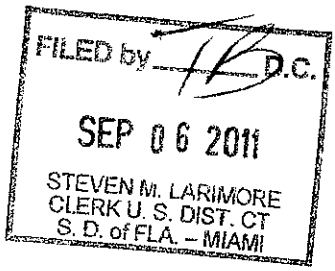
UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 11-20621 CR-UNGARO
/TORRES

18 U.S.C. § 1349
18 U.S.C. § 371
18 U.S.C. § 982



UNITED STATES OF AMERICA

vs.

ROBERTO GONZALEZ,
OLGA GONZALEZ,
and
FABIAN GONZALEZ,

Defendants.
_____/

INDICTMENT

The Grand Jury charges that:

GENERAL ALLEGATIONS

At all times material to this Indictment:

The Medicare Program

1. The Medicare Program ("Medicare") was a federal health care 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 were referred to as Medicare "beneficiaries."

2. Medicare was a "health care benefit program," as defined by Title 18, United States Code, Section 24(b).

3. "Part A" of the Medicare 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 were typically made directly to an HHA or provider based on claims submitted to the Medicare program for qualifying services that had been provided to eligible beneficiaries, rather than to the beneficiary.

4. Physicians, clinics and other health care providers, including HHAs, that provided services to Medicare beneficiaries were able to apply for and obtain a "provider number." A health care provider that received a Medicare provider number was able to file claims with Medicare to obtain reimbursement for services provided to beneficiaries. A Medicare claim was required to set forth, among other things, the beneficiary's name and Medicare information number, the services that were performed for the beneficiary, the date that 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 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.

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:

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.

7. 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.

8. In order to be reimbursed, 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" were 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.

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 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, 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 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.

11. Medicare Part A 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."

Special Outlier Provision

12. Medicare regulations allowed certified home health agencies to subcontract home health care services to nursing companies, registries, or groups (nursing groups), which would, in turn, bill the certified home health agency. That certified home health agency would then bill Medicare for all services provided to the patient by the subcontractor. The HHA's professional supervision over arranged-for services required the same quality controls and supervision of its own employees. However, Medicare regulations prohibit one home health agency merely serving as a billing mechanism for another agency.

13. For insulin-dependant diabetic beneficiaries, Medicare paid for insulin injections by an HHA when a beneficiary was determined to be unable to inject his or her own insulin and

the beneficiary had no available care-giver able and willing to inject the beneficiary. Additionally, for beneficiaries for whom occupational or physical therapy was medically necessary, Medicare paid for such therapy provided by an HHA. The basic requirements that a physician certify that a beneficiary is confined to the home or homebound and in need of home health services, as certified by a physician, was a continuing requirement for Medicare to pay for such home health benefits.

14. While payment for each episode of care was adjusted to reflect the beneficiary's health condition and needs, Medicare regulations contained an "outlier" provision to ensure appropriate payment for those beneficiaries who had the most extensive care needs, which may result in an Outlier Payment to the HHA. These Outlier Payments were additions or adjustments to the payment amount based on an increased type or amount of medically necessary care. Adjusting payments through Outlier Payments to reflect the HHA's cost in caring for each beneficiary, including the sickest beneficiaries, ensured that all beneficiaries had access to home health services for which they were eligible.

NANY Home Health, Inc.

15. NANY Home Health, Inc. ("NANY HH") was a Florida corporation incorporated on or about February 8, 1995, that did business in Miami-Dade County, Florida, as an HHA that purported to provide home health care and physical therapy services to eligible Medicare beneficiaries.

16. On or about February 8, 1995, **ROBERTO GONZALEZ** incorporated NANY HH and took ownership and control of NANY HH, listing himself as the owner and President of NANY HH.

17. On or about February 2, 2002, NANY HH obtained Medicare provider number

10-7732, authorizing NANY HH to submit claims to Medicare for HHA-related benefits and services.

18. On or about January 27, 2006, **ROBERTO GONZALEZ** listed himself on the For Profit Corporation Annual Report as the Registered Agent of NANY HH and listed the NANY HH principal place of business as 9010 SW 137 Avenue, Suite 111, Miami, Florida.

19. On or about October 1, 2007, through an amendment to the Articles of Incorporation, **OLGA GONZALEZ** took 50% ownership and control of NANY HH, listing herself as an owner and Vice President of NANY HH. **ROBERTO GONZALEZ** maintained a 50% ownership and control of NANY, listing himself as President of NANY HH.

