

UNITED STATES DISTRICT COURT  
SOUTHERN DISTRICT OF FLORIDA

Case No.

09-21736

UNITED STATES OF AMERICA,

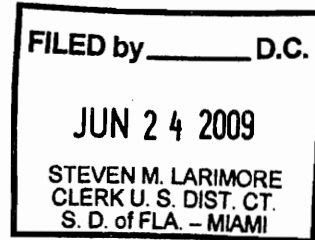
Plaintiff,

CIV-MORENO /TORRES

vs.

ABC HOME HEALTH CARE, INC.;  
FLORIDA HOME HEALTH CARE  
PROVIDERS, INC.; GLADYS ZAMBRANA;  
ENRIQUE PEREZ; JAVIER ZAMBRANA;  
CARLOS CASTANEDA;  
ALEJANDRO HERNANDEZ QUIROS  
a/k/a ALEX HERNANDEZ; and  
VICENTA TELLECHEA,

Defendants.



FILED UNDER SEAL

**MEMORANDUM OF LAW AND INCORPORATED STATEMENT OF FACTS IN  
SUPPORT OF UNITED STATES' EMERGENCY EX PARTE MOTION FOR ENTRY OF  
TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION**

The United States of America seeks a temporary restraining order, preliminary injunction, and other equitable relief in this matter to prevent further losses from being suffered by the United States through the Medicare program as a result of Defendants' submitting, or causing to be submitted, false or fraudulent health care claims for payment. As of the date of this Memorandum, Medicare has paid Defendants ABC HOME HEALTH CARE, INC. ("ABC") and FLORIDA HOME HEALTH CARE PROVIDERS, INC. ("FHH"), over \$15.1 million as a result of their false, fictitious, and fraudulent health care billings.

Injunctive and equitable relief are necessary because they are the only certain methods of relief that can stop Defendants from continuing to obtain Medicare money through false claims and Federal health care offenses and that can prevent the dissipation or concealment from the United States of funds and assets that were obtained by Defendants through their submission of false claims.

## **I. STATEMENT OF FACTS**

The United States has collected substantial evidence that demonstrates that Defendants are engaging in an elaborate scheme to defraud the Medicare program. *See* Declaration of Special Agent Lynnette Alvarez-Karnes in Support of United States' *Ex Parte* Motion for Temporary Restraining Order and Preliminary Injunction ("Alvarez-Karnes Decl."). In brief, the information collected to date demonstrates that Defendants operated ABC and then FHH for the exclusive purpose of defrauding the United States. The evidence demonstrates that Defendants submitted **over \$22 million** in false claims for home health care services that were not medically necessary, not actually provided, and often obtained through the payment of illegal kickbacks.

In particular, the investigation shows four critical types of evidence that persuasively demonstrate that Defendants were perpetrating a massive fraud on the Medicare program:

1. Defendants represented to Medicare that the home health services they allegedly provided were ordered by physicians who in fact never ordered any such services. Indeed, Medicare paid ABC \$427,717.59 for such false claims relating to just one doctor, who

was already cooperating with federal authorities and did not prescribe the services ABC billed for when ABC claimed he ordered the services. Alvarez-Karnes Decl. ¶¶ 42-43.

2. Defendants billed Medicare more than **\$19 million** for allegedly sending skilled nurses to patients' homes to inject insulin twice a day, even though the patients had no medical need of insulin injections. Medicare paid Defendants more than **\$12 million** for these false claims. Alvarez-Karnes Decl. ¶¶ 15-24.

3. Defendants obtained patients' information and fraudulent orders from physicians by paying illegal cash kickbacks to patients and doctors, and paid at least one lab technician to alter blood results to make it appear as if the patients actually needed insulin injections, when in fact they did not. Alvarez-Karnes Decl. ¶¶ 15-24.

4. After using ABC to defraud Medicare of over \$11 million, Defendants assumed ownership and control of FHH, transferred 43 of their patients from ABC to FHH, and used FHH to defraud Medicare of more than \$4 million, using the same schemes they used at ABC. Alvarez-Karnes Decl. ¶ 16.

The inescapable conclusion is that since Defendants took control of ABC and FHH, ABC and FHH had no legitimate purpose and have not provided any medical services but rather have been engaged in a massive scheme to defraud Medicare. Thus, Defendants have violated numerous federal statutes, including those involving health care fraud and submitting false, fraudulent, or fictitious statements and/or claims to the United States. In particular, Defendants have violated 18 U.S.C. § 1347, and have committed other Federal health care offenses as defined in 18 U.S.C. § 24. Violations of these statutes trigger the right to injunctive relief sought herein by the United States under 18 U.S.C. § 1345.

**A. The Defendants.**

ABC is a company organized and existing under the laws of the State of Florida, and was incorporated on February 10, 2004. According to ABC's public filings with the Florida Secretary of State, Defendant JAVIER A. ZAMBRANA (the son of Defendant GLADYS ZAMBRANA) became ABC's sole officer, director, and registered agent, effective January 31,

2006. On August 15, 2006, Defendant ENRIQUE PEREZ (“PEREZ”) became ABC’s vice president and partial owner. On February 27, 2007, Defendant GLADYS ZAMBRANA became ABC’s treasurer. On June 28, 2007, GLADYS ZAMBRANA was removed as ABC’s treasurer, and PEREZ replaced JAVIER ZAMBRANA as ABC’s registered agent. On July 1, 2007, according to ABC’s public filings, PEREZ became ABC’s sole officer, director, and owner. In fact, however, Defendants PEREZ, GLADYS ZAMBRANA, and ALEJANDRO HERNANDEZ QUIROS a/k/a ALEX HERNANDEZ (“HERNANDEZ”) were the true owners of ABC. Alvarez-Karnes Decl. ¶¶ 4-7, 11, 12, 15.

