IN THE SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
Civil Division

DISTRICT OF COLUMBIA, a municipal corporation, 400 6th Street, N.W Washington, D.C. 20001, Plaintiff, v. OJI FIT WORLD LLC 318 Oneida Street, N.E. Washington, D.C. 20001, **And** AMAKA OJI 1893 Powells Landing Circle Woodbridge, VA Defendant.	Civil Action No.: 2021 CA 001259 B

COMPLAINT FOR VIOLATIONS OF THE FALSE CLAIMS ACT AND COMMON LAW

1. The District of Columbia ("District"), by its Office of the Attorney General, brings this action against Defendants Oji Fit World LLC ("Oji Fit World") and Amaka Oji ("Oji"), pursuant to the District's False Claims Act, D.C. Code § 2-381.02, *et seq.*, seeking treble damages and civil penalties, and other common law damages and all appropriate relief, as follows.

2. In 2011, Oji became an approved Medicaid provider and a Department on Disability Services (DDS) Home and Community Based Services (HCBS) Waiver Provider in the District and founded Oji Fit World to provide fitness services to Medicaid beneficiaries. Instead of providing the services herself, Oji hired employees to provide the services with little to no supervision. While Oji made determinations about how

much she paid her employees based on time they spent providing services to beneficiaries, she made no such distinction in her billing of Medicaid. Instead, she billed Medicaid consistently for one hour of service per beneficiary whether they received the full period of service, or any service at all. Instead of using the District's Medicaid program as intended, to provide services to District residents in need, Oji abused the system by filing numerous false and fraudulent claims to maximize every payment she could obtain from Medicaid. As a result, Oji improperly obtained thousands of dollars from the District Medicaid program.

Jurisdiction and Parties

3. This Court has jurisdiction over the subject matter of this action pursuant to D.C. Code § 11-921 as this action is brought by the District, and D.C. Code § 2-381.02, as the District asserts claims arising under the District's False Claims Act. This Court has personal jurisdiction over Defendant pursuant to D.C. Code §§ 13-422 and 13-423.

4. Plaintiff, the District of Columbia, a municipal corporation empowered to sue and be sued, is the local government for the territory constituting the permanent seat of the government of the United States. The District is represented by and through its chief legal officer, the Attorney General for the District of Columbia. The Attorney General has general charge and conduct of all legal business of the District and all suits initiated by and against the District and is responsible for upholding the public interest. D.C. Code § 1-301.81(a)(1). The Attorney General is specifically authorized to enforce the District's False Claims Act pursuant to D.C. Code § 2-381.03(a).

5. Oji is the sole owner and administrator of Oji Fit World. Oji was approved as a Medicaid provider in the District for fitness training services in March 2011.

Through her company Oji Fit World, Oji provided fitness training services as an HCBS Waiver provider to over 75 patients in the District from at least January 2012 through August 2015.

The District's Medicaid Program and Fitness Providers

6. Medicaid is a healthcare program established by Congress under Title XIX of the Social Security Act of 1965. In the District, Medicaid is jointly funded by the federal and District governments. The Department of Health Care Finance ("DHCF") is the agency that administers the District's Medicaid Program. The District's Medicaid Program provides healthcare coverage to residents of the District whose incomes are below a certain financial threshold as measured against the poverty line.

7. DHCF enters into agreements with medical providers to secure particular services. To participate in the District's Medicaid program, a provider must submit a Provider Application Form to DHCF. Among other things, the prospective provider agrees (i) "[t]o provide to Medicaid patients, services as covered in Title XXI of the Social Security Act and the State Plan of Medical Assistance[;]" (ii) "[t]o satisfy all requirements of the Social Security Act, as amended, and be in full compliance with the standards prescribed by Federal and [District] standards[;]" and (iii) "[t]o maintain all records relevant to this Agreement at his/her cost, for a period of six years or until all audits are completed, whichever is longer. Such records shall include all physical records originated or prepared pursuant to performance under this Agreement, including but not limited to, financial records, medical records, charts and other documents pertaining to costs, payments received and made, and services provided to covered Medicaid recipients[.]" The Provider Application Form is incorporated by reference into the District Medicaid Provider Agreement and made a part thereof.

