UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 22-60157-CR- SMITH/VALLE

18 U.S.C. § 1349
18 U.S.C. § 1347
18 U.S.C. § 371
18 U.S.C. § 641
18 U.S.C. § 1957(a)
18 U.S.C. § 2
18 U.S.C. § 981(a)(1)(C)
18 U.S.C. § 982(a)(1), (a)(7)

UNITED STATES OF AMERICA

vs.

LUIS M. PEREZ and
JESTIL TAPIA,

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 and below-cost health care benefits to 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 & 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 covered different types of benefits and was separated into different program "parts." Medicare "Part A" covered, among others, health services provided by hospitals, skilled nursing facilities, hospices, and home health agencies. Medicare "Part B" covered, among other things, medical items and services provided by physicians, medical clinics, laboratories, and other qualified health care providers, such as office visits, minor surgical procedures, durable medical equipment ("DME"), and laboratory testing, that were medically necessary and ordered by licensed medical doctors or other qualified health care providers. Medicare "Part C," or "Medicare Advantage," provided Medicare beneficiaries with the option to receive their Medicare benefits (Parts A and B) through a wide variety of private managed care plans. Medicare "Part D" covered, among other things, certain prescription drugs.

4. Medicare "providers" included physicians, DME companies, independent clinical laboratories, and other health care providers who provided items or services to beneficiaries. To bill Medicare, a provider was required to submit a Medicare Enrollment Application Form ("Provider Enrollment Application") to Medicare. The Provider Enrollment Application contained certifications that the provider was required to make before the provider could enroll with Medicare. Specifically, the Provider Enrollment Application required the provider to certify, among other things, that the provider would abide by the Medicare laws, regulations, and program instructions, including the Federal Anti-Kickback Statute, and that the provider would not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare.

5. A Medicare "provider number" was assigned to a provider upon approval of the provider's Medicare Enrollment Application. A health care provider that received a Medicare

provider number was able to file claims with Medicare to obtain reimbursement for items or services provided to beneficiaries.

6. A Medicare claim was required to contain certain important information, including: (a) the beneficiary's name and Health Insurance Claim Number ("HICN"); (b) a description of the health care benefit, item, or service that was provided or supplied to the beneficiary; (c) the billing codes for the benefit, item, or service; (d) the date upon which the benefit, item, or service was provided or supplied to the beneficiary; (e) the name of the referring physician or other health care provider; and (f) the referring provider's unique identifying number, known either as the Unique Physician Identification Number ("UPIN") or National Provider Identifier ("NPI"). The claim form could be submitted in hard copy or electronically via interstate wire.

7. When submitting claims to Medicare for reimbursement, providers were required to certify that: (1) the contents of the forms were true, correct, and complete; (2) the forms were prepared in compliance with the laws and regulations governing Medicare; and (3) the items and services that were purportedly provided, as set forth in the claims, were medically necessary.

8. Medicare claims were required to be properly documented in accordance with Medicare rules and regulations. Medicare would not reimburse providers for claims that were procured through the payment of kickbacks and bribes.

9. When initially enrolling or updating ownership or management information, the Provider Enrollment Application required the provider to disclose all owners and any individuals or businesses with managing control over the provider. This disclosure obligation included any individual or entity with five (5) percent or more ownership, managing control, or a partnership interest, regardless of the percentage of ownership the partner had.

10. This disclosure obligation was necessary, in part, because, under Title 42, Code of Federal Regulations, Section 424.530, CMS could deny a provider's enrollment in the Medicare program if, among other reasons, the "provider, supplier, or any owner or managing employee of the provider or supplier was, within the preceding 10 years, convicted . . . of a Federal or State felony offense that CMS determines is detrimental to the best interests of the Medicare program and its beneficiaries."

Part B Coverage and Regulations

11. CMS acted through fiscal agents called Medicare administrative contractors ("MACs"), which were statutory agents for CMS for Medicare Part B. The MACs were private entities that reviewed claims and made payments to providers for items and services rendered to beneficiaries. The MACs were responsible for processing Medicare claims arising within their assigned geographical area, including determining whether the claim was for a covered item or service.

