FILED by _____ D.C.
OCT 19 2010
STEVEN M. LARIMORE
CLERK U. S. DIST. CT.
S. D. of FLA. – MIAMI

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 10-23765

CIV-MARTINEZ

MAGISTRATE JUDGE
BROWN

Sealed

FILED UNDER SEAL

UNITED STATES OF AMERICA,

Plaintiff,

v.

AMERICAN THERAPEUTIC CORPORATION, a Florida corporation; LAWRENCE S. DURAN; MARIANELLA A. VALERA; JUDITH NEGRON; MARGARITA ACEVEDO; MEDLINK PROFESSIONAL MANAGEMENT GROUP, INC., a Florida corporation; AMERICAN SLEEP INSTITUTE, INC.; a Florida corporation; D&V DEVELOPMENT, INC. a Florida corporation;

Defendants.

UNITED STATES' *EX PARTE* COMPLAINT FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY AND PERMANENT INJUNCTION

Plaintiff, the United States of America, by and through the undersigned attorneys, hereby alleges as follows:

JURISDICTION AND VENUE

1. The United States brings this action for a temporary restraining order, preliminary and permanent injunction, and other equitable relief pursuant to 18 U.S.C. § 1345.

2. This Court has subject matter jurisdiction over this action pursuant to 18 U.S.C. § 1345, and 28 U.S.C. §§ 1331 and 1345.

3. This Court has personal jurisdiction over Defendants and venue is proper in this District pursuant to 28 U.S.C. §§ 1391(b) and 1391(c) because Defendants reside in this District or

transact business in this District and Defendants' actions that gave rise to this case all occurred in this District.

PARTIES

Plaintiff

4. Plaintiff is the United States of America. At all times material to this action, the Department of Health and Human Services ("HHS") was an agency and instrumentality of the United States, and the Centers for Medicare and Medicaid Services ("CMS") was the component agency of HHS that administers and supervises the Health Insurance Program for the Aged and Disabled established by Title XVIII of the Social Security Act ("Act"), 42 U.S.C. §§ 1395 *et seq.* ("Medicare Program").

Defendants

ATC

5. Defendant American Therapeutic Corporation ("ATC") is a company organized and existing under the laws of the State of Florida. On December 13, 2002, ATC filed its Articles of Incorporation with the Florida Secretary of State indicating that it was incorporated effective December 3, 2002, as a not-for-profit corporation. ATC identified its principal place of business as 1801-03 NE 2nd Avenue, Miami, Florida 33132, and identified Defendant Marianella Valera (VALERA) as ATC's incorporator and registered agent. On January 24, 2003, ATC filed with the Florida Secretary of State an Articles of Amendment to Articles of Incorporation that added VALERA as the sole officer of ATC.

6. On April 9, 2007, ATC filed with the Florida Secretary of State an Articles of Dissolution that voluntarily dissolved ATC as a non-profit corporation, effective March 27, 2007.

7. Also on April 9, 2007, ATC filed with the Florida Secretary of State a new Articles of Incorporation, re-forming ATC as a for-profit company, effective March 26, 2007. In that filing ATC identified its principal place of business as 1801 NE 2nd Avenue, Miami, Florida 33132, and identified VALERA as its incorporator, sole officer, and registered agent.

8. At all times relevant to this Complaint, however, Defendant Lawrence Duran ("DURAN") directly, or through his alter ego entity Defendant MedLink Professional Management Group ("MEDLINK"), owned, controlled, and operated ATC.

9. As explained more fully below, ATC is a Medicare provider that, from 2003 through the present, submitted claims to Medicare that resulted in approximately $83 million in Medicare payments to ATC.

ASI

10. Defendant American Sleep Institute, Inc. ("ASI") is a corporation organized and existing under the laws of the State of Florida. On January 24, 2005, ASI filed its Articles of Incorporation with the Florida Secretary of State indicating that it was incorporated effective January 19, 2005. In this filing, ASI identified its principal place of business as 848 Brickell Avenue Suite 1220, Miami, Florida 33131. ASI further identified Defendant Judith C. Negron ("NEGRON") and Defendant VALERA as ASI's sole officers, and identified Defendant DURAN as ASI's registered agent.

11. On March 29, 2007, ASI filed with the Florida Secretary of State its Annual Report, that changed ASI's principal place of business to 7150 West 20th Avenue, Suite 510, Hialeah, Florida 33016; and changed the address of the registered agent (Defendant DURAN) and ASI's

only two officers (Defendants NEGRON and VALERA), to 1809 N.E. 2nd Avenue, Miami, Florida 33132.