8. When a provider signs a District Medicaid Provider Agreement, the provider agrees that the provider's submission of claims to the District's Medicaid program is a declaration "that the provisions of this Agreement and supplemental providers[']manuals and instructions have been understood and complied with . . . .".

9. To be eligible to participate in the District's Medicaid Program, providers are required to abide by all federal and local laws, regulations, and District program manuals governing Medicaid payments.

10. Under the DDS HCBS Waiver program, providers can be reimbursed by Medicaid for certain wellness services provided to Medicaid beneficiaries with intellectual and developmental disabilities. Wellness services, such as fitness training, are designed to promote and maintain good health and assist in increasing a person's independence, participation, emotional well-being, and productivity in their home, work, and community.

11. The District's Medicaid Billing Manual for HCBS Waiver services is available on DHCF's DC-Medicaid website. It provides authoritative coding and billing guidance and "serves as a reference guide for healthcare providers who participate in the District's Medicaid program."

12. The Medicaid billable unit of service for wellness services is 15 minutes. One hour of service is 4 billable units. A provider must provide at least 8 minutes of service in the span of 15 continuous minutes to bill a unit of service. During the relevant period, wellness services for fitness training were paid by Medicaid at $18.75 per unit, equaling $75.00 per hour.

13. For a Medicaid beneficiary to qualify for fitness training services, the services must be ordered by a physician and identified as a need in an Individual Support

Plan (ISP) and Plan of Care (POC). The intensity, frequency, and duration of the service provided shall be determined by the person's individual needs and documented in the beneficiary's ISP and POC.

14. The provider offering fitness training services must conduct an intake assessment with long- and short-term goals; develop and implement a person-centered plan consistent with the person's choices, goals, and prioritized needs; and record progress notes on each visit as well as quarterly reports. The plan also must include treatment strategies including direct therapy, caregiver training, monitoring requirements and instructions, and specific outcomes.

15. HCBS Waiver sole practitioners are required to individually supervise assistants and aides employed directly by the independent practitioner.

16. Fitness trainers must be certified by the American Fitness Professionals Association.

Oji's Scheme to Unlawfully Obtain Medicaid Funds

17. From on or about January 2012 to on or about August 2015, Oji filed, or caused to be filed, false and fraudulent claims to DHCF to unlawfully obtain money from the District Medicaid Program. The claims were for fitness services that were either not provided at all or were billed for a greater number of time units than were actually provided.

18. After being approved as a Medicaid provider by DHCF, Oji initially performed some fitness services for a small number of Medicaid beneficiaries, but Oji relinquished most of those responsibilities to other people. During all relevant times, Oji maintained full time employment as a petroleum engineer while operating Oji Fit World.

19. At no time during the relevant period did Oji operate a gym or workout facility. Instead, after she became an approved Medicaid provider, Oji employed multiple fitness trainers to provide fitness services to Medicaid beneficiaries at their homes or recreation facilities near their homes.

20. Oji held a monthly meeting for fitness trainers where she purportedly provided training on timekeeping for payment, collected paperwork, and disseminated paychecks. Oji did not individually supervise fitness trainers as they worked with beneficiaries.

21. Fitness trainers were required to complete daily fitness reports at each fitness session they conducted. The daily fitness report tracked service date, time spent, and exercises performed. The daily fitness report required a signature from the trainer and the beneficiary or their caregiver. Trainers turned the daily fitness report into Oji Fit World's administrative employees for payment and fitness tracking purposes.

22. Oji Fit World administrative employees reviewed the daily fitness reports to determine employee payments. There were no timecards, and fitness trainers were not questioned about actual time spent training beneficiaries. If there were any discrepancies on the daily fitness report, the staff sent the daily fitness report and the discrepancy to Oji for her review and approval. Oji made all final decisions on employee pay and amounts billed to Medicaid.

23. Fitness trainers regularly scheduled one-hour fitness sessions with beneficiaries regardless of a beneficiary's capabilities or needs. These one-hour sessions were often cut short due to the beneficiary's desire or need to stop the session early or not exercise at all. Some trainers accurately reflected those shortened sessions on their daily fitness reports. For example, on July 2, 2013, a fitness trainer documented that

"[Beneficiary] had to go to a dentist appointment at 12:30 pm." This particular fitness session started at noon. In another example, on March 21, 2015 a fitness trainer wrote on a daily fitness report that "[Beneficiary] let me take her weigh [sic] and measurement today but she would not work out today."