FHH is also a company organized and existing under the laws of the State of Florida, and was incorporated on August 25, 2004. According to FHH’s public filings with the Florida Secretary of State, Defendant VINCENTA TELLECHEA (“TELLECHEA”) became FHH’s president and registered agent on September 28, 2007. On November 30, 2007, GLADYS ZAMBRANA became FHH’s secretary. On June 30, 2008, according to its public filings, GLADYS ZAMBRANA became FHH’s vice-president and secretary. In fact, however, GLADYS ZAMBRANA and Defendant CARLOS CASTANEDA (“CASTANEDA”), who is TELLECHEA’s son, were the true owners of FHH. Alvarez-Karnes Decl. ¶¶ 9-10, 11, 14.

Defendants GLADYS ZAMBRANA, JAVIER ZAMBRANA, PEREZ, CASTANEDA, HERNANDEZ, and TELLECHEA, all residents of Miami-Dade County, are collectively referred to as the “Individual Defendants.”

**B. The Medicare Program.**

Medicare is a federal health insurance program that provides coverage for people age 65 or older and for certain disabled people. Individuals who receive benefits under Medicare are commonly referred to as “beneficiaries.” Medicare is financed by federal funds including funds from payroll taxes and premiums paid by beneficiaries. Benefits available under Medicare are prescribed by statute and by federal regulations administered by HHS, through its agency, CMS. Alvarez-Karnes Decl. ¶ 19.

The Medicare program is divided into different “parts.” “Part A” of the Medicare program covers certain health services provided by hospitals, skilled nursing facilities, hospices, and – at issue in this case – home health agencies (“HHAs”). Defendants ABC and FHH were both HHAs participating in Medicare. *Id.* ¶ 20.

Payments under the Medicare program are often made directly to a provider of the services, such as an HHA, rather than to the beneficiary. This occurs when the HHA provider accepts assignment of the right to payment from the beneficiary. In that case, the HHA provider submits the claim to Medicare for payment, either directly or through a billing company.

Claims for payment are not submitted directly to CMS. Instead, various entities are under contract to provide services to CMS. These services include processing and paying Medicare claims and safeguarding the integrity of the Medicare program. In the Southern District of Florida, Palmetto Government Benefits Administrators (“Palmetto”) is responsible for processing and paying claims related to home health services provided by HHAs. *Id.* ¶ 22.

In order to be eligible to file a claim for payment with Medicare, an HHA must submit an enrollment application to obtain a provider number. In the application, the HHA agrees to abide by all Medicare laws, regulations, and program instructions applicable to HHAs. Further, the HHA certifies that it understands that payment of a claim by Medicare is conditioned upon the claims and the underlying transaction complying with such laws, regulations, and applicable program instructions and on the HHA’s compliance with all applicable conditions of participation in Medicare. After obtaining a provider number, the HHA would then submit or cause the submission of claims to an entity that processed those claims for CMS, such as Palmetto. When a claim was submitted, the HHA would specifically certify that the contents of the claim were true, correct, and complete, and that the claim was prepared in compliance with all Medicare laws and regulations. *Id.* ¶¶ 23-24

In order to bill Medicare for services purportedly rendered, Defendants ABC and FHH submitted a claim form (Form 1450) to Palmetto. When a Form 1450 was submitted, usually in electronic form, the provider HHA certified that the contents of the claim form were true,

correct, complete, and that the form was prepared in compliance with all Medicare laws and regulations. The information in the claim form, including the beneficiary's name, the specific services provided, the dates of service, and the prescribing or referring physician, was the basis for the payment to the HHA provider. *Id.* ¶ 26.

1. **Home Health Agency Billings and Payment Under Medicare.**

Medicare paid for specified home health services provided by or under arrangement with an HHA only when certain requirements were met. Specifically, Medicare paid for such services only when the beneficiary was: (1) confined to the home; (2) under the care of a physician who established and periodically reviewed a Plan Of Care ("POC"); and (3) in need of skilled services, which included skilled nursing care, physical and speech therapy, and, if one of these skilled services was required, occupational therapy. 42 U.S.C. § 1395n(a)(2)(A); 42 C.F.R. § 409.42. In addition, Medicare would only pay for home health services if those services were medically necessary. 42 U.S.C. § 1395f(a)(2); 42 U.S.C. § 1395n(a)(2)(A).

As relevant to this case, assuming the above criteria were met, Medicare would pay for skilled nursing visits to administer insulin injections to eligible beneficiaries if they were insulin-dependent diabetics who were confined to their home, unable to inject their own insulin and had no care-giver available able or willing to inject the insulin, and had an appropriate POC. (However, such reimbursement would not include the actual insulin, syringes, needles, and other supplies needed to inject the insulin, or durable medical equipment supplies needed to test and monitor a beneficiary's blood glucose level. The insulin and other supplies had to be provided by the beneficiary, and was reimbursed under Medicare Part D and Part B.) Alvarez-Karnes Decl. ¶ 28.

