UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 14-20266-CR-LENARD (s)
18 U.S.C. § 1349
18 U.S.C. § 1347
42 U.S.C. § 1320a-7b(b)(2)(A)
42 U.S.C. § 1320a-7b(b)(1)(A)
18 U.S.C. § 2
18 U.S.C. § 982

UNITED STATES OF AMERICA

vs.

ADALBERTO PEREZ PEGUERO,
MAYDELIN MATOS FERNANDEZ,
ROBERTO ROGELIO ROJAS, and
MARIA ARCE,

Defendants.
_____/

Sealed

SUPERSEDING INDICTMENT

The Grand Jury charges that:

GENERAL ALLEGATIONS

At all times material to this Superseding Indictment:

The Medicare Program

1. The Medicare Program ("Medicare") was a federally funded program that provided free or below-cost health care benefits to certain individuals, primarily the elderly, blind, and disabled. The benefits available under Medicare were governed by federal statutes and regulations. The United States Department of Health and Human Services ("HHS"), through its agency, the Centers for Medicare and Medicaid Services ("CMS"), oversaw and administered Medicare. Individuals who received benefits under Medicare were commonly referred to as Medicare "beneficiaries."

2. Medicare was a "health care benefit program," as defined by Title 18, United States Code, Section 24(b) and a "Federal health care program," as defined by Title 42, United States Code, Section 1320a-7b(f).

3. Medicare programs covering different types of benefits were separated into different program "parts." "Part A" of the Medicare program covered certain eligible home health care costs for medical services provided by a home health agency ("HHA"), also referred to as a "provider," 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 were typically made directly to a Medicare-certified HHA or provider based on claims submitted to the Medicare program for qualifying services that had been provided to eligible beneficiaries.

4. Home health care agencies, pharmacies, physicians, and other health care providers that provided services to beneficiaries were able to apply for and obtain a Medicare Identification Number or "provider number." In the application, the provider acknowledged that to be able to participate in the Medicare program, the provider must comply with all Medicare related laws and regulations. A provider who was issued a Medicare Identification Number was able to file claims with Medicare to obtain reimbursement for services provided to beneficiaries. The Medicare Identification Number uniquely identified the provider on its submissions to Medicare. A Medicare claim was required to set forth, among other things, the beneficiary's name and Medicare identification number, the services that were performed for the beneficiary, 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.

5. CMS did not directly pay Medicare Part A claims submitted by Medicare-certified HHAs. CMS contracted with different private 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"), located in Columbia, South Carolina. As administrator, Palmetto was to receive, adjudicate and pay claims submitted by HHA providers under the Part A program for home health claims. Additionally, CMS separately contracted with companies in order to review HHA providers' claims data. CMS contracted with SafeGuard Services, a Zone Program Integrity Contractor. SafeGuard Services safeguarded the Medicare Trust Fund by reviewing HHA providers' claims for potential fraud, waste, and/or abuse.

Part A Coverage and Regulations

Reimbursements

6. The Medicare Part A program 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 the patient:

(a) was confined to the home, also referred to as homebound;

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

(c) the determining physician signed a certification statement specifying that the beneficiary needed intermittent skilled nursing, physical therapy, speech therapy, or a continued need for occupational therapy; 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 P.O.C.

7. Medicare paid 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 of care could commence. There were no limits to the number of episodes of home health benefits a beneficiary could receive as long as the beneficiary remained eligible.

8. In order to be reimbursed, the HHA would submit a Request for Anticipated Payment ("RAP") and subsequently received a portion of their payment in advance at the beginning of the episode. At the end of a 60 day episode, the HHA submitted the final claim and received the remaining portion of the payment.

Record Keeping Requirements

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

10. Among the written records required to document the appropriateness of home health care claims submitted under Part A of Medicare was a (i) POC that included the physician order, diagnoses, types of services/frequency of visits, prognosis/rehab potential, functional limitations/activities permitted, medications/treatments/nutritional requirements, safety measures/discharge plans, goals, and the physician's signature; and (ii) 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.