12. As explained more fully below, from 2005 through 2009, ASI submitted claims to Medicare that resulted in approximately $2 million dollars in Medicare payments to ASI.

MedLink

13. Defendant MEDLINK is a for-profit management services corporation organized and existing under the laws of the State of Florida.

14. On November 4, 2003, MEDLINK filed its Articles of Incorporation with the Florida Secretary of State indicating that it was incorporated effective November 4. In that filing, MEDLINK identified its principal place of business as 8937 NW 176 Lane, Miami, Florida 33018. MEDLINK further identified Defendants DURAN and NEGRON as the sole officers and owners of the corporation, with DURAN owning 70% and NEGRON owning 30%. Defendant DURAN was also identified as MEDLINK's registered agent.

15. On April 13, 2004, MEDLINK filed with the Florida Secretary of State its 2004 Annual Report, that changed MEDLINK's principal place of business to 848 Brickell Avenue, Suite 1220, Miami, Florida 33131 – the same address Defendant ASI identified as its principal place of business at that time. That filing also changed the address of the registered agent, Defendant DURAN, to 1801 NE 2nd Ave, Miami, Florida – the same address Defendant ATC identified as its place of business.

16. On March 29, 2007, MEDLINK filed with the Florida Secretary of State its 2007 Annual Report, that changed MEDLINK's principal place of business to 1809 NE 2nd Ave.,

Miami, Florida 33132 – the same address that Defendant ASI identified as its new place of business.

Duran

17. Defendant DURAN is a resident of Miami, Florida.

18. At all times relevant to this Complaint, DURAN maintained an undisclosed ownership interest and control of ATC and ASI.

19. At all times relevant to this Complaint, DURAN recruited VALERA, NEGRON, and Margarita M. Acevedo as co-conspirators, to serve as straw owners and/or operators of ATC, ASI, and MEDLINK in order to conceal DURAN's ownership and control of those entities.

Valera

20. Defendant VALERA is a resident of Miami, Florida.

21. As referenced above, according to Defendant ATC's and ASI's public filings with the Florida Secretary of State, and ATC's certified filings with Medicare, VALERA was the Chief Executive Officer, President, Secretary, Treasurer, and sole owner of ATC, and the Vice President of ASI.

Negron

22. Defendant Judith NEGRON is a resident of Miami, Florida.

23. As referenced above, in MedLink's and ASI's public filings with the Florida Secretary of State, NEGRON was the Vice President and 30% owner of MedLink, and President of ASI.

Acevedo

24. Defendant Margarita M. Acevedo, a.k.a. Maggie Acevedo, a.k.a. Margarita or Maggie de la Cruz ("ACEVEDO") is a resident of Miami, Florida.

25. At all times relevant to this Complaint, Acevedo was employed as ATC's Marketing Director and as MEDLINK's Education and Behavioral Analyst.

D&V

26. Defendant D&V Development, Inc. ("D&V") is a for-profit corporation organized and existing under the laws of the State of Florida.

27. On August 12, 2004, D&V filed its Articles of Incorporation with the Florida Secretary of State indicating that it was incorporated effective August 12th. In that filing, D&V identified its principal place of business as 848 Brickell Ave., Suite 1220, Miami, Florida 33131. This was the same address identified as MEDLINK and ASI as their primary business address. D&V further identified Defendants DURAN and VALERA as the sole officers and owners of the corporation, with each Defendant owning 50% of the stock. Defendant DURAN was also identified as MEDLINK's registered agent.

28. On March 29, 2007, D&V filed with the Florida Secretary of State its 2007 Annual Report, that changed D&V's principal place of business to 1809 NE 2nd Ave., Miami, Florida 33132 – the same address that Defendants ASI and MEDLINK identified as their new place of business.

THE MEDICARE PROGRAM

29. In 1965, Congress enacted Title XVIII of the Social Security Act, known as the Medicare Program, to pay for the costs of certain healthcare services. Entitlement to Medicare

is based on age, disability or affliction with end-stage renal disease. *See* 42 U.S.C. §§ 426, 426A. 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.

30. The Medicare program is divided into different "parts." "Part A" of the Medicare program covers certain health services provided by hospitals, skilled nursing facilities, home health services, and hospice care.

31. Part "B" of the Medicare program covers physician services, outpatient care, and – at issue in this case – psychiatric partial hospitalization programs ("PHP") and payment for outpatient sleep studies provided by sleep clinics. PHP services are provided by hospitals or community mental health centers ("CMHC"). *See* 42 U.S.C. §§ 1395c-1395i-4 & §§ 1395j-1395w-4. An entity that enrolls in the Medicare Part B program and provides PHP services or sleep studies is known as a provider. At all times relevant, Defendant ATC was a CMHC provider participating in the Medicare program, and Defendant ASI was also a provider participating in the Medicare program.