20. From in or about January 1, 2006, through November 15, 2009, NANY HH submitted approximately $60 million in claims to the Medicare program for home health services that it purportedly provided to approximately 1474 beneficiaries. As a result of the submission of these claims, Medicare, through Palmetto, paid approximately $40 million to NANY HH.

The Defendants

21. Defendant **ROBERTO GONZALEZ,** a resident of Miami-Dade County, Florida, was President of NANY HH. **ROBERTO GONZALEZ** was also an owner and operator of NANY HH.

22. Defendant **OLGA GONZALEZ,** a resident of Miami-Dade County, Florida, was Vice President of NANY HH and the wife of **ROBERTO GONZALEZ. OLGA GONZALEZ** was also an owner and operator of NANY HH.

23. Defendant **FABIAN GONZALEZ,** a resident of Miami-Dade County, Florida, was the head of the Quality and Assurance Department for NANY HH and the son of **ROBERTO GONZALEZ** and **OLGA GONZALEZ.**

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

1. Paragraphs 1 through 23 of the General Allegations section of this Indictment are realleged and incorporated by reference as though fully set forth herein.

2. From in or around January 2006, through in or around November 2009, the exact dates being unknown to the Grand Jury, at Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendants,

ROBERTO GONZALEZ,
OLGA GONZALEZ,
and
FABIAN GONZALEZ,

did knowingly and willfully combine, conspire, confederate and agree with each other and 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 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) causing the submission of false and fraudulent claims to Medicare; (b) offering and paying kickbacks and bribes to Medicare beneficiaries for the purpose of such beneficiaries arranging for the use of their Medicare beneficiary numbers by the co-conspirators as the bases of claims filed for home health care; (c)

offering and paying kickbacks and bribes to home health agencies for such home health agencies providing beneficiary claims that formed the bases of claims filed for home health care; (d) causing the concealment of the submission of false and fraudulent claims to Medicare, the receipt and transfer of the proceeds from the fraud, and the payment and receiving of kickbacks; and (e) causing the diversion of the proceeds of the fraud for the personal use and benefit of the defendants and their co-conspirators.

MANNER AND MEANS

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

4. **ROBERTO GONZALEZ** and **OLGA GONZALEZ** would own and control NANY HH.

5. **ROBERTO GONZALEZ** and **OLGA GONZALEZ** would serve as corporate officers of NANY HH and administer NANY HH.

6. **ROBERTO GONZALEZ, OLGA GONZALEZ, FABIAN GONZALEZ** and other co-conspirators would pay kickbacks to co-conspirator patient recruiters for recruiting Medicare beneficiaries to be placed at NANY HH, which would, in turn, bill Medicare for home health services that were not medically necessary and were not provided.

7. **ROBERTO GONZALEZ, OLGA GONZALEZ, FABIAN GONZALEZ** and other co-conspirators would pay kickbacks to co-conspirator patient recruiters, knowing that the recruiters would pay kickbacks to Medicare beneficiaries in exchange for the beneficiaries signing documents stating that they had received the home health care services that were billed to Medicare, when, in fact, the home health care services were not provided and were not medically necessary.

8. **ROBERTO GONZALEZ, OLGA GONZALEZ, FABIAN GONZALEZ** and other co-conspirators caused the patient files and POCs to be falsified to make it appear that Medicare beneficiaries qualified for and received home health services that in reality were not medically necessary and never provided.

9. **ROBERTO GONZALEZ, OLGA GONZALEZ** and other co-conspirators would distribute kickback payments to the patient recruiters on behalf of NANY HH.

10. **ROBERTO GONZALEZ, OLGA GONZALEZ** and other co-conspirators would use medical billers to submit false and fraudulent claims to Medicare on behalf of NANY HH.

11. **ROBERTO GONZALEZ, OLGA GONZALEZ, FABIAN GONZALEZ** and their co-conspirators would cause the submission of approximately $60 million in false and fraudulent claims to Medicare under the provider number of NANY HH, seeking payment for the costs of home health services, including but not limited to diabetic injections, skilled nursing visits, therapy, and other treatments and services, that were not medically necessary and not provided.

12. **ROBERTO GONZALEZ, OLGA GONZALEZ, FABIAN GONZALEZ** and other co-conspirators would use the money paid by Medicare and transferred to themselves and their sham companies to compensate themselves and pay kickbacks and bribes to their co-conspirators.