12. Payments under Medicare Part B were often made directly to the health care provider rather than to the patient or beneficiary. For this to occur, the beneficiary would assign the right of payment to the health care provider. Once such an assignment took place, the health care provider would assume the responsibility for submitting claims to, and receiving payments from, Medicare.

Durable Medical Equipment

13. DME was reusable medical equipment such as orthotic devices, walkers, canes, or hospital beds. Orthotic devices were a type of DME that included knee braces, back braces, shoulder braces, and wrist braces (collectively, "braces").

14. A claim for DME submitted to Medicare qualified for reimbursement only if the DME was medically necessary for the treatment of the beneficiary's illness or injury, ordered by a licensed provider, and actually provided to the beneficiary.

Telemedicine

15. Telemedicine provided a means of connecting patients to doctors by using telecommunications technology, such as the internet or telephone, to interact with a patient.

16. Telemedicine companies provided telemedicine services, or telehealth services, to individuals by hiring doctors and other health care providers. Telemedicine companies typically paid doctors a fee to conduct consultations with patients. In order to generate revenue, telemedicine companies typically either billed insurance or received payment from patients who utilized the services of the telemedicine company.

17. Medicare Part B covered expenses for specific telehealth services if certain requirements were met. These requirements included that: (a) the beneficiary was located in a rural or health professional shortage area; (b) services were delivered via an interactive audio and video telecommunications system; and (c) the beneficiary was in a practitioner's office or a specified medical facility—not at a beneficiary's home—during the telehealth service with a remote practitioner. In or around March 2020, in response to the COVID-19 pandemic, some of these requirements were amended temporarily to, among other things, cover telehealth services for certain office and hospital visits, even if the beneficiary was not located in a rural area or a health professional shortage area and even if the telehealth services were furnished to beneficiaries in their home.

The CARES Act

18. In March 2020, Congress passed the Coronavirus Aid, Relief, and Economic Security ("CARES") Act, which was designed to provide emergency financial assistance to the millions of Americans suffering due to the COVID-19 pandemic.

19. The CARES Act established several new temporary programs and provided for expansion of others, including programs created and/or administered by HHS and the United States Small Business Administration ("SBA").

The Provider Relief Fund

20. One source of relief provided by the CARES Act was the appropriation of moneys to help health care providers ("Providers") that were financially impacted by COVID-19, as well as to provide care to patients who were suffering from COVID-19 and compensate providers for the cost of that care (the "Provider Relief Fund"). HHS, through its agency, the Health Resources and Services Administration ("HRSA"), oversaw and administered the Provider Relief Fund.

21. In order to rapidly provide funding to Providers during the pandemic, HRSA distributed payments under the CARES Act Provider Relief Fund ("Provider Relief Fund Payment" or "Payment") to Providers who: (a) billed Medicare fee-for-service (Parts A or B) in Calendar Year 2019; (b) were not currently terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D; (c) were not currently excluded from participation in Medicare and other Federal health care programs; and (d) did not currently have Medicare billing privileges revoked. Providers meeting these criteria automatically received the Provider Relief Fund Payment and did not have to apply for the funding, but they were required to comply with the terms and conditions of the Provider Relief Fund ("Terms and Conditions") if they retained such funding.

22. Provider Relief Fund recipients attested to their compliance with the Terms and Conditions in one of two ways. First, Provider Relief Fund recipients were notified that they could submit an attestation through an online portal confirming receipt of the funds and agreeing to the Terms and Conditions. Second, recipients were notified that, if they kept the money for a period that exceeded 90 days from receipt, they were deemed to have accepted the Terms and Conditions of the Provider Relief Fund.

23. Providers who attested to the Terms and Conditions acknowledged that their commitment to full compliance with the terms and conditions was material to the HHS Secretary's decision to disburse Provider Relief Fund Payments to them. Providers further acknowledged that non-compliance with any Term or Condition could cause the HHS Secretary to recoup some or all of the Payment.