The POC was required to identify the medical treatments to be furnished, the type of home health discipline that would furnish those services (*i.e.*, skilled nursing for insulin injections or physical therapy), and the frequency the services would be provided. Specifically, among other things, the POC had to include: the medical necessity of the home health services; all pertinent diagnoses, including mental status; types of services and equipment required;

frequency of visits; nutritional requirements; medications and treatments; instructions for timely discharge or referral; and any other appropriate items. POCs that included an order for rehabilitation therapy services had to include the specific procedures and modalities to be used and the amount, frequency, and duration. 42 C.F.R. § 409.43.

The physician who established the POC had to sign and date the POC. The physician certified that the beneficiary was confined to the home, needed skilled nursing services or rehabilitation therapy, and was under an established POC that was regularly reviewed by a physician. 42 U.S.C. § 1395n(a)(2)(A); 42 U.S.C. § 1395f(a)(2)(C); 42 C.F.R. § 424.22. The POC had to be reviewed by a physician, in consultation with the HHA personnel, at least every 60 days. 42 C.F.R. § 409.43(e). Each 60-day period was referred to as an “episode.” *Id.* Payment for covered home health services was calculated and provided to HHAs based on each 60-day episode. 42 C.F.R. § 484.205.

Medicare payments to HHAs for each 60-day episode were based on fixed, predetermined amounts that could be adjusted downward based on low utilization or to reflect an episode lasting less than 60 days. 42 C.F.R. § 484.205(b). This fixed amount was geographically adjusted, based on the beneficiary’s location. It was also adjusted to reflect the characteristics and corresponding home health care needs of the individual beneficiary. This patient-specific adjustment (known as a “case-mix adjustment”) was calculated based on the Outcome and Assessment Information Set (“OASIS”) that had to be submitted to Medicare by the HHA at the start of the beneficiary’s first episode of care. A registered nurse had to conduct and complete the OASIS, and that OASIS evaluation had to be conducted at least once every 60-day episode. 42 C.F.R. § 484.55. The nurse could be an employee of the HHA, or could be providing those services under arrangement with the HHA.

In addition to the case-mix adjustment, the fixed per-episode payments could be increased if the beneficiary’s 60-day episode qualified as an outlier. 42 C.F.R. § 484.205(b). Outliers were beneficiaries whose home health care needs, as determined by and recorded on the OASIS and the POC, exceeded the average, and thus the costs of providing home health services

to those beneficiaries would be far higher than the normal threshold dollar amount. Medicare therefore paid an HHA additional amounts for each beneficiary who was categorized as an outlier. 42 C.F.R. § 484.240; 42 C.F.R. § 484.205(e).

Unlike traditional Medicare reimbursements, HHAs did not have to wait until after the services were provided in order to bill Medicare. Instead, they could submit a claim for payment in anticipation of providing services. Such a claim was called a Request for Anticipated Payments (“RAP”). 42 C.F.R. § 409.43(c)(2). For a beneficiary’s first 60-day episode of care, when an HHA submitted a RAP, Medicare would pay the HHA 60% of the total expected payment for that patient’s episode, including payments for case-mix, geographic, and outlier adjustments. 42 C.F.R. § 484.205(b). Upon completion of the beneficiary’s first 60-day episode, the HHA would then submit its final claim to Medicare. Medicare would then pay the HHA the remaining 40% of the total payment for that episode. *Id.* A physician had to certify the POC, as detailed above, before the final claim was submitted to Medicare. 42 C.F.R. § 409.43(c)(3).

The HHA would then submit to Medicare a RAP at the beginning of each subsequent 60-day episode, and a final claim at the end of each episode, but the reimbursement was split 50%-50% for these subsequent episodes, rather than the 60%-40% split in the first episode. 42 C.F.R. § 484.205(b). Thus, for each beneficiary, an HHA would submit two claims to Medicare for each 60-day episode of providing home health services.

The RAP is a “claim” for purposes of Federal criminal, civil, and administrative law enforcement authorities, including but not limited to the False Claims Act. 42 C.F.R. § 409.43(c)(2). The Health Care Fraud Statute, 18 U.S.C. § 1347, prohibits the knowing and intentional submission of false or fraudulent claims for payment to any health care benefit program. Medicare is a health care benefit program, as defined in 18 U.S.C. § 24(b)

**C. Defendants’ Fraudulent Billing Schemes.**

Because they were owned and operated by the same group of people – the Individual Defendants – ABC and FHH committed the same health care fraud using the same schemes (and

indeed, once the Defendants took control of FHH, they simply transferred fraudulent billings for 43 beneficiaries from ABC to FHH). Alvarez-Karnes Decl. ¶ 60. Both ABC and FHH's primary function was to act as vehicle to perpetrate a massive fraud upon the Medicare program. ABC and FHH failed to provide home health services they billed for, failed to obtain proper POCs, paid kickbacks to obtain POCs and beneficiaries, and claimed to have provided home health services to Medicare beneficiaries who were not eligible to receive such services. ABC and FHH submitted false, fabricated claims to Medicare for reimbursement of home health services.