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

33. Claims for payment are not submitted directly to CMS. Instead, various fiscal intermediaries 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, First Coast Service Options ("FCSO") is responsible for processing and paying all Part A and Part B claims, and all cost reports, including those related to PHP services provided by CMHCs and sleep studies provided by providers such as ASI.

34. In order to be eligible to file a claim for payment with Medicare, providers must submit an enrollment application to obtain a Medicare provider number. 42 U.S.C. § 1395cc. In the application, the provider agrees to abide by all Medicare laws, regulations, and program instructions. Further, the provider 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 provider's compliance with all applicable conditions of participation in Medicare.

35. Providers, such as Defendants ATC and ASI, seeking reimbursement from Medicare had to meet certain obligations. Among other things, these obligations were to:

a. bill Medicare only for reasonable and necessary medical services;

b. not make false statements or misrepresentations of material facts concerning requests for payment under Medicare;

c. assure that such services were not substantially in excess of the needs of such patients; and

d. not submit or cause to be submitted bills or requests for payment substantially in excess of the provider's costs.

36. After obtaining a provider number, the provider would then submit or cause the submission of claims to an entity that processed those claims for CMS, such as FCSO.

37. When a provider submitted or caused to be submitted a claim to Medicare, usually in electronic form, the provider would 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. The information in the claim form, including for example the beneficiary's name, the specific services provided, and the dates of service, was the basis for Medicare's payment to the provider.

38. In order to receive payment from Medicare, CMHCs such as Defendant ATC, submitted to Medicare a claim form known as the CMS-1450 (also known as a "UB-92" and, beginning in 2007, a "UB-04"). ATC submitted its CMS-1450 claim forms to FCSO.

39. In order to receive payment from Medicare, providers such as ASI submitted to Medicare a claim form known as the CMS-1500. ASI submitted its CMS-1500 claim forms to FCSO.

PHP Billing And Payment Under Medicare

40. PHP was intended to be an intensive outpatient program of psychiatric services provided to patients in lieu of psychiatric inpatient hospitalization. It was designed to provide patients who had profound and disabling mental health conditions with an individualized, coordinated, comprehensive, and multidisciplinary treatment program.

41. Medicare coverage and PHP eligibility required that services be reasonable and necessary for the diagnosis and active treatment of the individual's condition. In addition, the patient must be under the care of a physician who certified the need for the services; the patient or legal guardian must provide written informed consent for PHP treatment; the patient must have the mental and physical capacity to actively participate in all phases of the program; there must be a reasonable expectation of improvement of the patient's disorder and level of functioning as a

result of treatment in the PHP; and the treatment must be pursuant to an individualized treatment plan developed by the physician and multidisciplinary team, with the patient's involvement.

42. In order to qualify for reimbursement, Medicare required that certain documentation be maintained in the patient's medical records, which Medicare could review to determine eligibility for coverage, including, but not limited to: physician certifications and re-certifications of need for PHP treatment; reports of initial psychiatric evaluations; medical history and physical examination establishing the medical necessity for PHP services; treatment plans; and progress notes for each billed service.

43. During the time period covered by this Complaint, Medicare reimbursed CMHCs that provided PHP services under a prospective payment system, that is, Medicare reimbursed CMHCs a set amount for each day qualifying services were rendered.

44. CMHCs, such as ATC, providing PHP services are required to prepare and submit two types of documents in order to receive reimbursement from Medicare: 1) the CMS-1450 claim form, and 2) an annual cost report known as CMS-2088-92 (Outpatient Rehabilitation Provider Cost Report) detailing the expenses incurred by the CMHC in operating the PHP.

45. ATC was, at all times relevant to this complaint, required to submit an annual cost report to FSCO.

46. Every cost report contains a "Certification" that must be signed by the chief administrator of the provider or a responsible designee of the administrator.

47. At all times relevant to this complaint, the cost report certification page included the following notice:

> I. Misrepresentation or falsification of any information contained in this cost report may be punishable by criminal, civil and

> administrative action, fine and/or imprisonment under federal law. Furthermore, if services identified in this report were provided or procured through the payment directly or indirectly of a kickback or were otherwise illegal, criminal, civil and administrative action, fines and/or imprisonment may result.