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

COUNT 2
Conspiracy to Defraud the United States and to Receive and Pay Health Care Kickbacks (18 U.S.C. § 371)

1. Paragraphs 1 through 23 of the General Allegations section of this Indictment are

realleged and incorporated by reference as though fully set forth herein.

2. From in or around January 2006, and continuing through in or around November 2009, the exact dates being unknown to the Grand Jury, at Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendants,

ROBERTO GONZALEZ,
OLGA GONZALEZ,
and
FABIAN GONZALEZ,

did willfully, that is, with the intent to further the objects of the conspiracy, and knowingly combine, conspire, confederate and agree with each other and with others known and unknown to the Grand Jury, to commit certain offenses against the United States, that is,

a. 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 program;

b. To violate Title 42, United States Code, Section 1320a-7b(b)(1), by knowingly and willfully soliciting and receiving remuneration, specifically, kickbacks and bribes, directly and indirectly, overtly and covertly, in return for referring individuals for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole or in part by a Federal health care program, that is, Medicare; and in return for the purchasing, leasing, ordering, and arranging for and recommending the purchasing, leasing, and ordering of any good, item, and service for which payment may be made in whole and in part by a Federal health care program, that is, Medicare; and

c. To violate Title 42, United States Code, Section 1320a-7b(b)(2), by knowingly and willfully offering and paying remuneration, specifically, kickbacks and bribes, directly and indirectly, overtly and covertly, in return for referring individuals for the furnishing and

arranging for the furnishing of any item and service for which payment may be made in whole or in part by a Federal health care program, that is, Medicare; and in return for the purchasing, leasing, ordering, and arranging for and recommending the purchasing, leasing, and ordering of any good, item, and service for which payment may be made in whole and in part by a Federal health care program, that is, Medicare.

MANNER AND MEANS OF THE CONSPIRACY

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

3. **ROBERTO GONZALEZ, OLGA GONZALEZ,** and **FABIAN GONZALEZ** would offer and pay kickbacks to co-conspirator patient recruiters in return for referring Medicare beneficiaries to NANY HH for home health services.

4. **ROBERTO GONZALEZ, OLGA GONZALEZ,** and **FABIAN GONZALEZ** would cause co-conspirator patient recruiters of NANY HH to offer and pay kickbacks to Medicare beneficiaries in order to induce them to serve as patients for NANY HH regardless of whether they actually needed home health services.

5. **ROBERTO GONZALEZ, OLGA GONZALEZ,** and **FABIAN GONZALEZ** would offer and pay kickbacks to NANY HH co-conspirator patient recruiters in the same check they received for providing purported skilled nursing visits in order to disguise the payment of the kickback.

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 27, 2006, **ROBERTO GONZALEZ** added himself as the Registered Agent of NANY HH.

2. In or about December 2006, **OLGA GONZALEZ** paid a kickback to a co-conspirator via NANY HH check #24208, drawn on NANY HH's corporate account at Bank of America.

3. In or about December 2006, **OLGA GONZALEZ** paid a kickback to a co-conspirator via NANY HH check #23869, drawn on NANY HH's corporate account at Bank of America.

4. On or about October 1, 2007, **OLGA GONZALEZ** took 50% ownership and control of NANY HH, adding herself as an owner and Vice President of NANY HH.

5. On or about May 31, 2007, **ROBERTO GONZALEZ** drafted check #26298 in the amount of $7,500 from the NANY HH corporate account made payable to F.G.S., a company for which **FABIAN GONZALEZ** was an authorized signatory on its bank account.

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

CRIMINAL FORFEITURE
(18 U.S.C. § 982)

1. The allegations contained Count 1 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 one or more of defendants, **ROBERTO GONZALEZ, OLGA GONZALEZ,** and **FABIAN GONZALEZ,** have an interest.

2. Upon conviction of Count 1, as alleged in this Indictment, the defendants, **ROBERTO GONZALEZ, OLGA GONZALEZ,** and **FABIAN 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 pursuant to Title 18, United States Code, Section 982(a)(7).

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

a. cannot be located upon the 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)(I).

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

WIFREDO A. FERRER
UNITED STATES ATTORNEY

For HANK BOND WALTHER
DEPUTY CHIEF
CRIMINAL DIVISION, FRAUD SECTION
U.S. DEPARTMENT OF JUSTICE

For JOSEPH S. BEEMSTERBOER
TRIAL ATTORNEY
CRIMINAL DIVISION, FRAUD SECTION
U.S. DEPARTMENT OF JUSTICE