UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 15-cr-20387-WPD/LSS
18 U.S.C. § 1349
18 U.S.C. § 371
42 U.S.C. § 1320a-7b(b)(1)(A)
18 U.S.C. § 2
18 U.S.C. § 982(a)(7)

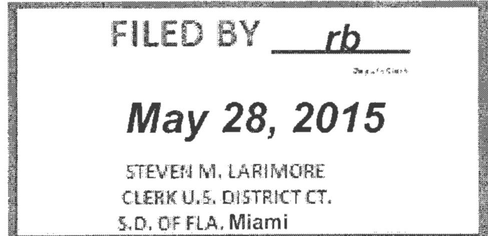
UNITED STATES OF AMERICA

vs.

IVAN FONSECA and
IVON FONSECA,

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 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 persons who already qualified for Medicare and who additionally 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. 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"). 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 first contracted with TriCenturion, a Program Safeguard Contractor. Subsequently, on December 15, 2008, CMS contracted with SafeGuard Services, a Zone Program Integrity Contractor. Both TriCenturion and 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

5. 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.

Record Keeping Requirements

6. 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 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.

7. Among the written records required to document the appropriateness of home health care claims submitted under Part A of Medicare were a: (i) P.O.C. 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.

8. 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."

9. Medicare regulations allowed Medicare certified HHAs to subcontract home health care services to nursing companies, therapy staffing services agencies, 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.

10. Medicare paid for insulin injections by an HHA when a beneficiary was determined to be unable to inject his/her own insulin and the beneficiary had no available caregiver able or

willing to inject the beneficiary. The basic requirement that the beneficiary be confined to the home or be homebound was a continuing requirement for a Medicare beneficiary to receive home health benefits.

The Defendants and Related Companies

11. RPH Home Health Care Inc. ("RPH") was incorporated on or about February 10, 2009, and did business in Miami-Dade County, purportedly providing skilled nursing services to Medicare beneficiaries that required home health services.

12. F&D Palmetto Consultant, Inc. ("F&D") was incorporated on or about January 14, 2011, and purportedly did business in Miami-Dade County.

13. Unlimited Care of Florida, Inc. ("Unlimited") was incorporated on or about September 24, 2003, and did business in Miami-Dade County, purportedly providing skilled nursing services to Medicare beneficiaries that required home health services.

14. Exceptional Kidz Rehab Academy, Inc. ("Exceptional") was incorporated on or about May 24, 2010, and did business in Miami-Dade County, purportedly providing physical therapy services to Medicare beneficiaries that required home health services.

15. C&M Health Care Management, Inc. ("C&M") was incorporated on or about April 6, 2010, and did business in Miami-Dade County, purportedly providing medical services to Medicare beneficiaries and other patients.

16. Defendant **IVAN FONSECA,** a resident of Miami-Dade County, was an owner of RPH. **IVAN FONSECA** was an owner and the president of F&D.

17. Defendant **IVON FONSECA,** a resident of Miami-Dade County, was an owner and the president of RPH. **IVON FONSECA** was an owner of F&D.

18. Eduardo Hernandez, a resident of Miami-Dade County, was the president of Unlimited.

19. Rosina Levy-Cheverez, a resident of Miami-Dade County, was the president of Exceptional.

20. Maria Martins, a resident of Miami-Dade County, was the president of C&M.

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

1. Paragraphs 1 through 12, 14 through 17, 19 and 20 of the General Allegations section of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

2. From on or about July 14, 2011, and continuing through at least on or about July 27, 2012, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendants,

IVAN FONSECA and
IVON FONSECA,

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

a. to knowingly and willfully 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, in violation of Title 18, United States Code, Section 1347; and

b. to knowingly and with the intent to defraud devise and intend to devise a scheme and artifice to defraud and for obtaining money and property by means of materially false and fraudulent pretenses, representations, and promises, knowing the pretenses, representations, and promises were false and fraudulent when made, and for the purpose of executing the scheme and artifice, did knowingly transmit and cause to be transmitted by means of wire communication in interstate commerce, certain writings, signs, signals, and sounds, in violation of Title 18, United States Code, Section 1343 .

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; and (b) concealing the submission of false and fraudulent claims to Medicare.

MANNER AND MEANS

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

4. **IVAN FONSECA** and **IVON FONSECA** purchased home health prescriptions from Maria Martins which falsely and fraudulently represented that Medicare beneficiaries qualified for home health services when, in fact, they did not qualify for home health services.

5. **IVAN FONSECA** and **IVON FONSECA** paid Rosina Levy Cheverez to provide

them with documentation that falsely and fraudulently represented that RPH provided physical therapy to Medicare beneficiaries, when in fact, RPH had not provided physical therapy to Medicare beneficiaries.