At all times relevant to this complaint, the responsible provider official or administrator was required to certify, in pertinent part:

> II. . . . to the best of my knowledge and belief, it [the cost report] is a true, correct and complete report prepared from the books and records of the provider in accordance with applicable instructions, except as noted.
>
> III. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Thus, the provider was required to certify that the filed cost report is (1) truthful, *i.e.*, that the cost information contained in the report is true and accurate; (2) correct, *i.e.*, that the provider is entitled to reimbursement for the reported costs in accordance with applicable instructions; (3) complete, *i.e.*, that the cost report is based upon all information known to the provider; and (4) that the services provided in the cost report were not tainted by kickbacks.

48. As part of the Medicare fraud scheme, in order to get paid by Medicare, Defendants caused VALERA to sign ATC's cost reports and attest to the certifications quoted above, and then submit those cost reports to Medicare.

Outpatient Sleep Study Clinic Billing and Payment Under Medicare

49. The diagnostic evaluation of sleep disorders often requires overnight examination of the sleeping patient by means of polysomnography to assess severity, cardiac function, and other symptoms. The overnight stay is considered an integral part of these tests.

50. Medicare will reimburse all reasonable and necessary diagnostic sleep disorder testing if ordered by a physician and provided by a qualified technician under the direction and control of a licensed physician.

51. During the time period covered by this Complaint, Medicare reimbursed sleep clinics that performed diagnostic tests under a Medicare fee-for-service schedule based on services provided.

52. ASI was, at all times relevant to this Complaint, required to submit the CMS-1500 claim form to FSCO. Each claim form required the provider to certify that it is in compliance with the terms of the form in order to obtain reimbursement for the services provided.

53. ASI regularly submitted false claims to Medicare and falsely certified that it was in compliance with applicable Medicare regulations, when in fact it was not.

Medicare's Related Party Regulations

54. Under the Medicare regulations, if a provider receives services from a "related" organization, its reimbursement is limited to the organization's cost rather than the amount paid by the provider. 42 C.F.R. § 413.17 provides:

> (a) Principle . . . (C) costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provide by common ownership or control are includable in the allowable costs of the provider at the cost to the related organization . . .
>
> (iii) Definitions –
>
> (1) Related to the provider. Related to the provider means that

the provider to a significant extent is associated with or has control of or is controlled by the organization furnishing the services, facilities or supplies.

(2) Common ownership. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

(3) Control. Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

55. Further, section A-6 of the Medicare cost report asks providers: "Are there any costs included on the worksheet A which resulted from transactions with related organizations as defined in HCFA Pub. 15-1, Chapter 10?".

56. Medicare cost reports require providers to submit a Provider Cost Report Reimbursement Questionnaire (Form 339) that requires the disclosure of goods or services purchased from a "related party." That form states:

> The provider, member of the board of directors, officers, medical staff or management personnel are associated with or involved business transactions with the following: Related organizations, management contracts and services under arrangements as owners (stockholders), management, by family relationship, or any other similar type relationship.

57. During routine audits of providers, Medicare's fiscal intermediary auditors will also inquire if there were any related party transactions as defined by Medicare regulations.

58. However, at all times relevant to the complaint, ATC did not once, on any of its annual cost reports or otherwise, disclose to Medicare any related party transactions with MEDLINK.

DEFENDANTS' MEDICARE FRAUD SCHEME

59. Defendants ATC and ASI's primary purpose was to act as a vehicle to perpetrate a massive fraud upon the Medicare program. Defendants' scheme included: (1) conspiring to

submit and submitting false claims to the Medicare Program that were tainted by illegal kickback payments; (2) conspiring to submit and submitting false claims and statements to the Medicare Program for medically unnecessary PHP services provided by ATC and sleep study services provided by ASI; (3) making false statements and claims in Medicare cost reports where ATC failed to disclose related party transactions; and (4) engaging in fraudulent transfers to convert Medicare funds to ill gotten personal gains.

60. On or about August 29, 2003, Defendant ATC signed and submitted a Medicare enrollment application (CMS form 855A), in which, among other things, ATC agreed to abide by all Medicare laws and regulations. On or about September 24, 2003, ATC submitted another enrollment application for a second ATC location. In total, ATC submitted enrollment applications for five locations: Miami, Homestead, Boca Raton, Fort Lauderdale, and Orlando.

61. ATC subsequently received a Medicare provider number from Medicare for each location (Miami: 10-1445; Homestead: 10-1459; Boca Raton: 10-1453; Fort Lauderdale: 10-1465; and Orlando 10-1497) . The first provider number awarded to ATC, for the Miami location, was effective as of May 8, 2003.

62. Once it received Medicare provider numbers, Defendant ATC was able to bill and be paid by Medicare for covered and eligible PHP services.

63. From on or about June 21, 2003, through on or about August 24, 2010, Defendant ATC submitted claims to Medicare totaling approximately **$191,799,600**. More than 95.5% of these claims were for PHP services that ATC claimed to have provided to eligible Medicare beneficiaries.

