STEPHANIE M. HINDS (CABN 154284)
Acting United States Attorney

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. VERONICA KATZ, and VENNESA HERRERA, Defendant.	CASE NO. 3:21-cr-00310 MMC VIOLATIONS: 18 U.S.C. § 1349 – Conspiracy to Commit Health Care Fraud; 18 U.S.C. § 1347 – Health Care Fraud 18 U.S.C. § 981(a)(1)(C) and 28 U.S.C. § 2461(c) – Forfeiture Allegation SAN FRANCISCO VENUE

INFORMATION

The United States Attorney charges:

Introductory Allegations

1. Defendant Veronica Katz ("KATZ") resided in South San Francisco, California. HealthNow's articles of incorporation list KATZ as HealthNow's president, Chief Executive Officer, and agent for service of process.

2. Defendant Vennesa Herrera ("HERRERA") resided in the Northern District of California and worked as the office manager of HealthNow Home Healthcare, Inc. ("HealthNow").

3. HealthNow was a home health agency ("HHA") located in Hayward, California. California Secretary of State Records indicated that HealthNow was incorporated in 2014 under the name Home Healthcare, Inc. and that in 2015 its name was changed to HealthNow Home Healthcare,

Inc.

4. Pharadja Andrews ("ANDREWS") resided in the Northern District of California and worked as a Licensed Vocational Nurse ("LVN") at HealthNow.

The Medicare and Medicaid Programs

5. Medicare was a federally-funded health care program that provided benefits to persons who were at least 65 or older and certain younger people with disabilities. The Medicare program is administered by the Centers for Medicare and Medicaid Services ("CMS"). Medicare is a "Federal health care program" as defined in Title 42, United States Code, Section 1320a-7b(f) and is a "health care benefit program" as defined by Title 18, United States Code, Section 24(b). Different parts of Medicare cover different services; for example, Medicare Part A covers hospital and other inpatient services, while Medicare Part B covers outpatient health services, such as medical office visits, lab work, and home visits. Individuals who qualify for Medicare benefits are referred to as Medicare "beneficiaries." Each beneficiary is given a unique health insurance claim number ("HICN").

6. Health care providers that provide medical services that are reimbursed by Medicare are referred to as Medicare "providers." To participate in Medicare Part B, providers, including physicians and HHAs, are required to submit an application in which the provider agrees to comply with all Medicare-related laws and regulations, including the federal False Claims Act (31 U.S.C. §§ 3729-3733), which makes it illegal to submit claims for payment to Medicare or Medicaid that you know, or should know, are false or fraudulent. If Medicare approves a provider's application, Medicare assigns the provider a Medicare "provider number," which is used for processing and payment of claims.

7. A provider can submit a claim to Medicare through the mail or electronically. Every claim submitted by, or on behalf of, a provider certifies that the information on the claim form is truthful and that the services were reasonable and necessary to the health of the Medicare beneficiary. Medicare only reimburses providers for services and procedures that are medically necessary.

8. Medicare Part A and Medicare Part B cover eligible home health care services, such as intermittent skilled nursing care, physical therapy, and continued occupational services. These services, and others covered by Medicare, are commonly provided at the beneficiaries' homes. In this sense, home health care differs from care provided at health care facilities where the patient may reside or stay

for extended periods, such as skilled nursing facilities and other inpatient facilities.

9. HHAs who provide services to Medicare beneficiaries can submit claims for reimbursement to the Medicare program. Medicare will cover home health services only if, among other requirements, (1) the Medicare beneficiary is homebound; (2) the beneficiary needs skilled nursing services on an intermittent basis, or physical, speech pathology, or occupational therapy services; (3) the beneficiary is under the care of a qualified physician; and (4) a Plan of Care (CMS Form 485) is established by a physician.

10. In order for a beneficiary to be considered "homebound," a physician must certify that a beneficiary is "confined to the home," that is, the beneficiary must either (1) because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person in order to leave their place of residence; or (2) have a condition such that leaving their home is medically contraindicated. In addition, there must exist a normal inability to leave the home and leaving the home must require a considerable and taxing effort.

11. Medicare requires that the homebound determination be the result of a face-to-face consultation. A physician must conduct the consultation, or it must be done with one of the following under the supervision of the physician: a nurse practitioner, a certified nurse midwife, or a physician assistant. The physician must also certify that the beneficiary needs home health care, that a plan of care has been established, and that the services were furnished while the beneficiary was under the care of a physician.