24. Providers who attested to the Terms and Conditions certified that they:

a. billed Medicare in Calendar Year 2019;

b. provided diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 after January 31, 2020;

c. were not then terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D;

d. were not then excluded from participation in Medicare and other Federal health care programs;

e. did not then have Medicare billing privileges revoked;

f. would only use the Payment to prevent, prepare for, and respond to coronavirus, and that the Payment would reimburse the recipient only for health-care-related expenses or lost revenues that were attributable to coronavirus;

g. provided information relating to the Payment that was true, accurate, and complete and that any deliberate omission, misrepresentation, or falsification of any information was punishable by, inter alia, criminal penalties, including but not limited to imprisonment; and

h. would maintain appropriate records and cost documentation to substantiate the reimbursement of costs under the disbursement.

The Defendants, Related Entities, and Relevant Persons

25. Lion Medical Supply LLC ("LION MEDICAL"), a limited liability company formed under the laws of Florida, was a medical supply company enrolled with Medicare that purportedly provided DME to individuals, including Medicare beneficiaries. LION MEDICAL had a listed place of business in Palm Beach County. LION MEDICAL held an account at Bank 1 ending in x9811 ("Lion Medical Account").

26. Titan Medical Supply LLC ("TITAN MEDICAL"), a limited liability company formed under the laws of Florida, was a medical supply company enrolled with Medicare that purportedly provided DME to individuals, including Medicare beneficiaries. TITAN MEDICAL had a listed place of business in Palm Beach County. TITAN MEDICAL held an account at Bank 1 ending in x5739 ("Titan Medical Account").

27. Redmed Medical Supply LLC ("REDMED"), a limited liability company formed under the laws of Florida, was a medical supply company enrolled with Medicare that purportedly provided DME to individuals, including Medicare beneficiaries. REDMED had a listed place of business in Palm Beach County.

28. Giant Medical Supplies, LLC ("GIANT MEDICAL"), a limited liability company formed under the laws of Florida, was a medical supply company enrolled with Medicare that

purportedly provided DME to individuals, including Medicare beneficiaries. GIANT MEDICAL had a listed place of business in Broward County.

29. Superior Medical Supplies, LLC ("SUPERIOR MEDICAL"), a limited liability company formed under the laws of Florida, was a medical supply company enrolled with Medicare that purportedly provided DME to individuals, including Medicare beneficiaries. SUPERIOR MEDICAL had a listed place of business in Broward County. SUPERIOR MEDICAL held an account at Bank 1 ending in x2972 ("Superior Medical Account").

30. Aptitude Marketing Group, LLC ("APTITUDE"), a limited liability company formed under the laws of Florida, was purportedly a marketing company with a listed place of business in Broward County. APTITUDE held an account at Bank 1 ending in x6651 ("Aptitude Account").

31. Enhanced Media Group, Inc. ("ENHANCED"), a corporation formed under the laws of Florida, was purportedly a marketing company with a listed place of business in Broward County. ENHANCED held an account at Bank 1 ending in x1357 ("Enhanced Account").

32. Enriched Marketing Group LLC ("ENRICHED"), a limited liability company formed under the laws of Florida, was purportedly a marketing company with a listed place of business in Broward County. ENRICHED held an account at Bank 1 ending in x2796 ("Enriched Account").

33. CRH Holdings, LLC ("CRH HOLDINGS"), a limited liability company formed under the laws of Florida, was purportedly a marketing company with a listed place of business in Hillsborough County. CRH HOLDINGS held an account at Bank 3 ending in x1640 ("CRH Holdings Account").

34. Mendez Digital, LLC ("MENDEZ DIGITAL") was a limited liability company formed under the laws of Florida, with a listed place of business in Palm Beach County. MENDEZ DIGITAL held an account at Bank 4 ending in x7724 ("Mendez Digital Account").