**1. ABC.**

On or about March 3, 2005, ABC signed and submitted a Medicare enrollment application (CMS form 855A), in which, among other things, ABC agreed to abide by all Medicare laws and regulations. ABC subsequently received a Medicare provider number (10-8147) from Medicare, effective March 22, 2005. On or about March 30, 2006, ABC submitted to Medicare an updated form 855A advising Medicare that Defendant JAVIER ZAMBRANA had become the new owner of ABC, effective January 11, 2006. In or around August 2007, ABC submitted another updated form 855A, stating to Medicare that, effective July 1, 2007, Defendant ENRIQUE PEREZ replaced JAVIER ZAMBRANA as ABC's owner. The August 2007 submission was certified by Defendant PEREZ. Alvarez-Karnes Decl. ¶¶ 37-39.

From on or about January 12, 2006, through December 4, 2008, ABC submitted approximately 2,580 claims to Medicare, totaling \$17,026,543.00. These home health services claims were principally for skilled nursing services (the administration of injectable insulin to purported insulin-dependent beneficiaries allegedly confined to their homes), home health aides, and physical therapy that ABC claimed to have provided to eligible Medicare beneficiaries. However, many if not all of these claims were for services not rendered, not medically necessary, or otherwise tainted by fraud. Based on those submitted claims, Medicare, through Palmetto, ultimately paid ABC approximately \$11,293,852.39. Alvarez-Karnes Decl. ¶ 40.

2. **FHH**

On or about August 22, 2005, FHH signed and submitted a Medicare enrollment application (CMS form 855A), in which, among other things, FHH agreed to abide by all Medicare laws and regulations. FHH subsequently received a Medicare provider number (10-8298) from Medicare, effective May 9, 2006. Once it received a Medicare provider number, FHH was able to bill and be paid by Medicare for covered and eligible home health services. On or about January 18, 2008, FHH submitted to Medicare an updated form 855A advising Medicare that TELLECHEA had been added as an owner, managing employee, and officer of FHH, effective September 28, 2007. On or about December 19, 2007, FHH submitted to Medicare an updated form 855A advising Medicare that Defendant GLADYS ZAMBRANA had become an owner of FHH, effective November 30, 2007. Alvarez-Karnes Decl. ¶¶ 57-58.

From on or about September 28, 2007, when Defendant GLADYS ZAMBRANA and her co-conspirators took control and ownership of FHH, continuing through the present, FHH submitted at least 1,022 claims to Medicare, totaling more than \$5,475,723.18. At least \$5,153,953.87 of that amount were home health services claims for skilled nursing services – specifically, the administration of injectable insulin to purported insulin-dependent beneficiaries who were allegedly confined to their homes – along with home health aides and physical therapy that FHH claimed to have provided to such Medicare beneficiaries. In fact, most if not all of these claims were for services never rendered and not medically necessary, and otherwise tainted by fraud. Medicare paid FHH more than \$4,007,003.57 for these false claims. Alvarez-Karnes Decl. ¶ 59.

3. **Billing for Services Not Rendered and Not Medically Necessary.**

Among other claims, ABC submitted 82 claims to Medicare totaling \$662,200.00 for home health services allegedly provided to six beneficiaries. According to the claims ABC submitted to Medicare, Jorge Valido, M.D., was the physician who signed the POC for each of those beneficiaries and who certified the need for the home health services. However, Dr. Valido never treated those beneficiaries and never certified any POCs. All 82 claims submitted

by ABC to Medicare that identified Dr. Valido as the certifying physician are completely false claims. Medicare paid ABC \$427,717.59 for those 82 false claims. *Id.* ¶ 42-43.

Among other claims, FHH submitted 24 claims to Medicare totaling \$169,480.88 for home health services allegedly provided to beneficiaries M.L. and B.R. FHH claimed to have provided skilled nursing visits to each beneficiary several times a day for the injection of insulin. However, the physicians actually treating these beneficiaries stated that both of the beneficiaries take oral hyperglycemic agents to control their diabetes, and neither beneficiary needs nor takes any injectable insulin. Medicare paid FHH \$120,461.51 for the false claims relating to M.L. and B.R. Alvarez-Karnes Decl. ¶¶ 61-66.

Among other claims, from on or about March 9, 2006, through December 5, 2008, ABC submitted to Medicare 226 claims totaling \$1,623,354.00 for home health services allegedly provided to 21 beneficiaries. Among other claims, from on or about September 28, 2007, through March 19, 2009, FHH submitted to Medicare at least 470 claims totaling \$2,774,419.60 for home health services allegedly provided to 61 beneficiaries. According to the claims submitted by ABC and FHH to Medicare, all of these beneficiaries were insulin-dependent diabetics confined to the home and in need of skilled nursing care to administer the insulin. ABC and FHH thus billed Medicare for providing two or more skilled nursing visits a day to each beneficiary, as well as home health aides and physical therapy services. Alvarez-Karnes Decl. ¶¶ 44-45, 67.

In fact, none of these beneficiaries were insulin-dependent diabetics confined to the home, and they did not need a skilled nurse to administer insulin. Analysis of Medicare records and billing data establish that these beneficiaries failed to order sufficient insulin, needles, and/or syringes necessary to receive the numerous daily insulin injections ABC and FHH claimed to have provided. Indeed, some beneficiaries failed to order any insulin at all, and others were already taking oral hyperglycemic agents to manage or control their diabetes, and had no medical need for insulin injections. Many other beneficiaries never purchased the lancets, test strips, and controls that are absolutely indispensable to conduct the multiple-times-a-day testing of their

blood glucose levels that had to be done before receiving any insulin injections. In short, the claims submitted by Defendants were false, fraudulent claims for services that were not medically necessary and never actually rendered. Medicare paid ABC at least \$1,063,037.40 for those false claims, and Medicare paid FHH at least \$2,026,314.94 for those false claims. *Id.* ¶¶ 46, 68-69.

