, and dialysis facilities.

COUNT ONE
Conspiracy to Make False Statements
Relating to Health Care Matters
18 U.S.C. § 371

THE CONSPIRACY

Paragraphs 1 through 17 of this Information are re-alleged and incorporated by reference as though fully set forth herein.

Beginning in January of 2002, the exact date unknown, and continuing up to and including August of 2005, within the Eastern District of North Carolina and elsewhere, JANET JOHNSON-HUNTER, defendant herein, did combine, conspire, confederate and agree with co-conspirators known to the United States Attorney to commit an offense against the United States, specifically, in a matter involving a health care benefit program, to knowingly and willfully conceal and cover up by trick, scheme, and device, material facts in connection with the delivery of and payment for health care benefits, items and services, in violation of Title 18, United States Code, Section 1035.

OBJECT OF CONSPIRACY

It was the object of the unlawful conspiracy for JANET JOHNSON-HUNTER and co-conspirators to conceal and cause others to conceal from Medicare and Medicaid material facts in an effort to

maximize likelihood of reimbursement from Medicare and Medicaid to CCI for non-emergency ambulance transportation, and to further maximize the personal wealth of the conspirators.

OVERT ACTS

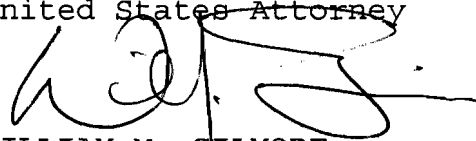
In furtherance of the unlawful conspiracy and to effect the objects thereof, the co-conspirators committed overt acts in the Eastern District of North Carolina and elsewhere, among them:

(1) Between in or about January 2002 and August 2005, JANET JOHNSON-HUNTER and other co-conspirators, directly and through subordinates, instructed employees to omit from Ambulance Call Reports if a patient could sit upright, stand up, walk, or ride in a wheelchair.

(2) Between in or about January 2002 and August 2005, JANET JOHNSON-HUNTER, directly and through subordinates, instructed employees to re-write Ambulance Call Reports to remove references concerning the ability of patients to sit upright, stand, walk, or ride in a wheelchair.

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

GEORGE E.B. HOLDING
United States Attorney



By: WILLIAM M. GILMORE
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