64. Based on those submitted claims, Medicare, through FCSO, paid ATC approximately **$83,021,115.54.**

65. On or about April 22, 2005, and again on July 20 and August 3, 2005, Defendant ASI signed and submitted a Medicare enrollment application in which, among other things, ASI agreed to abide by all Medicare laws and regulations. ASI subsequently received a provider number (U5251) from Medicare, effective July 29, 2005.

66. ASI was enrolled in the Medicare program as an Independent Diagnostic Testing Facility ("IDTF"). Most of the IDTF services provided by ASI related to sleep studies.

67. From on or about December 22, 2005, through on or about August 31, 2009, ASI submitted approximately 3,622 claims to Medicare totaling at least **$5,043,860**. These claims were principally for sleep studies that ASI claims to have provided for eligible Medicare beneficiaries.

68. Based on those submitted claims, Medicare, through FCSO, paid ASI approximately **$1,951,200.35**.

69. However, most if not all of the claims submitted by ATC and ASI were tainted by kickbacks, for services that were not medically necessary or reasonable, for services that were not delivered, or otherwise tainted by fraud.

Kickbacks

70. Defendants engaged in a kickback scheme to gain referrals of Medicare beneficiaries to ATC and ASI, so ATC and ASI could then bill Medicare for services they allegedly provided to those beneficiaries.

71. Beginning in 2003, Defendants paid kickbacks (primarily in cash) to so-called patient recruiters in exchange for collecting Medicare beneficiaries and referring them to ATC and ASI. These recruiters were paid a fixed amount for each Medicare beneficiary they referred to ATC or ASI. In turn, many of these recruiters also paid or offered kickbacks to the beneficiaries themselves, in exchange for the beneficiaries going to ATC and ASI, so that ATC and ASI could submit Medicare claims on behalf of those beneficiaries. These kickbacks were usually in the form of cash or free temporary housing.

72. Patient recruiters were often paid with checks from Defendant ATC or MEDLINK. These checks were sometimes signed by Defendant DURAN or VALERA and paid to recruiters by ACEVEDO.

73. ATC kept detailed records of these unlawful kickback arrangements and payments. For example, each ATC facility maintained a Master Patient List ("MPL") that included the beneficiary name, attending physician and therapist, date of admission, and date of discharge.

74. The MPLs also included a column entitled "source," "contact person," or "referral source" that indicated the name of the patient recruiter for each beneficiary.

75. From June 2003 continuing to the present, ATC submitted to Medicare approximately 24,036 claims that were tainted by kickback payments, totaling **$41,896,775**. The claims were for PHP services that ATC allegedly provided to approximately 1,445 beneficiaries.

76. Medicare paid ATC approximately **$18,643,321** for these false claims, which arose out of and were tainted by the payment of unlawful kickbacks.

77. At the direction of Defendants, most Medicare beneficiaries unlawfully referred via patient recruiters to ATC were also referred to ASI to participate in sleep studies.

78. From 2005 continuing to the present, ASI submitted to Medicare approximately 1,254 claims totaling $1,782,400. The claims were for sleep studies that ASI claimed it provided to Medicare beneficiaries.

79. Medicare paid ASI approximately **$688,258** for these false claims, which arose out of and were tainted by the payment of unlawful kickbacks.

ATC and ASI's False Claims and Statements

80. In addition to the tens of millions of dollars in claims ATC and ASI submitted to Medicare that were rendered false by the payment of kickbacks, most if not all of ATC and ASI's claims to Medicare were rendered false because the services were provided to beneficiaries who were not eligible, the services were not medically necessary, and/or the services were never actually rendered.

Services Provided to Ineligible Medicare Beneficiaries; Falsified Medical Records

81. From 2003 to the present, ATC routinely admitted beneficiaries to the PHP program who suffered from Alzheimer's and severe dementia and therefore were not eligible for the PHP program because their mental capacity did not allow them to benefit from group therapy.

82. ATC employees repeatedly complained to Defendants VALERA, DURAN, and NEGRON about the ineligibility of beneficiaries attending PHP services because, for example, they could not feed themselves, would often defecate on themselves, and they lacked mental capacity to respond adequately to the group therapy.

83. Employees who failed to cooperate or participate in the fraud were terminated. One ATC employee was fired after she discharged several beneficiaries she felt were not eligible

for PHP services due to their mental state. Defendant VALERA subsequently readmitted the beneficiaries.

84. In addition, Defendants VALERA, NEGRON, and DURAN coached ATC therapists to include false references to insomnia or sleep difficulties in medical progress notes of beneficiaries receiving services at ATC in order to justify a referral to ASI for sleep study tests that would be reimbursed by Medicare. ASI submitted claims for these medically unnecessary services to Medicare, and Medicare paid ASI for these false claims.