For example, from on or about December 21, 2006, through May 9, 2008, ABC submitted to Medicare 18 claims totaling \$144,200.00 for home health services allegedly provided to beneficiary A.J. From on or about March 24, 2007, through July 12, 2008, ABC submitted to Medicare 14 claims totaling \$121,200.00 for home health services allegedly provided to beneficiary J.S. And from on or about March 12, 2007, through October 23, 2008, ABC submitted to Medicare 20 claims totaling \$161,607.20 for home health services allegedly provided to beneficiary R.U. *Id.* ¶¶ 47-51.

Similarly, by way of example, from on or about February 12, 2008, through February 13, 2009, FHH submitted to Medicare 18 claims totaling \$145,153.14 for home health services allegedly provided to beneficiary O.F. From on or about September 28, 2007, through February 6, 2009, FHH submitted to Medicare 18 claims totaling \$94,470.88 for home health services allegedly provided to beneficiary M.G. From on or about October 24, 2007, through October 23, 2008, FHH submitted to Medicare 12 claims totaling \$72,060.00 for home health services allegedly provided to beneficiary R.A. *Id.* ¶¶ 70-76.

However, none of these beneficiaries were insulin-dependent diabetics confined to their homes, and Defendants did not provide the skilled nursing or other services they billed to Medicare. All six beneficiaries failed to order insulin and syringes for much of the time that Defendants billed Medicare for allegedly sending a nurse to their homes to inject the insulin. Indeed, J.S. failed to order any syringes – needed to inject the insulin – during the entire time Medicare paid ABC for allegedly injecting her twice a day with insulin. R.U. and M.G. rarely ordered the lancets or glucose test strips that would have been absolutely indispensable to conduct the multiple-times-a-day testing of blood glucose levels that had to be done before

administering any insulin injections.<sup>1</sup> *Id.* ¶¶ 47-52, 70-76.

Without insulin and syringes, nurses sent by ABC or FHH could not have injected any insulin, and without the appropriate supplies, the beneficiaries could not check their glucose level and thus could not know when or how much insulin should be administered. In sum, none of these beneficiaries had any medical need of a skilled nurse to inject insulin twice a day, and Defendants did not provide that service to these beneficiaries. All of Defendants' claims to Medicare for home health services allegedly provided to these six beneficiaries are false, fabricated claims. Medicare paid ABC \$276,740.10 for these false claims, and Medicare paid FHH \$227,163.84 for these false claims.<sup>2</sup> *Id.* ¶¶ 48, 50, 52, 71, 74, 76.

#### **4. Kickbacks Paid By ABC & FHH.**

In addition, many of the claims Defendants submitted to Medicare through ABC and FHH are fraudulent because they were obtained through the payment of kickbacks to beneficiaries and others, in violation of Medicare rules and regulations and the federal anti-kickback statute, 42 U.S.C. § 1320a-7b(b)(2). Defendants GLADYS ZAMBRANA, PEREZ, HERNANDEZ, CASTANEDA, and TELLECHEA, among others, paid such kickbacks. Alvarez-Karnes Decl. ¶¶ 53-54, 77-79.

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<sup>1</sup> Moreover, from January 2006 until March 2007, when ABC began billing for her nurse visits and insulin injections, R.U. ordered insulin only twice, in January and March of 2006, and was instead apparently managing her diabetes by oral hyperglycemic agents. R.U.'s Medicare claims data after October 2008, when she left ABC and switched to FHH, displays similar gaps in obtaining syringes and testing supplies. Further, M.G. was regularly filling prescriptions for Glipizide ER, an oral hyperglycemic agent used to treat type II diabetes. However, FHH stated on its billings to Medicare that M.G. suffered from Type I, or juvenile, diabetes. Persons with Type I diabetes do not need and do not take oral hyperglycemic agents. Alvarez-Karnes Decl. ¶¶ 52, 73.

<sup>2</sup> Beneficiary M.G. is a perfect example of how Defendants simply transitioned their fraud from ABC to FHH. Prior to FHH's fraudulent billings to Medicare for home health services allegedly provided to M.G., ABC had similarly billed Medicare such services, principally a skilled nurse to inject insulin. From on or about May 19, 2006, through September 25, 2007, ABC submitted 16 claims to Medicare totaling \$136,600.00 for such home health services, allegedly provided by ABC to M.G. from May 19, 2006, to August 29, 2007. However, M.G. failed to order insulin or syringes for six of those months. In addition, from August 30, 2007, when ABC purportedly stopped providing a nurse to administer insulin to M.G., through September 28, 2007, when FHH allegedly began such services, M.G. had no home health nurse to administer insulin, so he either never needed the nurse to inject insulin or was miraculously cured of his alleged insulin-dependence for a month. Either way, all of ABC and FHH's claims to Medicare were false claims. In addition to the \$69,992.14 Medicare paid to FHH for services it never provided to M.G., Medicare paid ABC \$84,707.28 for similar false claims. Alvarez-Karnes Decl. ¶ 74.