12. Medicare is generally billed for home health care services in 60-day periods referred to as "episodes." These episodes cover the services provided by home health care in those 60-day windows. If a beneficiary continues to require home health care, another physician certification (or "recertification") is required for each subsequent episode.

13. In order to ensure adequate cash flow to HHAs, Medicare pays a percentage at the beginning of the episode through a request for anticipated payment ("RAP") by the HHA. The RAP provides an initial upfront payment to the HHA, typically 50%–60% in the first and second episodes.

14. One of the conditions an HHA must meet in order to receive a RAP from Medicare is the submission a Home Health Outcome and Assessment Information Set ("OASIS"). An OASIS is an

assessment, such as a start of care ("SOC"), a resumption of care, or a discharge, which is performed on a patient in order to determine, amongst other things, reimbursement to the HHA by Medicare.

15. Only specific medical professionals are authorized to complete an OASIS, depending on the type of care being assessed. For example, for nursing care, an OASIS must be completed by a registered nurse ("RN") or for any of the therapies, such as physical therapy, it must be completed by a physical therapist ("PT"). Conversely, a licensed practical nurse ("LPN"), licensed vocational nurse ("LVN"), or physical therapy aide ("PTA") may not complete an OASIS.

16. An HHA such as HealthNow must be accredited to bill Medicare. There are a number of accreditation organizations permitted to assist with the accreditation process. Accreditation organizations are third parties that certify that the HHA is in compliance with CMS rules and regulations. Accreditation organizations are entitled to perform random surveys to determine if they will re-accredit a particular HHA.

The Scheme to Defraud

17. Beginning in or around December 2017 and continuing through in or around October 2019, KATZ and HERRERA, together with others known and unknown, engaged in a fraudulent scheme to obtain money and property by deceiving Medicare about insurance claims that KATZ, HERRERA, and their co-conspirators caused to be submitted to Medicare.

18. It was a part of the scheme that KATZ, HERRERA, and others used a variety of manners and means, among others:

a. Created fraudulent electronic medical records and billing documentation in support of Medicare claims.

b. Used the identities of licensed medical practitioners on electronic medical records and billing information without the practitioners' knowledge or consent and submitted such documentation in support of Medicare claims.

c. Caused LVNs to conduct OASIS SOCs knowing that an individual must have an RN credential to conduct an OASIS SOC.

d. Manipulated electronic patient medical and billing records to remove the names of LVNs who had improperly conducted OASIS SOCs and replaced the names of those LVNs with

the names of RNs in order to make medical records and billing documents submitted to Medicare appear legitimate for billing purposes.

e. Submitted fraudulent medical records and billing documents to bill Medicare.

f. Billed Medicare for physical therapy services not provided.

19. It was further part of the scheme to defraud that KATZ, HERRERA, and others took the following actions, among others:

a. At KATZ's direction, ANDREWS represented herself as having an RN credential, even though ANDREWS was an LVN and had not earned an RN credential. HERRERA and KATZ knew that ANDREWS was an LVN and not an RN.

b. At KATZ's direction, and with HERRERA's knowledge, ANDREWS improperly conducted OASIS SOCs on behalf of HealthNow.

c. At KATZ's direction, and with HERRERA's knowledge, ANDREWS prepared and signed medical records corresponding to OASIS SOC's that ANDREWS had improperly conducted.

d. HERRERA and KATZ manipulated HealthNow's electronic medical records to remove ANDREWS' name from medical records associated with OASIS SOCs conducted by ANDREWS and replace ANDREWS' name with the name of an RN who had not conducted the OASIS SOCs. HERRERA and KATZ frequently replaced ANDREWS' electronic signature with the electronic signature of RNs who did not work at HealthNow.

e. At KATZ's direction, HERRERA assisted in HealthNow improperly billing Medicare for OASIS SOCs conducted by ANDREWS.