11. Additionally, Medicare Part A regulations required HHAs to maintain medical records of every visit made by a nurse, therapist, or home health aide to a patient. 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 aide was 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 "skilled nursing progress notes" and "home health aide notes/observations."

12. Medicare regulations allowed Medicare certified HHAs to subcontract home health care services to nursing companies, registries, or groups (nursing groups), which would bill the certified home health agency. The Medicare certified HHA would, in turn, bill Medicare for all services rendered to the patient. The HHA's professional supervision over subcontracted-for services required the same quality controls and supervision as of its own salaried employees.

The Defendants and Related Companies

13. Alephzayn Health Services. Inc. ("Alephzayn") was a corporation organized under the laws of the State of Florida and located at 7360 West 20th Avenue, Hialeah, Florida 33016. Alephzayn was purportedly engaged in the business of home health services to Medicare beneficiaries. Alephzayn had a Medicare provider number and was eligible to receive reimbursement from Medicare for home health services provided to beneficiaries.

ADALBERTO 5/2/14

14. Defendant ~~ALBERTO~~ **PEREZ PEGUERO**, a resident of Miami-Dade County, managed and operated Alephzayn.

15. Defendant **MAYDELIN MATOS FERNANDEZ**, a resident of Miami-Dade County, was employed by Alephzayn as a Physical Therapy Assistant.

16. Defendant **ROBERTO ROGELIO ROJAS** was a resident of Miami-Dade County.

17. **MARIA ARCE**, a resident of Miami-Dade County, was a Medicare beneficiary.

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

1. Paragraphs 1 through 17 of the General Allegations section of this Superseding Indictment are re-alleged and incorporated by reference as though fully set forth herein.

2. From at least as early as in or around June of 2013, and continuing through in or around December of 2013, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendants,

ADALBERTO 5/2/14

~~ALBERTO~~ PEREZ PEGUERO,
MAYDELIN MATOS FERNANDEZ,
ROBERTO ROGELIO ROJAS,
and
MARIA ARCE,

did knowingly and willfully combine, conspire, confederate and agree with each other and 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 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 defendants and their co-conspirators to unlawfully enrich themselves by, among other things: (a) submitting and causing the submission of false and fraudulent claims to Medicare; (b) concealing the submission of false and fraudulent claims; and (c) diverting the fraud proceeds for their personal use and benefit, and the use and benefit of others, and to further the fraud.

Manner and Means of the Conspiracy

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

4. ADALBERTO ~~ALBERTO~~ **PEREZ PEGUERO,** offered and paid kickbacks and bribes to patient recruiters, including **ROBERTO ROGELIO ROJAS,** in return for referring beneficiaries to Alephzayn so Alephzayn could bill Medicare for services that were not medically necessary and that were never provided.

5. ADALBERTO ~~ALBERTO~~ **PEREZ PEGUERO** caused patient recruiters to offer and pay kickbacks and bribes to the recruited beneficiaries, and caused patient recruiters to coach the recruited beneficiaries on how to obtain false and fraudulent prescriptions, so that Alephzayn could bill Medicare for home health services that were not medically necessary and that were never provided.

6. **ROBERTO ROGELIO ROJAS** and others recruited patients and offered and paid kickbacks and bribes to Medicare beneficiaries who permitted their beneficiary information to be used to submit claims to Medicare for services which were not provided and were not

medically necessary.

7. **MARIA ARCE** and others solicited and accepted kickbacks and bribes in exchange for permitting their beneficiary information to be used to submit claims to Medicare for services which were not provided and were not medically necessary.

8. ADALBERTO ~~ALBERTO~~ **PEREZ PEGUERO** and **MAYDELIN MATOS FERNANDEZ** caused Alephzayn to submit false and fraudulent claims to Medicare seeking payment for home health services purportedly provided to beneficiaries when, in truth, and in fact, such home health services were not provided and were not medically necessary.

9. As a result of such false and fraudulent claims, **ADALBERTO PEREZ PEGUERO** and **MAYDELIN MATOS FERNANDEZ** caused Medicare to make payments to Alephzayn.

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

COUNTS 2-4
Health Care Fraud
(18 U.S.C. § 1347)

1. Paragraphs 1 through 16 of the General Allegations section of this Superseding Indictment are re-alleged and incorporated by reference as though fully set forth herein.