24. In other instances, the total time documented for fitness service to a beneficiary was between 10 to 20 minutes. For example, on February 16, 2015 a fitness trainer documented on a daily fitness report that a beneficiary only performed 10 minutes of exercise by walking outdoors.

25. At times, beneficiaries canceled their training session or did not show up. If the trainer drove to the location and the beneficiary failed to show, Oji paid the trainer a small fee for gas, but nothing more.

26. Regardless of the time reported by the fitness trainer on the daily fitness report, including if the session was cancelled, Oji billed Medicaid and accepted payment for a full hour of service. In fact, in over 9,500 Medicaid reimbursement claims submitted prior to May 2013, Oji filed a mere 10 claims that were for less than 1 hour (4 units) of service. Beginning in May 2013, every claim that Oji filed for reimbursement from Medicaid was for 1 hour (4 units) of fitness services.

27. There are numerous other examples of Oji knowingly filing false and fraudulent claims, including:

a. Hundreds of daily fitness reports lack information necessary to assess proper billing. Discrepancies include documenting start time but no end time, blank fitness logs in daily fitness report, no exercise times documented, no beneficiary signature, and daily fitness forms that are clear duplicates with just the dates changed. Oji billed Medicaid for one hour of service regardless of the lack of information required to do so.
b. On multiple occasions, Oji double-billed Medicaid for fitness services. For example, according to a daily fitness report, a beneficiary received

45 minutes of fitness training on August 13, 2013. Oji billed Medicaid for 2 hours for the same session.

c. Some fitness trainers documented fitness services at one address for an hour and then immediately recorded an hour of services at another location. For example, a fitness trainer provided services at an address in Northwest DC from 4:00 – 5:00 pm and then provided services at a Northeast DC address, 1.6 miles away, from 5:00 – 6:00 pm. Oji billed for one hour of service for each client.
d. Trainers held group fitness sessions that were not person-centered or direct therapy. For example, one fitness trainer provided fitness services to three beneficiaries at the same time. Each beneficiary had different needs and abilities. On one occasion, one beneficiary did not complete the cardio work out. On another occasion, the fitness trainer used the majority of the hour to take the measurements of the three individuals. Oji billed Medicaid for one hour for each beneficiary separately.

28. Oji did not directly supervise any of the fitness trainers she employed while they were providing services as she was required to do. Oji did not interact with the beneficiaries or visit the facilities in which her employees trained them. Some trainers documented providing services using equipment that was not available. For example, one trainer claimed that the beneficiary completed cardio exercise using both an elliptical and a treadmill. However, the beneficiary did not have access to either machine.

29. Additionally, trainers documented exercise routines that a beneficiary could not accomplish. For example, a trainer documented that a beneficiary walked over a mile on multiple occasions when in fact, the beneficiary used a walker to assist with daily living and was unable to walk long distances under any circumstances.

30. In another example, a trainer claimed on numerous occasions that a beneficiary walked between 1.5 and 2 miles. In one instance he claimed that on May 28, 2014, she walked 1.5 miles in 20 minutes. However, the beneficiary uses a wheelchair for mobility and cannot walk long distances. When she does walk, it is a short distance at a measured pace. Oji provided fitness training to this beneficiary in 2013 when she first signed up for services and was aware of the beneficiary's limitations. Nevertheless, Oji

filed a claim for reimbursement from Medicaid for one hour based on the false daily fitness report.

31. Oji had access to ISPs on each of the beneficiaries that Oji Fit World provided fitness services to. ISPs detailed the abilities and limitations of each beneficiary. Oji also had access to and reviewed the trainers' daily fitness reports and annual fitness reports. The annual reports documented the progress, if any, of each beneficiary every year and recommended future services for that beneficiary. Oji had ultimate authority and control over billing Medicaid for services that her fitness trainers provided to beneficiaries.

32. At all times relevant to the actions described in this Complaint, Defendant Oji, directly or through her administrative biller, submitted claims for reimbursement to the District's Medicaid program and Oji received reimbursement for those claims. Oji reviewed all claims submitted and maintained control over billing decisions.