85. In an attempt to substantiate the treatments provided by ATC and ASI, Defendants ATC, ASI, DURAN, VALERA, and NEGRON falsified medical records, by, among other things: documenting fake symptoms and illnesses, creating bogus psychiatric evaluations, forging physician signatures, documenting fake treatments that were never given, and utilizing pre-printed templates to fill out beneficiaries' medical records. Defendants then used these altered medical records as justification when Medicare questioned claims that ATC and ASI submitted.

False Statements in Annual Cost Reports

86. In addition to submitting to Medicare tens of thousands of false claims (via the CMS-1450 claim form) for ineligible beneficiaries, medically unnecessary services, and services that were never rendered, ATC also submitted to Medicare annual cost reports that were contaminated by false statements and certifications.

87. Each year, from 2003 though the present, ATC submitted an annual cost report to Medicare. These costs reports documented ATC's purported expenses for providing treatments to ineligible beneficiaries, providing medically unnecessary services, and for services that were never rendered.

88. Defendants also documented on these costs reports as purported legitimate business expenses costs incurred solely because of paying unlawful kickbacks to patient recruiters and beneficiaries.

89. Moreover, ATC failed to disclose on its cost reports its numerous transactions with related parties, specifically D&V and MEDLINK.

90. On or about January 1, 2005, ATC entered into a lease agreement with D&V for the building owned by D&V and located at 1801-1809 NE 2nd Avenue; the address of record for ATC, ASI, and D&V. According to the terms of the lease, ATC paid D&V approximately $13,000 in monthly in lease expenses.

91. DURAN and VALERA are the sole owners and operators of D&V. DURAN and VALERA established D&V in an effort to divert funds received by ATC and ASI from Medicare. Every year from 2005 to the present, ATC included D&V lease costs in its annual cost report to Medicare.

92. However, in each cost report ATC filed from 2005 to 2009, ATC failed to disclose D&V as a related party. Only in 2010, after becoming aware of a Federal government investigation, did ATC finally identify D&V as a related party in its annual cost report.

93. On or about January 4, 2004, ATC entered into a management services agreement with MEDLINK to manage and control ATC's operations and finances. According to the contract, ATC was to pay MEDLINK $30,000 per month per ATC facility for management services MEDLINK would provide to all ATC facilities; with all seven facilities in operation, ATC would pay MEDLINK $150,000 per month, or $1.8 million per year.

94. Defendant DURAN was the majority owner of MEDLINK, and controlled ATC. Defendant NEGRON was the minority owner of MEDLINK. Thus, ATC's contract with MEDLINK was a transaction with a related party, a mechanism by which Defendants could pay themselves nearly $2 million a year and identify it as a business expense on ATC's annual Medicare cost reports.

95. However, in each cost report ATC filed between 2004 and 2009, ATC failed to disclose MEDLINK as a related party. Only in June 2010, after becoming aware of a Federal government investigation, did ATC finally identify MEDLINK as a related party in its annual cost report.

96. Thus, every cost report ATC filed between 2004 and 2009 was false. Medicare paid ATC approximately **$57,969,099.79** for the time period covered by these false cost reports.

DEFENDANTS' DISSIPATION OF THE PROCEEDS OF THE MEDICARE FRAUD

97. On or about August 29, 2003, ATC completed an Authorization Agreement for Electronic Funds Transfer, by which ATC agreed to accept Medicare payments via direct deposit into its bank account ending in 8219.

98. From in or around August 2003 through the present, ATC opened or maintained several accounts at Wachovia Bank, including accounts ending in 2210, 5837, 6543, and 4829.

99. From June 2003 through the present, Medicare paid ATC's claims by depositing funds into one or more of ATC's accounts at Wachovia Bank.

100. From in or around June 2003, continuing to the present, Medicare deposited at least **$84,225,591.28** into ATC's corporate bank accounts, either through checks or electronic funds transfers.

101. These deposits by Medicare to ATC were in payment for the false claims submitted by ATC.

102. In or around February 2005, ASI opened a corporate bank account with Wachovia Bank, account number ending in 9513. In or around September 2005, ASI opened a second bank account at Wachovia Bank, ending in 6530.

103. On or about September 16, 2005, ASI completed an Authorization Agreement for Electronic Funds Transfer, by which ASI agreed to accept Medicare payments via direct deposit into its bank account ending in 9513.

104. From 2005 through the present, Medicare paid ASI's claims by depositing funds into ASI's account at Wachovia Bank via electronic funds transfer.