2. From at least as early as in or around June of 2013, and continuing through in or around December of 2013, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendants,

ADALBERTO PEREZ PEGUERO,
MAYDELIN MATOS FERNANDEZ, and
MARIA ARCE,

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

Medicare, a health care benefit program affecting commerce, as defined by Title 18, United States Code, Section 24(b), 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, Medicare, that is, the defendants, submitted and caused the submission of false and fraudulent claims to Medicare, seeking reimbursement for the cost of various home health services.

Purpose of the Scheme and Artifice

3. It was a purpose of the scheme and artifice for the defendants and their accomplices to unlawfully enrich themselves by, among other things: (a) submitting and causing the submission of false and fraudulent claims to Medicare; (b) offering, paying, soliciting and receiving kickbacks and bribes in exchange for the use of Medicare beneficiary numbers as the bases of claims filed for home health care; and (c) concealing the submission of false and fraudulent claims and the payment and receipt of kickbacks.

The Scheme and Artifice

4. The allegations contained in paragraphs 4 through 9 of the Manner and Means section of Count 1 of this Superseding Indictment are re-alleged 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, the defendants as specified in each count below, 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 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 defendants submitted and caused the submission of false and fraudulent Medicare claims, representing that Alephzayn had provided various home health services to beneficiaries pursuant to physicians' POCs:

Count	Defendant(s)	Approx. Date of Billing	Service Claimed; Approx. Amount Paid
2	**ADALBERTO PEREZ PEGUERO, MARIA ARCE, and MAYDELIN MATOS FERNANDEZ**	12/04/2013	Physical Therapy; $5,061
3	**ADALBERTO PEREZ PEGUERO, MAYDELIN MATOS FERNANDEZ**	12/04/2013	Physical Therapy; $4,450
4	**ADALBERTO PEREZ PEGUERO, MAYDELIN MATOS FERNANDEZ**	12/06/2013	Physical Therapy; $4,450

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

COUNTS 5-8
Payment of Kickbacks in Connection with a Federal Health Care Program
(42 U.S.C. § 1320a-7b(b)(2)(A))

1. Paragraphs 1 through 14, and 17 of the General Allegations section of this Superseding 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 below, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

ADALBERTO PEREZ PEGUERO,

did knowingly and willfully offer and pay any remuneration, that is, kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind, to a person to induce such person to refer an individual for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole or in part under a Federal health care program, that is, Medicare, as set forth below:

Count	Approximate Date	Approximate Kickback Amount
5	08/01/2013	$1,000
6	08/26/2013	$1,000
7	10/01/2013	$1,000
8	12/23/2013	$4,500

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

COUNTS 9-10
Receipt of Kickbacks in Connection with a Federal Health Care Program
(42 U.S.C. § 1320a-7b(b)(1)(A))

1. Paragraphs 1 through 13 and 16 through 17 of the General Allegations section of this Superseding 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, as specified in each count below,

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

Count	Defendant	Approximate Date	Approximate Kickback Amount
9	**ROBERTO ROGELIO ROJAS**	08/01/2013	$3,000
10	**MARIA ARCE**	01/03/2014	$1,000

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 (a)(7))

1. The allegations contained in this Superseding 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 the defendants **ADALBERTO PEREZ PEGUERO, MAYDELIN MATOS FERNANDEZ, ROBERTO ROGELIO ROJAS** and **MARIA ARCE** have an interest.

2. Upon conviction of any violation of Title 18, United States Code, Section 1347 or Title 42, United States Code, Section 1320a-7b, or any conspiracy to commit such violations, as alleged in this Indictment, the defendant so convicted 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 pursuant to Title 18, United States Code, Section 982(a)(7).

All pursuant to Title 18, United States Code, Section 982(a)(7), and the procedures set forth in Title 21, United States Code, Section 853, made applicable by Title 18, United States Code, Section 982(b).

A TRUE BILL
FOREPERSON

WIFREDO A. FERRER
UNITED STATES ATTORNEY

JAMES V. HAYES
ASSISTANT U.S. ATTORNEY