35. Gulf Marketing Group Inc. ("GULF MARKETING"), a corporation formed under the laws of Florida, was purportedly a marketing company with a listed place of business in Broward County. GULF MARKETING held an account at Bank 3 ending in x9169 ("Gulf Marketing Account").

36. Broad Street Lifestyles LLC ("BROAD STREET") was a limited liability company formed under the laws of Florida, with a listed place of business in Palm Beach County. BROAD STREET held an account at Bank 2 ending in x6973 ("Broad Street Account").

37. Defendant **LUIS M. PEREZ** was a resident of Broward County. **PEREZ** was the listed owner of LION MEDICAL, REDMED, APTITUDE, and ENHANCED, and the beneficial owner of TITAN MEDICAL.

38. Defendant **JESTIL TAPIA** was a resident of Broward County. **TAPIA** was a beneficial owner of GIANT MEDICAL, SUPERIOR MEDICAL, and ENRICHED.

39. Conspirator 1 was a resident of Palm Beach County and an owner of BROAD STREET.

40. Conspirator 2 was a resident of Palm Beach County and an owner of GULF MARKETING.

41. Conspirator 3 was a resident of Broward County and an owner of MENDEZ DIGITAL.

42. Conspirator 4 was a resident of Hillsborough County and an owner of CRH HOLDINGS.

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

1. Paragraphs 1 through 17 and 25 through 42 of the General Allegations section of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

2. From in or around January 2019, and continuing through in or around August 2020, in Broward County, in the Southern District of Florida, and elsewhere, the defendant,

LUIS M. PEREZ,

did knowingly and willfully, that is, with the intent to further the objects of the conspiracy, combine, conspire, confederate, and agree with 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 to obtain 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, to knowingly transmit and cause to be transmitted by means of wire communication in interstate and foreign commerce, certain writings, signs, signals, pictures, 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 defendant and his co-conspirators to unlawfully enrich themselves by, among other things: (a) offering, paying, and causing the payment of kickbacks and bribes to patient recruiters in exchange for the referral of Medicare beneficiaries and doctors' orders for DME to LION MEDICAL, TITAN MEDICAL, and REDMED; (b) offering, paying, and causing the payment of kickbacks and bribes to telemedicine and marketing companies in exchange for ordering and arranging for the ordering of DME for Medicare beneficiaries, without regard to the medical necessity of the prescribed DME or whether the DME was eligible for Medicare reimbursement; (c) submitting and causing the submission, via interstate wire communication, of false and fraudulent claims to Medicare through DME companies, including LION MEDICAL, TITAN MEDICAL, and REDMED, for DME that was procured through the payment of kickbacks and bribes, not medically necessary, and not eligible for Medicare reimbursement; (d) concealing and causing the concealment of false and fraudulent claims to Medicare; and (e) diverting fraud proceeds for their personal use and benefit, the use and benefit of others, and to further the conspiracy.

Manner and Means

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

4. **LUIS PEREZ** and others acquired beneficial ownership interests in DME companies, including LION MEDICAL, TITAN MEDICAL, and REDMED.

5. **LUIS PEREZ** and others recruited and paid individuals to serve as nominee owners of DME companies to conceal the identities of the beneficial owners of the DME companies.

6. **LUIS PEREZ** and others, through and on behalf of LION MEDICAL, TITAN MEDICAL, and REDMED, paid and caused to be paid kickbacks and bribes to patient recruiters, through APTITUDE, ENHANCED, and other entities, in exchange for referring beneficiaries and doctors' orders for DME to DME companies, including LION MEDICAL, TITAN MEDICAL, and REDMED.

7. **LUIS PEREZ** and others, through and on behalf of LION MEDICAL, TITAN MEDICAL, and REDMED, negotiated the kickback and bribe arrangements, and disguised the true nature and source of these kickbacks and bribes as being for other purported services, and further concealed such payments by entering into sham contracts.

