UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 14 -20288

18 U.S.C. § 1349
18 U.S.C. § 371
42 U.S.C. § 1320a-7b(b)(1)(A)
18 U.S.C. § 1347
18 U.S.C. § 2
18 U.S.C. § 982

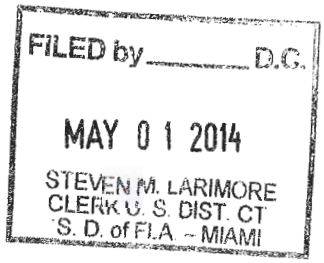
LENARD/

UNITED STATES OF AMERICA

vs.

YAMILE CALVO-GONZALEZ,

Defendant.
_____/



INDICTMENT

The Grand Jury charges that:

GENERAL ALLEGATIONS

At all times material to this Indictment:

1. The Medicare Program ("Medicare") was a federal healthcare program providing benefits to persons who were over the age of 65 or disabled. Medicare was administered by the United States Department of Health and Human Services ("HHS") through its agency, the Centers for Medicare & Medicaid Services ("CMS"). Individuals who received benefits under Medicare where referred to as Medicare "beneficiaries."

2. The Florida Medicaid Program ("Medicaid") was a federal health care program providing benefits to low-income individuals and families. Medicaid was administered by CMS and the State of Florida Agency for Health Care Administration ("AHCA".)

3. Medicare and Medicaid were each a "health care benefit program," as defined by Title 18, United States Code, Section 24(b).

4. "Part A" of the Medicare program and the Medicaid program covered certain eligible home health care costs for medical services provided by a home health agency ("HHA"), to beneficiaries who required home health services because of an illness or disability that caused them to be homebound. Payments for home health care medical services under Medicare Part A and Medicaid were typically made directly to an HHA or provider based on claims submitted to the Medicare and Medicaid program for qualifying services that had been provided to eligible beneficiaries, rather than to the beneficiary.

5. Physicians, clinics, and other health care providers, including HHAs, which provided services to Medicare beneficiaries and Medicaid recipients were able to apply for and obtain a "provider number." Health care providers that received a Medicare or Medicaid provider number were able to file claims with Medicare or Medicaid to obtain reimbursement for services provided to beneficiaries. A Medicare or Medicaid claim was required to set forth, among other things, the beneficiary's or recipient's name and Medicare or Medicaid information number, the services that were performed for the beneficiary or recipient, the date the services were provided, the cost of the services, and the name and identification number of the physician or other health care provider who ordered the services.

6. CMS did not directly pay Medicare Part A claims submitted by Medicare-certified HHAs. CMS contracted with different companies to administer the Medicare Part A program throughout different parts of the United States. In the State of Florida, CMS contracted with Palmetto Government Benefits Administrators ("Palmetto") to administer Part A HHA

claims. As administrator, Palmetto was to receive, adjudicate, and pay, claims submitted by HHA providers under the Part A program for home health claims.

7. In the State of Florida, AHCA contracted with HP Enterprises ("HP"), formerly known as Electronic Data Systems (EDS) to administer Medicaid claims. As administrator, HP was to receive, adjudicate, and pay, claims submitted by HHA providers under the Medicaid program for home health claims.

Part A Coverage and Regulations

Reimbursements

8. The Medicare Part A program and Medicaid reimbursed 100% of the allowable charges for participating HHAs providing home health care services only if the patient qualified for home health benefits. A patient qualified for home health benefits only if:

a. the patient was confined to the home, also referred to as homebound;

b. the patient was under the care of a physician who specifically determined there was a need for home health care and established the Plan of Care ("POC"); and

c. the determining physician signed a certification statement specifying that the beneficiary needed intermittent skilled nursing services, physical therapy, or speech therapy, and that the beneficiary was confined to the home; that a POC for furnishing services was established and periodically reviewed; and that the services were furnished while the beneficiary was under the care of the physician who established the POC.

9. Under the Medicare Part A program, HHAs were reimbursed under the Home Health Prospective Payment System ("PPS"). Under PPS, Medicare paid Medicare-certified

HHAs a predetermined base payment for each 60 days that care was needed. This 60-day period was called an "episode of care." The base payment was adjusted based on the health condition and care needs of the beneficiary. This adjustment was done through the Outcome and Assessment Information Set ("OASIS"), which was a patient assessment tool for measuring and detailing the patient's condition. If a beneficiary was still eligible for care after the end of the first episode of care, a second episode could commence. There were no limits to the number of episodes of home health benefits a beneficiary could receive as long as the beneficiary continued to qualify for home health benefits.