For example, among other claims, from on or about March 9, 2006, through on or about September 6, 2008, ABC submitted to Medicare 76 claims totaling \$532,892.40 for home health services allegedly provided to beneficiaries C.C., F.C., and G.C. From on or about July 16, 2008, through on or about February 23, 2009, FHH submitted to Medicare 14 claims totaling \$82,720.00 for home health services allegedly provided to two of those same beneficiaries, C.C. and F.C. ABC and FHH claimed to have provided two skilled nursing visits every single day to administer insulin injections, plus some physical therapy and home health aides. *Id.* ¶¶ 54, 78.

Just like the six beneficiaries discussed above, these beneficiaries were not insulin-dependent, confined to their homes, or in need of a nurse to administer insulin. Moreover, ABC stopped providing a skilled nurse for insulin injections to C.C. on June 10, 2008. However, FHH did not begin providing that alleged service until July 16, 2008. For nearly a month, therefore, C.C. did not have any skilled nursing visits, indicating that the visits were not medically necessary and in fact were not provided. Medicare paid ABC \$359,355.08 for those false claims relating to C.C., F.C., and G.C.; Medicare paid FHH \$59,612.61 for similar false claims. *Id.* ¶¶ 55, 80.

**D. Dissipation of Assets.**

Defendants have been steadily dissipating most of the money paid out by Medicare. From in or around January 2006, through November 2008, Medicare deposited at least \$11,293,852.39 into ABC's various bank accounts, first through checks and then through Electronic Funds Transfers. From in or around October 2007, continuing through the present, Medicare deposited at least \$3,919,510.57 into FHH's various bank accounts. Alvarez-Karnes Decl. ¶¶ 82-86, 119-123. These deposits by Medicare to ABC and FHH were in payment for the false claims submitted by Defendants. Using transfers to and from numerous shell companies owned by the Individual Defendants, and through other means, Defendants have now dissipated more than \$14.7 million in Medicare funds.<sup>3</sup> *Id.* ¶¶ 87-117, 123-131. Currently, less than

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<sup>3</sup> The specific bank accounts, shell companies, and fraudulent transfers are set forth in detail in the Complaint and in the Alvarez-Karnes Declaration. *See* Alvarez-Karnes Decl. ¶¶ 82-118 (ABC), 119-134 (FHH).

\$200,000 remains in ABC and FHH's bank accounts, though some money is located in the bank accounts of the Defendants and their various shell companies. *Id.* ¶¶ 118, 132. Failure to enjoin Defendants from removing and dissipating those remaining assets will likely result in the dissipation of the remaining funds, and a permanent loss to the United States.

## II. MEMORANDUM OF LAW

### A. Federal Law Authorizes Injunctions To Prohibit The Commission Of Fraud Against The United States, The Commission Of Federal Health Care Offenses, And The Dissipation Of Proceeds Of Such Fraud.

Injunctive relief to restrain a violation of a Federal health care offense and the dissipation of assets is authorized by 18 U.S.C. § 1345 (“§ 1345” or “fraud injunction statute”). *See, e.g., United States v. DBB, Inc., et al.*, 180 F.3d 1277, 1283 (11<sup>th</sup> Cir. 1999); *United States v. Fang*, 937 F. Supp. 1186, 1192 (D. Md. 1996). In relevant part, 18 U.S.C. § 1345 provides that:

(a)(1) If a person is –

(C) committing or about to commit a Federal health care offense,

the Attorney General may commence a civil action in any Federal court to enjoin such violation.

(2) If a person is alienating or disposing of property, or intends to alienate or dispose of property, obtained as a result of . . . a Federal health care offense or property which is traceable to such violation, the Attorney General may commence a civil action in any Federal court–

(A) to enjoin such alienation or disposition of property; or

(B) for a restraining order to –

(i) prohibit any person from withdrawing, transferring, removing, dissipating, or disposing of any such property or property of equivalent value; and

(ii) appoint a temporary receiver to administer such restraining order.

(3) A permanent or temporary injunction or restraining order shall be granted without bond.

The fraud injunction statute further states that the Court may take such other action as is warranted to prevent a continuing and substantial injury to the United States. 18 U.S.C. § 1345(b).

Essentially, § 1345 provides two independent avenues of injunctive relief, each or both of which are available in any given case. As relevant to this health care fraud case, § 1345(a)(1) provides that the United States may enjoin ongoing or future violations of any “Federal health care offense.” 18 U.S.C. § 1345(a)(1). The term “Federal health care offense” is defined in 18 U.S.C. § 24(a)<sup>4</sup> and includes numerous crimes, including health care fraud, 18 U.S.C. § 1347<sup>5</sup>, committed on any “health care benefit program.” A “health care benefit program” is defined to mean “any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract.” 18 U.S.C. § 24(b). Medicare is thus a health care benefit program.

In addition to enjoining the commission of Federal health care offenses and other fraud, § 1345 also authorizes the United States to enjoin the dissipation of property or assets obtained as a result of any such fraud. 18 U.S.C. § 1345(a)(2). In cases like this one, in which the Defendants are committing Federal health care offenses and are alienating or disposing of assets,

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<sup>4</sup> 18 U.S.C. § 24 states:

As used in this title, the term “Federal health care offense” means a violation of, or a criminal conspiracy to violate—

- (1) section 669, 1035, 1347, or 1518 of this title;
- (2) section 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of this title, if the violation or conspiracy relates to a health care benefit program.