8. **LUIS PEREZ** and others, through and on behalf of LION MEDICAL, TITAN MEDICAL, and REDMED, offered and paid, and caused to be paid, kickbacks and bribes to telemedicine and marketing companies in exchange for doctors' orders for DME that was not medically necessary and not eligible for Medicare reimbursement. These doctors' orders were written by doctors contracted with the telemedicine companies who did not have a pre-existing doctor-patient relationship with the beneficiaries, were not treating the beneficiaries, did not conduct a physical examination, and did not conduct a proper telemedicine visit.

9. **LUIS PEREZ** and others submitted, and caused the submission of, false and fraudulent claims to Medicare, through the use of interstate wire communications, on behalf of LION MEDICAL, TITAN MEDICAL, and REDMED, totaling approximately $12,641,463, for DME that was not medically necessary and not eligible for reimbursement. As a result of these false and fraudulent claims, LION MEDICAL, TITAN MEDICAL, and REDMED received payment in the approximate amount of $6,075,681.

10. **LUIS PEREZ** and others used the fraud proceeds to benefit themselves and others, and to further the fraud.

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

COUNTS 2-3
Health Care Fraud
(18 U.S.C. § 1347)

1. Paragraphs 1 through 17 and 25 through 42 of the General Allegations section of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

2. From in or around January 2019, and continuing through in or around August 2020, in Broward County, in the Southern District of Florida, and elsewhere, the defendant,

LUIS PEREZ,

did knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud a health care benefit program affecting commerce, as defined in Title 18, United States Code, Section 24(b), that is, Medicare, and to obtain by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of, said healthcare benefit program, in connection with the delivery of and payment for health care benefits, items, and services.

Purpose of the Scheme and Artifice

3. It was a purpose of the scheme and artifice for the defendant and his accomplices to unlawfully enrich themselves by, among other things: (a) offering, paying, and causing the payment of kickbacks and bribes to patient recruiters in exchange for the referral of Medicare beneficiaries and doctors' orders for DME to LION MEDICAL, TITAN MEDICAL, and REDMED; (b) offering, paying, and causing the payment of kickbacks and bribes to telemedicine and marketing companies in exchange for ordering and arranging for the ordering of DME for

Medicare beneficiaries, without regard to the medical necessity of the prescribed DME or whether the DME was eligible for Medicare reimbursement; (c) submitting and causing the submission of false and fraudulent claims to Medicare through DME companies, including LION MEDICAL, TITAN MEDICAL, and REDMED, for DME that was procured through the payment of kickbacks and bribes, not medically necessary, and not eligible for Medicare reimbursement; (d) concealing and causing the concealment of false and fraudulent claims to Medicare; and (e) diverting fraud proceeds for their personal use and benefit, the use and benefit of others, and to further the fraud.

The Scheme and Artifice

4. The Manner and Means section of Count 1 of this Indictment is re-alleged and incorporated by reference as though fully set forth herein as a description of the scheme and artifice.

Acts in Execution or Attempted Execution of the Scheme and Artifice

5. On or about the dates specified below as to each count, in Broward County, in the Southern District of Florida, and elsewhere, the defendant did knowingly and willfully execute, and attempt to execute, the above-described scheme and artifice to defraud a health care benefit program, in that the defendant submitted and caused the submission of false and fraudulent claims, seeking the identified dollar amounts, and representing that such benefits, items, and services were medically necessary and eligible for Medicare reimbursement:

Count	Medicare Beneficiary	Approx. Date of Claim Submission	Claim No.; DME	Description of Claims; Total Approx. Amount Billed
2	B.A.	9/5/2019	119252720749001 (LION)	Shoulder, elbow, wrist, hand orthosis; $868
3	J.C.	3/26/2020	120087800092000 (TITAN)	Knee orthosis; $1,200

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

COUNT 4
Conspiracy to Defraud the United States and to Pay and Receive Health Care Kickbacks
(18 U.S.C. § 371)

1. Paragraphs 1 through 17 and 25 through 42 of the General Allegations section of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

2. From in or around January 2019, and continuing through in or around August 2020, in Broward County, in the Southern District of Florida, and elsewhere, the defendants,