10. In order to be reimbursed under the Medicare Part A program, the HHA would submit a Request for Anticipated Payment ("RAP") and subsequently receive a portion of its payment in advance of services being rendered. At the end of a 60 day episode, when the final claim was submitted, the remaining portion of the payment would be made. As explained in more detail below, "Outlier Payments" are additional PPS payments based on visits in excess of the norm. Palmetto paid Outlier Payments to HHA providers under PPS where the providers' RAP submissions established that the cost of care exceeded the established Health Insurance Prospective Payment System ("HIPPS") code threshold dollar amount.

11. Under the Medicaid program, to be reimbursed the HHA would submit, to AHCA, a request for prior authorization for home health services. Prior authorization is required before certain services are provided to recipients. The prior authorization must include the POC, the certification period covered by the POC not to exceed 60 days, and medical information related to the recipient. When the request is approved by AHCA, the approval will contain a prior authorization number for billing and reference. Only one prior authorization number will

be issued per certification period. HHAs must submit a claim for payment under the Medicaid program for a prior authorized procedure after the service has been approved and provided.

Record Keeping Requirements

12. Medicare Part A and Medicaid regulations required HHAs providing services to Medicare and Medicaid patients to maintain complete and accurate medical records reflecting the medical assessment and diagnoses of their patients, as well as records documenting actual treatment of the patients to whom services were provided and for whom claims for reimbursement were submitted by the HHAs. These medical records were required to be sufficient to permit Medicare or Medicaid, through Palmetto and other contractors, to review the appropriateness of Medicare and Medicaid payments made to the HHA under the Part A or Medicaid program.

13. Among the written records required to document the appropriateness of home health care claims submitted under Part A of Medicare or the Medicaid program was a POC that included the physician order for home health care, diagnoses, types of services/frequency of visits, prognosis/ rehabilitation potential, functional limitations/activities permitted, medications/treatments/ nutritional requirements, safety measures/discharge plans, goals, and the physician's signature. Also required was a signed certification statement by an attending physician certifying that the patient was confined to his or her home and was in need of the planned home health services, and an OASIS.

14. Medicare Part A and Medicaid regulations required provider HHAs to maintain medical records of every visit made by a nurse, therapist, and home health aide to a beneficiary. The record of a nurse's visit was required to describe, among other things, any significant observed signs or symptoms, any treatment and drugs administered, any reactions by

the patient, any teaching and the understanding of the patient, and any changes in the patient's physical or emotional condition. The home health nurse, therapist, and aide were required to document the hands-on personal care provided to the beneficiary as the services were deemed necessary to maintain the beneficiary's health or to facilitate treatment of the beneficiary's primary illness or injury. These written medical records were generally created and maintained in the form of "clinical notes" and "home health aide notes/observations."

The Defendant and Related Entities

15. WY Medical Group and Rehabilitation Services, Inc. ("WY"), formerly known as W&Y Rehabilitation services, Inc., was a Florida corporation incorporated on or about March 19, 2010, and did business in Miami-Dade County, Florida, as a company that purportedly provided rehabilitation services.

16. The Defendant, **YAMILE CALVO-GONZALEZ**, a resident of Miami-Dade County, Florida, was listed as the president and registered agent of WY.

17. Trust Care Health Services, Inc. ("Trust"), was a Florida corporation incorporated on or about October 10, 2005, and did business in Miami-Dade County, Florida, as a company that purportedly provided home health services to Medicare beneficiaries and Medicaid recipients.

18. Centrum Home Health Care Inc. ("Centrum"), was a Florida corporation incorporated on or about June 29, 2007, and did business in Miami-Dade County, Florida, as a company that purportedly provided home health services to Medicare beneficiaries and Medicaid recipients.

19. A & B Health Services Inc. ("A&B"), was a Florida corporation incorporated on or about December 27, 2006, and did business in Miami-Dade County, Florida, as a company

that purportedly provided home health services to Medicare beneficiaries and Medicaid recipients.

COUNT 1
Conspiracy to Commit Health Care Fraud
(18 U.S.C. § 1349)

1. Paragraphs 1 through 19 of the General Allegations section of this Indictment are realleged and incorporated by reference as though fully set forth herein.

2. Beginning on or about May 4, 2010, and continuing through on or about September 5, 2013, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

YAMILE CALVO-GONZALEZ,

did knowingly and willfully combine, conspire, confederate, and agree with others, known and unknown to the Grand Jury, to violate Title 18, United States Code, Section 1347, that is, to execute a scheme and artifice to defraud a health care benefit program affecting commerce, as defined in Title 18, United States Code, Section 24(b), that is, Medicare and Medicaid, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of, said health care benefit program, in connection with the delivery of and payment for health care benefits, items, and services.