f. In September 2018, February 2019, and March 2019, California Department of Public Health ("CDPH") representatives conducted site visits at HealthNow in connection with HealthNow's Medicare accreditation. During the site visits, CDPH representatives uncovered evidence that ANDREWS had improperly conducted OASIS SOCs on behalf of HealthNow and that HealthNow had improperly billed Medicare for OASIS SOCs conducted by ANDREWS. During the site visits, KATZ misled CDPH representatives about ANDREWS conducting OASIS SOCs. Specifically, KATZ told CDPH

representatives that where HealthNow records showed ANDREWS' name on an OASIS SOC for a HealthNow patient, ANDREWS was shadowing another RN—an individual referred to herein as B.B. In truth, however, B.B. never worked for HealthNow, and ANDREWS did not shadow B.B. while conducting OASIS SOC's for HealthNow. During a conversation with CDPH representatives, HERRERA impersonated B.B., an RN, to help conceal the fact that ANDREWS had improperly conducted OASIS SOCs.

COUNT ONE: (18 U.S.C. § 1349 – Conspiracy to Commit Health Care Fraud)

20. The factual allegations in Paragraphs 1 through 19 are re-alleged and incorporated by reference as if fully set forth herein.

21. Beginning in or about December 2017 and continuing through in or about October 2019, in the Northern District of California and elsewhere, the defendants,

VERONICA KATZ, and
VENNESA HERRERA,

together with others known and unknown, did knowingly and willfully conspire to execute and intend to execute a scheme and artifice to defraud health insurance benefit programs (as defined by Title 18, United States Code, Section 24(b)) as to a material matter and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, and by concealment of material facts, money and property owned by, and under the custody and control of, such health care benefit programs, all in connection with the delivery of, and payment for, health care benefits, items, and services, in violation of Title 18, United States Code, Section 1347.

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

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COUNT TWO: (18 U.S.C. §§ 1347 and 2 – Health Care Fraud and Aiding and Abetting)

22. The factual allegations in Paragraphs 1 through 21 are re-alleged and incorporated by reference as if fully set forth herein.

23. On or about the dates set forth below, in the Northern District of California and elsewhere, the defendants,

VERONICA KATZ, and
VENNESA HERRERA,

did knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud health insurance benefit programs as to a material matter and to obtain by means of materially false and fraudulent pretenses, representations, and promises, and by concealment of material facts, money and property owned by, and under the custody and control of, those health care benefit programs, all of the preceding in connection with the delivery of, and payment for, health care benefits, items, and services. Defendants KATZ and HERRERA did so by submitting and causing to be submitted the following reimbursement claims to health insurance providers:

COUNT	DATE	DESCRIPTION OF REIMBURSEMENT CLAIM
TWO	April 5, 2018	Claim for $1,640 submitted to Medicare for physical therapy for Patient-1. HealthNow billed using HCPCS code G0151. Medicare received the claim on or about April 5, 2018, and identified it by claim number 21803800127007CAR.

FORFEITURE ALLEGATION: (18 U.S.C. § 981(a)(1)(C) & 982(a) & 28 U.S.C. § 2461(c))

24. The allegations in Paragraphs 1 through 23 are re-alleged and incorporated by reference for the purpose of alleging forfeiture pursuant to Title 18, United States Code, Sections 981(a)(1)(C) and 982(a), and Title 28, United States Code, Section 2461(c).

25. Upon conviction of the offense alleged in Counts One and Two, the defendants,

VERONICA KATZ, and
VENESSA HERRERA,

shall forfeit to the United States pursuant to Title 18, United States Code, Sections 981(a)(1)(C) and 982(a), and Title 28, United States Code, Section 2461, any property, real or personal, which constitutes

or is derived from proceeds traceable to said violations, including but not limited to a sum of money equal to the total proceeds from the commission of said offense.

24. If any of the property described above, as a result of any act or omission of the defendants:

a. cannot be located upon exercise of due diligence;

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

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

d. has been substantially diminished in value; or

e. has been commingled with other property which cannot be divided without difficulty,

the United States of America shall be entitled to forfeiture of substitute property pursuant to Title 21, United States Code, Section 853(p), as incorporated by Title 18, United States Code, Section 982(b)(1), and Title 28, United States Code, Section 2461(c).

All pursuant to Title 18, United States Code, Section 981(a)(1)(C) and 982(a), and Title 28, United States Code, Section 2461.

DATED: August 12, 2021

STEPHANIE M. HINDS
Acting United States Attorney

_____/s/_____
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