105. From in or around 2005, continuing to the present, Medicare deposited at least **$1,951,200.35** into ASI's corporate bank account, first through checks and then through Electronic Funds Transfers.

106. These deposits by Medicare to ASI were in payment for the false claims submitted by ASI.

107. Defendants implemented schemes to transfer these Medicare monies to themselves both directly and by using shell companies and sham transactions. These shell companies were owned and controlled by Defendants DURAN, VALERA and NEGRON.

108. From in or around January 2004 through the present, ATC transferred more than $10 million in Medicare funds to MEDLINK, as payment for purported management and consulting fees.

109. MEDLINK used the funds received from ATC to purchase a condominium for VALERA, pay personal property taxes for DURAN and NEGRON, pay school tuition for DURAN's children at private schools, purchase expensive jewelry at Tiffany's, and other purchases and expenses not related to MEDLINK's management contract with ATC or the provision of medical-related services.

110. ATC further disguised millions of dollars more in conveyances to ASI and MEDLINK as loans that were never intended to be repaid and in fact were never repaid by ASI or MEDLINK.

111. ATC routinely paid its executives exorbitant salaries and issued payments to Defendants DURAN, NEGRON, VALERA, and ACEVEDO under the guise of "advances to officer" or "loans to officers" that were never intended to be repaid and in fact were never repaid.

112. For example, from on or about November 27, 2009, through on or about March 5, 2010, ATC paid Valera an after-tax, take-home salary of over $8,000 every other week, totaling more than $67,000 in only three and a half months.

113. ATC issued suspicious payments to several entities, including property purchases through Fates Elites Holding, 2000 Biscayne LLC, Old Winter Garden Road Properties, LLC, and other entities in which Defendants DURAN, VALERA, NEGRON, and ACEVEDO hold an undisclosed ownership interest.

114. From on or about January 2005 through the present, ATC has paid D&V approximately $897,000 in rental payments.

115. At all times relevant to this Complaint, according to documents provided by Defendants, D&V's only sources of income derived from payments received from ATC, ASI, and

MEDLINK. All known property owned by D&V – including the ATC's place of business – was purchased in 2005 and 2007 with funds received from ATC and ASI's submission of false and fraudulent claims to Medicare.

116. Defendant DURAN utilized the proceeds of his Medicare fraud to purchase, among other things, a number of expensive vehicles, including: two Harley Davidson motorcycles, a BMW, a Land Rover, and a Maserati Quattroporte.

117. Defendant VALERA utilized the proceeds of her Medicare fraud to purchase, among other things, a number if expensive vehicles, including: a BMW M3 coupe, a Land Rover, a Harley Davidson motorcycle, and an Audi sports car.

118. Several individual defendants have engaged in frequent international travel to countries including the Dominican Republic, Cuba, and Switzerland. Defendants are believed to have transferred assets received from Medicare to accounts or properties located in these countries in an attempt to defraud the United States.

119. From 2003 to the present, Defendants have systematically dissipated the vast majority of the funds received from Medicare by writing checks and making transfers from ATC and ASI's bank accounts to themselves, to other entities they control, and to third parties to pay for real estate and personal luxury items.

120. For example, in 2003, ATC issued a check for $6,259.50 to Levinson's Jewelry inc., a popular high-end jewelry store in South Florida. The check was signed by DURAN. On ATC's General Ledger for 2003, this expense is designated as "patient related supplied and furniture." ATC wrote several other checks, totaling thousands of dollars, to Levinson's Jewelry.

121. Like ATC, MedLink also issued hefty checks to Levinson's Jewelry, including a $42,115 purchase in December 2007.

122. In 2005 and 2006, MEDLINK issued checks totaling $212,000 to "Slice of Paradise, LLC," for the purchase of a condo for VALERA at the Opera Towers, a luxury high rise development on the bay in Miami. MEDLINK has continued to issue multiple subsequent checks to "Opera Tower Condominium Association" for condominium fees, from April 2008 through at least December 2008.

123. On May 8, 2009, MEDLINK issued a check to Tiffany & Co. Jewelers in the amount of $11,839. This check was signed by Duran.

124. MEDLINK issued multiple checks for private school tuition for DURAN's children. Some examples include a June 2009 tuition check for $4,800 to Madonna College Prep, and a January 2009 tuition check for $4,400 to Belen Jesuit Preparatory School. These checks were signed by DURAN.

125. Although Medicare has paid Defendants ATC and ASI over $84 million since 2003, to date the United States has only been able to locate assets totaling well under $7 million (not accounting for reductions in property value, or outstanding mortgages and car loans). Defendants have dissipated over $77 million in Medicare funds, and unless enjoined will continue to dissipate to the proceeds of their Medicare fraud.