<sup>5</sup> 18 U.S.C. § 1347 states:

Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice—

- (1) to defraud any health care benefit program; or
- (2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program,

in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both. . . .

the injunction can reach not just the actual assets that are directly traceable to the fraud, but can also reach “property of equivalent value.” 18 U.S.C. § 1345(a)(2)(B)(i); *DBB, Inc.*, 180 F.3d at 1283, 1286.

In this case, the facts establish that Defendants – through operation of ABC and FHH and their submission of false claims to Medicare – are committing several Federal health care offenses, including, for example, 18 U.S.C. § 1347 (health care fraud) and 18 U.S.C. § 1349 (conspiracy to commit health care fraud). The facts also establish that Defendants have dissipated and could still dissipate the property and assets obtained as a result of their fraud.

Therefore, a temporary restraining order and preliminary injunction with respect to both (1) the ongoing fraud and (2) the dissipation of proceeds of the fraud as well as equivalent assets is warranted under 18 U.S.C. § 1345. Since the scope of the fraud in this case is large, totaling over \$22 million billed and over \$15.1 million paid, and the injunction can freeze both traceable and non-traceable assets, the United States seeks an injunction to freeze all of the assets in which Defendants have an interest up to the equivalent value of the proceeds of the scheme to defraud.

In addition, although the United States has identified one of the companies utilized by Defendants in this scheme, it is possible that other companies not yet identified are engaging in the fraud as well, either via the submission of the false claims or by acting as a vehicle to conceal and dissipate the fraud proceeds. Thus, the United States seeks an injunction that encompasses all fraud perpetrated by Defendants and those acting in concert and participation with them irrespective of the specific corporate vehicle used for that purpose. This approach is necessary to effectuate a proper remedy under the statute.

Pursuant to 18 U.S.C. § 1345 and the general equitable power of the court, the United States is asking this Court to enter a temporary restraining order and preliminary injunction in order to prevent a continuing and substantial injury to the United States by halting the submission of false claims by Defendants, and by preventing the disposition and concealment of fraudulently acquired funds and assets presently in the hands of Defendants, and by freezing any funds or assets of equivalent value.

**B. Prior Notice To The Defendants Is Unnecessary When Notice Could Cause The Very Harm Which The Application Seeks To Prevent.**

The issuance of the temporary restraining order without prior notice is necessary in this case. If advance notice of the application for the temporary restraining order were given to the Defendants, it is possible that the assets would immediately be transferred beyond the reach of the United States. This is especially true where the technology of electronic transfers is in the hands of unscrupulous operators who have already defrauded the United States of hundreds of thousands of dollars. To provide advance notice to Defendants would simply tip Defendants off and invite them to transfer the funds, thereby accentuating the very harm which this application seeks to prevent.

In these circumstances, the law provides for the issuance of *ex parte* temporary restraining orders. As stated by the court in *In the Matter of Vuitton Et Fils S.A.*, 606 F.2d 1, 5 (2<sup>nd</sup> Cir. 1979): “If notice is required, that notice all too often appears to serve only to render fruitless further prosecution of the action. This is precisely contrary to the normal and intended role of ‘notice,’ and it is surely not what the authors of the rule either anticipated or intended.” *Id.*; see also *Calero-Toledo v. Pearson Yacht Leasing Company*, 416 U.S. 663, 679 (1974) (pre-seizure notice and hearing not necessary where such procedure might frustrate the interests served by the statutes)<sup>6</sup>; *Little Tor Auto Center v. Exxon Company USA*, 822 F. Supp. 141, 143 (S.D.N.Y. 1993) (*ex parte* procedure allowed in connection with TRO application “where advance contact with the adversary would itself be likely to trigger irreparable injury”). It is appropriate that the United States’ application be granted without prior notice to the Defendants. Defendants can be fully protected by prompt post-seizure notice and opportunity for a hearing,

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<sup>6</sup> *Calero-Toledo* relied upon and reaffirmed the Supreme Court’s earlier finding that seizure of property without a hearing is constitutionally permissible and does not violate due process notice requirements where “[f]irst . . . the seizure has been directly necessary to secure an important governmental or general public interest. Second, there has been a special need for very prompt action. Third, the State has kept strict control over its monopoly of legitimate force; the person initiating the seizure has been a government official responsible for determining, under the standards of a narrowly drawn statute, that it was necessary and justified in the particular instance.” *Calero-Toledo*, 416 U.S. at 679, citing *Fuentes v. Shevin*, 407 U.S. 67, 91 (1972). As reflected by Congress’ amendment of § 1345 to include Federal health care offenses, all three identified concerns are satisfied in health care fraud cases.

both of which can be required by the terms of the temporary restraining order itself and have in fact been incorporated into the Proposed Order submitted herewith.

**C. The Traditional Prerequisites To A Temporary Restraining Order Are Not Applicable When The Government Seeks An Injunction Pursuant To A Federal Statute That Was Enacted To Protect The Public Interest.**

The traditional test for the issuance of a temporary restraining order does not apply where the United States is seeking an injunction pursuant to a federal statute that was enacted to protect the public interest and that authorizes injunctive relief. *United States v. Medina*, 718 F. Supp. 928, 930 (S.D. Fl. 1989). Under such circumstances the United States is not required to demonstrate irreparable harm in order to obtain an injunction. *Id.*; *U.S. v. Livdahl*, 356 F. Supp.2d 1289, 1293-94 (S.D. Fl. 2005); *U.S. v. Sene X Eleemosynary Corp., Inc.*, 479 F. Supp. 970, 981 (S.D. Fl. 1979). “The passage of the statute is, in a sense, an implied finding that violations will harm the public and ought, if necessary, be restrained.” *U.S. v. Diapulse Corp. of America*, 457 F.2d 25, 28 (2<sup>nd</sup> Cir. 1972).