Notice of Suspension of Medicaid Payments to Oji

33. On May 27, 2015, following an investigation of a fraud complaint concerning Defendant Oji, DHCF issued a "Notice of Suspension of Medicaid Payments" to Oji, informing her that DHCF was withholding all Medicaid payments due to her as a provider of Medicaid services. DHCF is required by federal regulations to suspend all Medicaid payments to a provider after the agency determines there is a "credible allegation of fraud for which an investigation is pending." 42 C.F.R. § 455.23(a). The Notice stated:

> DHCF is imposing the payment suspension in response to allegations of fraud, the credibility of which it has verified through a preliminary investigation. The investigation is ongoing at this time. The general allegations underlying the suspension include billing for excessive services units/hours in a day and billing for services not rendered.

34. Defendant Oji appealed DHCF's decision and, on July 21, 2015, the District's Office of Administrative Hearings affirmed DHCF's Notice of temporary suspension of Medicaid payments.

35. On or about July 30, 2015, Oji voluntarily terminated her Medicaid provider agreement, effective September 1, 2015.

COUNT I – FALSE CLAIMS ACT
Knowingly Presenting or Causing to Be Presented a False Claim
D.C. Code § 2-381.02(a)(1) (2011), § 2-381.02(a)(1) (2013, as amended)

36. The District incorporates by reference the allegations set forth in Paragraphs 1 to 35 above as if fully set forth herein.

37. The District's False Claims Act, D.C. Code § 2-381.02, has at all relevant times provided for the award of treble damages and civil penalties for, among other things, knowingly presenting or causing to be presented false or fraudulent claims to the District for payment or approval D.C. Code §§ 2-381.02(a)(1).

38. Oji knowingly presented and caused to be presented false or fraudulent claims to the District's Medicaid program for payment or approval for payment by seeking and accepting payment for fitness services performed by improperly supervised trainers and for services not provided for the length of time claimed or at all, and for services not supported by Oji's records.

39. As a result of Defendant Oji's false claims, the District was damaged in an amount to be determined at trial and therefore is entitled to treble damages under the District's False Claims Act, plus a civil penalty for each false claim.

COUNT II – FALSE CLAIMS ACT
Knowingly Making a False Record or Statement
D.C. Code § 2-381.02(a)(2) (2011); § 2-381.02(a)(2) (2013, as amended)

40. The District incorporates by reference the allegations set forth in Paragraphs 1 to 35 above as if fully set forth herein.

41. The District's False Claims Act, D.C. Code § 2-381.02, has at all relevant times provided for the award of treble damages and civil penalties for, among other things, knowingly making, using or causing to be used a false record or statement material to a false or fraudulent claim paid by the District. D.C. Code §§ 2-381.02(a)(2).

42. As described above, Oji knowingly made, used, and caused to be made or used false records or statements material to false or fraudulent claims to the District's Medicaid program.

43. As a result of Defendant Oji's use of these false records and statements, the District was damaged in an amount to be determined at trial and therefore is entitled to treble damages under the District's False Claims Act, plus a civil penalty for each false record or statement.

COUNT III – UNJUST ENRICHMENT

44. The District incorporates by reference the allegations set forth in Paragraphs 1 to 35 above as if fully set forth herein.

45. This is a claim for the recovery of monies by which Defendant Oji has been unjustly enriched.

46. By directly or indirectly obtaining government funds from the District Medicaid program to which she was not entitled, Oji was unjustly enriched to the detriment of the District and is liable to account and pay such amounts, or the proceeds or profits therefrom, in an amount to be determined at trial, to the District.

Prayer for Relief

WHEREFORE, the District respectfully requests that the Court enter judgment in its favor and award it the following relief:

(1) The amount of the District's damages to be determined at trial;

(2) Treble damages pursuant to the District's False Claims Act in an amount to be determined at trial;

(3) Civil penalties pursuant to the District's False Claims Act for each false claim and false record or statement;

(4) Interest, costs, and other recoverable expenses permitted by law; and

(5) Such other relief as may be just and appropriate.

Jury Demand

The District of Columbia hereby demands a trial by jury by the maximum number of jurors permitted by law.

Date: April 20, 2021

Respectfully submitted,

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