PURPOSE OF THE CONSPIRACY

3. It was a purpose of the conspiracy for the defendant and her co-conspirators to unlawfully enrich themselves by, among other things: (a) submitting and causing the submission of false and fraudulent claims to Medicare and Medicaid; (b) soliciting and receiving kickbacks and bribes in exchange for referring Medicare beneficiaries and Medicaid recipients to HHAs

and securing prescriptions and POC for the furnishing or arranging the furnishing of home health services for which payment may be made in whole or in part by Medicare and Medicaid; (c) concealing the submission of false and fraudulent claims to Medicare and Medicaid, the receipt and transfer of the proceeds from the fraud, and the payment and receiving of kickbacks.

MANNER AND MEANS

The manner and means by which the defendant and her co-conspirators sought to accomplish the object and purpose of the conspiracy included, among other things:

4. **YAMILE CALVO-GONZALEZ,** received kickbacks and bribes in return for referring beneficiaries to HHA's to serve as patients so that the HHA's could bill Medicare and Medicaid for services that were not medically necessary and not provided.

5. **YAMILE CALVO-GONZALEZ** and her co-conspirators, in exchange for kickback payments and bribes, provided HHAs with false and fraudulent prescriptions and POC's for home health services that were not medically necessary and not provided.

6. **YAMILE CALVO-GONZALEZ** and her co-conspirators filed and caused to be filed false and fraudulent claims with Medicare and Medicaid seeking payment for the costs of home health services that were not medically necessary and not provided.

7. As a result of these false and fraudulent claims, several HHAs received payment from Medicare.

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

COUNTS 2-3
Health Care Fraud
(18 U.S.C. § 1347)

1. Paragraphs 1 through 19 of the General Allegations section of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

2. Beginning on or about May 4, 2010, and continuing through on or about September 5, 2013, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

YAMILE CALVO-GONZALEZ,

in connection with the delivery of and payment for health care benefits, items, and services, did knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud a health care benefit program affecting commerce, as defined by Title 18, United States Code, Section 24(b), that is, Medicare and Medicaid, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of, said health care benefit program.

Purpose of the Scheme and Artifice

3. It was a purpose of the scheme and artifice for the defendant and her accomplices to unlawfully enrich themselves by, among other things: (a) submitting and causing the submission of false and fraudulent claims to Medicare and Medicaid; (b) paying and accepting kickbacks and bribes for referring Medicare beneficiaries and Medicaid recipients so that their Medicare beneficiary numbers and Medicaid recipient numbers would serve as the bases of claims filed for home health care; and (c) concealing the submission of false and fraudulent claims.

The Scheme and Artifice

4. The allegations contained in paragraphs 4 through 7 of the Manner and Means section of Count 1 of this Indictment are realleged and incorporated by reference as though fully set forth herein as a description of the scheme and artifice.

Acts in Execution or Attempted Execution of the Scheme and Artifice

5. On or about the dates set forth below as to each count, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant, **YAMILE CALVO-GONZALEZ**, in connection with the delivery of and payment for health care benefits, items, and services, did knowingly and willfully execute, and attempt to execute, the above-described scheme and artifice to defraud a health care benefit program affecting commerce, that is, Medicare and Medicaid, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of, said health care benefit program, in that the defendant caused the submission of false and fraudulent Medicare claims by Centrum Home Health Care and A&B Home Health Services, as further described below, representing that these home health agencies had provided various home health services to beneficiaries pursuant to physicians' P.O.C.s:

Count	Medicare Beneficiary	Approx. Date of Submission of Claim	Medicare Claim Number	Service Claimed; Approx. Amount Claimed
2	G.M.	5/3/2012	21231106793607FLR	Home Health Services; $3,884
3	D.H.	10/16/2012	21229001356207FLR	Home Health Services; $3,716

In violation of Title 18, United States Code, Sections 1347 and 2.

COUNT 4
Conspiracy to Defraud the United States and Receive Health Care Kickbacks
(18 U.S.C. § 371)

1. Paragraphs 1 through 19 of the General Allegations section of this Indictment are realleged and incorporated by reference as though fully set forth herein.

2. Beginning on or about May 4, 2010, and continuing through on or about September 5, 2013, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

YAMILE CALVO-GONZALEZ,

did willfully, that is, with the intent to further the objects of the conspiracy, and knowingly combine, conspire, confederate, and agree with others, known and unknown to the Grand Jury, to defraud the United States by impairing, impeding, obstructing, and defeating through deceitful and dishonest means, the lawful government functions of the United States Department of Health and Human Services in its administration and oversight of the Medicare and Medicaid program; and to commit certain offenses against the United States, that is: To violate Title 42, United States Code, Section 1320a-7b(b)(1)(A), by knowingly and willfully soliciting and receiving any remuneration, including any kickback and bribe, directly and indirectly, overtly and covertly, in cash and in kind, including by check, in return for referring an individual to a person for the furnishing and arranging for furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, that is, Medicare and Medicaid.