6. **IVAN FONSECA** and **IVON FONSECA** submitted and caused RPH to submit false and fraudulent claims to Medicare, via interstate wire, seeking payment for physical therapy services that were not medically necessary, not provided by properly licensed physical therapists, and not actually provided to Medicare beneficiaries.

7. As a result of these false and fraudulent claims, RPH received payment from Medicare in the approximate sum of at least $1,935,113.

8. **IVAN FONSECA** and **IVON FONSECA** diverted the fraud proceeds for the personal use and benefit of themselves and to further the fraud.

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

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

1. Paragraphs 1 through 10, 12 and 13, and 16 through 18 of the General Allegations section of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

2. From on or about September 24, 2012, and continuing through on or about February 20, 2013, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendants,

IVAN FONSECA and
IVON FONSECA,

did willfully, that is, with the intent to further the objects of the conspiracy, and knowingly

combine, conspire, confederate and agree each other and with Eduardo Hernandez and 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 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 kickbacks and bribes, 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 the furnishing and arranging 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.

Purpose of the Conspiracy

3. It was the purpose of the conspiracy for the defendants and their co-conspirators to unlawfully enrich themselves by: (1) soliciting and receiving kickbacks and bribes in return for referring Medicare beneficiaries to Unlimited to serve as patients; and (2) submitting and causing the submission of claims to Medicare for home health services Unlimited purported to provide to those beneficiaries.

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:

4. **IVAN FONSECA** and **IVON FONSECA** accepted kickbacks from Eduardo Hernandez in return for referring Medicare beneficiaries to Unlimited for home health services.

5. **IVAN FONSECA, IVON FONSECA** and their co-conspirators caused Unlimited

to submit claims to Medicare for home health services purportedly provided to the recruited Medicare beneficiaries.

6. **IVAN FONSECA, IVON FONSECA** and their co-conspirators caused Medicare to pay Unlimited based upon the home health services purportedly provided to the recruited 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 October 11, 2012, **IVAN FONSECA** withdrew the approximate sum of $5,470 from the F&D corporate bank account.

2. On or about October 13, 2012, **IVAN FONSECA** withdrew the approximate sum of $5,000 from the F&D corporate bank account.

3. On or about December 12, 2012, **IVAN FONSECA** and **IVON FONSECA** met with Hernandez and discussed the recruitment of specific Medicare beneficiaries to Unlimited. At this meeting, Hernandez paid **IVAN FONSECA** and **IVON FONSECA** a check in the approximate sum of $10,000 as a kickback for the referral of Medicare beneficiaries to Unlimited.

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

COUNTS 3-6
Receipt of Kickbacks in Connection with a Federal Health Care Program
(42 U.S.C. § 1320a-7b(b)(1)(A))

1. Paragraphs 1 through 10, 12, 13, and 16 through 18 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 defendants,

IVAN FONSECA and
IVON FONSECA,

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

Count	Approximate Date	Approximate Kickback Amount
3	9/24/2012	$11,000
4	11/21/2012	$5,000
5	12/12/2012	$10,000
6	2/20/2013	$9,700

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

FORFEITURE ALLEGATIONS
(18 U.S.C. § 982)

1. The General Allegations and the allegations of Counts 1 through 6 of this Indictment are re-alleged 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 defendants, **IVAN FONSECA** and **IVON FONSECA**, have an interest.

2. Upon conviction of a "Federal health care offense," as defined by Title 18, United

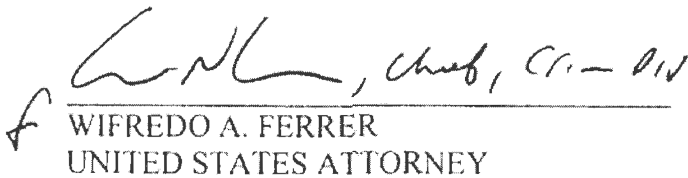
States Code, Section 24, as alleged in this Indictment, the defendant so convicted shall forfeit to the United States of America, pursuant to Title 18, United States Code, Section 982(a)(7), any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of such offense.

3. The property which is subject to forfeiture includes, but is not limited to, the following: No less than $2,194,065 (US), which sum of money approximately equal in value to the property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the fraud alleged in this Indictment, which the United States will seek as a forfeiture money against the defendants, jointly and severally, upon conviction.

All pursuant to Title 18, United States Code, Section 982(a)(7), and the procedures set forth at Title 21, United States Code, Section 853, as made applicable by Title 18, United States Code, Section 982(b)(1).

A TRUE BILL

FOREPERSON



WIFREDO A. FERRER
UNITED STATES ATTORNEY

KEVIN J. LARSEN
ASSISTANT UNITED STATES ATTORNEY