126. Indeed, Defendants' dissipation of assets continues to this day. As of the end of September, 2010, Defendants had known bank account balances exceeding $1 million; however, as of the filing of this Complaint, balances in Defendants' known accounts is less than $200,000.

COUNT I
(Injunctive Relief)
(18 U.S.C. § 1345)

127. The United States realleges and incorporates by reference paragraphs 1 through 126 of this Complaint as though fully set forth herein.

128. Among other things, Defendants committed a Federal health care offense, as defined in 18 U.S.C. § 24, by attempting to execute and actually executing a scheme or artifice to defraud a health care benefit program (as defined by 18 U.S.C. § 24(b)) – specifically, Medicare – in connection with the delivery of or payment for health care benefits, items, or services, in violation of 18 U.S.C. § 1347.

129. Defendants have already dissipated over $77 million of the proceeds of that fraud, and intend to continue dissipating the remainder of the proceeds of the fraud.

130. Defendants' fraud upon Medicare is a fraud against the United States and constitutes a continuing and substantial injury to the United States and its citizens.

131. The United States brings this action to protect Medicare and other funds by restraining Defendants' unlawful fraudulent conduct and to protect and restrain the transfer of funds and assets now in Defendants' hands as ill-gotten gains from their fraud upon the Medicare program.

132. Upon a showing that Defendants are committing or about to commit a Federal health care offense, the United States is entitled, under 18 U.S.C. § 1345(a)(1), to a temporary restraining order, a preliminary injunction, and a permanent injunction, restraining all future fraudulent conduct and any other action that this Court deems just in order to prevent a continuing and substantial injury to the United States.

133. Upon a showing that defendants are alienating or disposing, or intend to alienate or dispose, property obtained as the result of a Federal health care offense, the United States is entitled, under 18 U.S.C. § 1345(a)(2), to a temporary restraining order, a preliminary injunction, and a permanent injunction, enjoining defendants from alienating, disposing, withdrawing, transferring, removing, dissipating, or disposing of any property obtained as a result of a Federal health care offense, property traceable to such violation, or property of equivalent value.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff United States of America prays that this Court:

Issue a Temporary Restraining Order and Preliminary Injunction in this matter against defendants to include all assets of defendants, and that a permanent injunction shall be issued forthwith, that orders that defendants, their agents, servants, employees, attorneys, and all persons acting in concert and participation with defendants, including all corporations over which they exercise control, be enjoined as follows:

1. From making or conspiring to make any false claims to the Medicare Program or any health care benefit program, or otherwise from committing any Federal health care offense, as defined in 18 U.S.C. § 24;
2. From withdrawing or transferring any moneys or sums presently deposited, or held on behalf of either or both defendants by any financial institution, trust fund, or other financial agency, public or private, that are proceeds from false, fictitious, or fraudulent claims made by defendants, or any moneys of an equivalent value to those taken through false, fictitious, or fraudulent claims;

3. From transferring, selling, assigning, dissipating, concealing, encumbering, impairing or otherwise disposing of, in any manner, assets, real, or personal;

4. to preserve all business, financial, and accounting records, including bank records, that detail defendants' business operation and disposition of any payment that directly or indirectly arose from the payment of money to defendants on behalf of the Medicare Program;

5. to preserve all medical records, including patient records, which relate to defendants' business operation(s) and/or to services for which claims were submitted to the Medicare Program;

6. to provide an accounting of all assets, within seven calendar days, and to provide on a monthly basis, commencing forthwith, suitable reports detailing its financial condition; and

7. to complete a Financial Disclosure Statement form provided to defendants by the United States within seven calendar days;

8. For disgorgement and restitution of all of defendants' ill-gotten gains attributable to their fraud upon the United States; and

9. For such other and further relief as the Court shall deem just and proper.

Dated: October 19, 2010

Respectfully submitted,

TONY WEST
Assistant Attorney General

WIFREDO A. FERRER
United States Attorney
Southern District of Florida

By: Theodore L Radway

THEODORE L. RADWAY
Assistant United States Attorney
Court ID No. A5501010
99 N.E. 4th St., Suite 300
Miami, FL 33132
Tel: (305) 961-9337
Fax: (305) 530-7139
Email: Ted.Radway@usdoj.gov

JOYCE R. BRANDA
RENÉE BROOKER
VANESSA I. REED
CAROLYN B. TAPIE
Attorneys, Civil Division
U.S. Department of Justice
P. O. Box 261, Ben Franklin Station
Washington, D.C. 20044
(202) 514-7372

Attorneys for the United States of America