PURPOSE OF THE CONSPIRACY

3. It was the purpose of the conspiracy for the defendant and her co-conspirators to unlawfully enrich themselves by: (1) paying and accepting kickbacks and bribes for referring Medicare beneficiaries and Medicaid recipients to Trust Care Health Services, A&B Home Health Services, Centrum Home Health Care, so that their Medicare and Medicaid beneficiary numbers would serve as the bases of claims filed for home health care; and (2) submitting and causing the submission of claims to Medicare and Medicaid for home health services that the defendant and her co-conspirators purported to provide to those beneficiaries.

MANNER AND MEANS OF THE CONSPIRACY

The manner and means by which the defendant and her co-conspirators sought to accomplish the object and purpose of the conspiracy included, among others, the following:

4. **YAMILE CALVO-GONZALEZ** and her co-conspirators solicited and received kickbacks from co-conspirator HHA owners in cash and by check in return for referring Medicare beneficiaries and Medicaid recipients, and furnishing necessary prescriptions and POCs, to said HHAs for home health services.

5. **YAMILE CALVO-GONZALEZ** and her co-conspirators caused Trust Care Health Services, A&B Home Health Services, and Centrum Home Health Care to submit claims to Medicare and Medicaid for home health services purportedly rendered to Medicare beneficiaries.

6. **YAMILE CALVO-GONZALEZ** and her co-conspirators caused Medicare to pay Trust Care Health Services, A&B Home Health Services, Centrum Home Health Care based upon the home health services purportedly rendered to Medicare beneficiaries.

OVERT ACTS

In furtherance of the conspiracy, and to accomplish its objects and purpose, at least one of the co-conspirators committed and caused to be committed in the Southern District of Florida at least one of the following overt acts, among others:

1. On or about January 21, 2010, **YAMILE CALVO-GONZALEZ** received a kickback check from Trust Care Health Services, Inc., check No. 5385 in the approximate amount $3,000.

2. On or about May 7, 2010, **YAMILE CALVO-GONZALEZ** received a kickback check from a co-conspirator, the owner of A&B Home Health Services; check No. 158 in the approximate amount of $2,000.

3. On or about August 24, 2012, **YAMILE CALVO-GONZALEZ** received a kickback check from Centrum Home Health Care, check No. 1521 in the approximate amount of $1,500.

4. On or about August 30, 2012, **YAMILE CALVO-GONZALEZ** received a kickback check from Centrum Home Health Care, check No. 1547 in the approximate amount of $1,500.

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

COUNTS 5-8
Receipt of Kickbacks in Connection with a Federal Health Care Benefit Program (42 U.S.C. § 1320a-7b(b)(1)(A))

1. Paragraphs 1 through 19 of the General Allegations section of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

2. On or about the dates enumerated below as to each count, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

YAMILE CALVO-GONZALEZ,

did knowingly and willfully solicit and receive any remuneration, including any kickback and bribe, directly and indirectly, overtly and covertly, in cash and in kind, including by check, as set forth below, in return for referring an individual to a person for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole and in part under a Federal health care program, that is, Medicare and Medicaid:

Count	Approximate Date	Approximate Kickback Amount
5	January 21, 2010	$3,000
6	May 7, 2010	$2,000
7	August 24, 2012	$1,500
8	August 30, 2012	$1,500

In violation of Title 42, United States Code, Section 1320a-7b(b)(1)(A) and Title 18, United States Code, Section 2.

FORFEITURE
(18 U.S.C. § 982)

1. The allegations contained in Counts 1 through 4 and Counts 6 through 8 of this Indictment are realleged and incorporated by reference as though fully set forth herein for the purpose of alleging forfeiture to the United States of America of certain property in which **YAMILE CALVO-GONZALEZ** has an interest.

2. Upon conviction of any of Counts 1 through 4 and Counts 6 through 8, as alleged in this Indictment, the defendant, **YAMILE CALVO-GONZALEZ** shall forfeit to the United States any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.

All pursuant to Title 18, United States Code, Sections 982(a)(7) and the procedures outlined in Title 21, United States Code, Section 853, as incorporated by Title 18, United States Code, Section 982(b)(1).

A TRUE BILL

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FOREPERSON

WIFREDO A. FERRER
UNITED STATES ATTORNEY

HAGERENESH SIMMONS
SPECIAL ASSISTANT U.S. ATTORNEY