“Where an injunction is authorized by statute, it is proper to issue such an order to restrain violations of the law if the statutory conditions are satisfied.” *Sene X Eleemosynary Corp., Inc.*, 479 F. Supp. at 980. Florida District Courts have repeatedly found in § 1345 cases “that because both statutes expressly authorize injunctive relief, no specific finding of irreparable harm is necessary, no showing of the inadequacy of other remedies at law is necessary, and no balancing of the interests of the parties is required prior to the issuance of a preliminary injunction in this case.” *Livdahl*, 356 F. Supp.2d at 1290-91. Thus, the government does not need to establish the inadequacy of other remedies at law, and no balancing of the interests of the parties is required. *Id.*; *Medina*, 718 F. Supp. at 930; *Sene X Eleemosynary Corp.*, 479 F. Supp. at 981.

In order for the court to issue an injunction there need only be a showing that a defendant has violated the statute and that there exists “some cognizable danger of recurrent violation.” *Medina*, 718 F. Supp. at 930; *Sene X*, 479 F. Supp. at 981. The government satisfies its burden

under § 1345 when it shows that there is “probable cause” to believe that the defendant is violating, about to violate, or that there is some cognizable danger of recurrent violation of any of the sections specified in § 1345. *U.S. v. Livdahl*, 356 F. Supp.2d at 1293-94; *see also DBB*, 180 F.3d at 1280 (noting District Court adopted Magistrate Judge’s findings of a “reasonable probability”); *U.S. v. Payment Processing Center, LLC*, 461 F. Supp.2d 319, 323 (E.D. Pa. 2006) (citing “probable cause, i.e., a fair probability”); *U. S. v. Fang*, 937 F. Supp. 1186, 1199 (D. Md. 1996) (“Given this background, the Court is prepared to conclude that the ‘reasonable probability’ standard of conventional preliminary injunction analysis equates with ‘probable cause’ and that it applies in the present [§ 1345] case.”); *U.S. v. William Savran & Associates, Inc.*, 755 F. Supp. 1165, 1180 (E.D.N.Y. 1991); *U.S. v. Belden*, 714 F. Supp. 42, 45-46 (N.D.N.Y. 1987) (examining the legislative history and noting “it is unlikely that Congress intended to hold the government to a more stringent standard than that of probable cause when relief under § 1345 was sought”).

Once the government establishes probable cause to believe that a defendant has violated the statute, the burden shifts to the defendant to show that “there is no reasonable expectation that the wrong will be repeated.” *Sene X*, 479 F. Supp. at 981.

In sum, the United States is entitled to the requested injunction by showing that there is probable cause to believe that Defendants are violating Federal health care offense statutes, or have violated such statutes and that there is some cognizable danger of recurrent violation, and that Defendants have dissipated or are still attempting to dissipate the proceeds of their fraud. At that point, the United States has satisfied its burden. Defendants, if opposed to the issuance of an injunction as to any funds or assets, bear the burden of establishing that such funds or assets are beyond the equivalent value of the funds taken through the fraud.

In the *Savran* case, the court expressly held that the defendant bears the burden of showing by a preponderance of the evidence which funds are not the proceeds of fraud. *Savran*, 755 F. Supp. at 1183. *Savran* logically places the burden upon the party having knowledge and control of a bank account to provide information necessary to determine the amount of the fruits

of illegal activity deposited in the account. *Id.*; see *United States v. Eighty-Eight (88) Designated Accounts*, 786 F. Supp. 1578, 1581-82 (S.D. Fla. 1992) (discussing *Savran* with approval).

**D. The Defendants Have Violated Numerous Statutes And Injunctive Relief Should Be Granted Under 18 U.S.C. § 1345(a)(1) And (a)(2).**

Based upon the investigation conducted by the FBI and others, it is evident that Defendants are submitting fraudulent Medicare claims. Defendants have falsely claimed that they have provided medically necessary services, when, in fact, the services were never ordered by a physician, were not medically necessary, and were not even provided. In addition, it is evident that Defendants are dissipating the assets gained through the illegal conduct.

The facts summarized above and in the declaration of FBI Special Agent Lynette Alvarez-Karnes establish that Defendants are violating 18 U.S.C. § 1347, and are committing Federal health care offenses, by presenting or causing the presentation of fraudulent claims to Medicare and other health care benefit programs. Also, the declaration shows that the Defendants are dissipating the fraud proceeds. Accordingly, injunctive relief under 18 U.S.C. § 1345 is warranted.


**CONCLUSION**

The United States requests that this Court, pursuant to 18 U.S.C. § 1345, grant its motion for a temporary restraining order, preliminary injunction, and other equitable relief in this case.

Dated: June 24, 2009

Respectfully submitted,

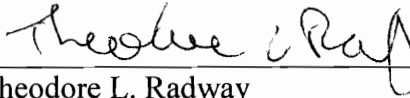
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**Certificate of Service**

I hereby certify that on June 24, 2009, I caused the foregoing document to be filed by hand, under seal, with the Clerk of Court.

  
Theodore L. Radway  
Assistant United States Attorney