LUIS PEREZ and
JESTIL TAPIA,

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 others known and unknown to the Grand Jury, including Conspirator 1, Conspirator 2, Conspirator 3, and Conspirator 4, to commit offenses against the United States, that is:

a. to defraud the United States by impairing, impeding, obstructing, and defeating through deceitful and dishonest means, the lawful government functions of HHS and CMS in their administration and oversight of Medicare;

b. to violate Title 42, United States Code, Section 1320a-7b(b)(1)(A), by soliciting and receiving remuneration, including kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind, including by wire transfer, in return for referring an individual to a person for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole and in part under a Federal health care program, that is, Medicare;

c. to violate Title 42, United States Code, Section 1320a-7b(b)(2)(B), by offering and paying remuneration, including kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind, to a person to induce such person to purchase, lease, order, and arrange for and recommend purchasing, leasing, and ordering any good, facility, service, and item for which

payment may be made in whole or in part under a Federal health care program, that is, Medicare; and

d. to violate of Title 42, United States Code, Section 1320a-7b(b)(2)(A), by offering and paying remuneration, including kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind, in return for referring an individual to a person for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole and in part under a Federal health care program, that is, Medicare.

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) falsifying and causing the falsification of Medicare Enrollment Applications to conceal the true ownership of TITAN MEDICAL, GIANT MEDICAL, and SUPERIOR MEDICAL; (b) soliciting and receiving kickbacks and bribes in exchange for the referral of Medicare beneficiaries and doctors' orders for DME to LION MEDICAL, TITAN MEDICAL, REDMED, GIANT MEDICAL, and SUPERIOR MEDICAL, and other DME companies; (c) offering and paying kickbacks and bribes to telemedicine and marketing companies in exchange for ordering and arranging for the ordering of DME for Medicare beneficiaries; (d) submitting and causing the submission of claims to Medicare through LION MEDICAL, TITAN MEDICAL, REDMED, GIANT MEDICAL, SUPERIOR MEDICAL, and other DME companies for braces; (e) concealing and causing the concealment of kickbacks and bribes; and (f) diverting kickback proceeds for their personal use and benefit, the use and benefit of others, and to further the conspiracy.

Manner and Means

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

4. **LUIS PEREZ** and **JESTIL TAPIA** acquired beneficial ownership interests in DME companies, including LION MEDICAL, TITAN MEDICAL, REDMED, GIANT MEDICAL, and SUPERIOR MEDICAL.

5. **LUIS PEREZ** and **JESTIL TAPIA** recruited and paid individuals to serve as nominee owners of DME companies in order to conceal the identities of the beneficial owners of the DME companies.

6. **LUIS PEREZ, JESTIL TAPIA**, and others falsified and caused the falsification of Medicare Enrollment Applications, corporate records, and other documents to conceal the true ownership and management of the DME companies.

7. **LUIS PEREZ, JESTIL TAPIA**, and others submitted and caused the submission of false and fraudulent Medicare Enrollment Applications to Medicare to enroll DME companies.

8. **LUIS PEREZ, JESTIL TAPIA**, and others solicited and received kickbacks and bribes from DME companies, in exchange for recruiting and referring Medicare beneficiaries and doctors' orders for DME, knowing that the DME companies would bill Medicare for DME purportedly provided to Medicare beneficiaries.

9. **LUIS PEREZ, JESTIL TAPIA**, and others offered and paid kickbacks and bribes to marketing companies in exchange for referring Medicare beneficiaries and doctors' orders to DME companies, including LION MEDICAL, TITAN MEDICAL, REDMED, GIANT MEDICAL, and SUPERIOR MEDICAL.

10. **LUIS PEREZ, JESTIL TAPIA**, and others negotiated the kickback and bribe arrangements with DME and marketing companies and disguised the nature and source of these kickbacks and bribes through sham contracts and otherwise concealed such kickbacks and bribes by describing them as payments for legitimate services.

11. **LUIS PEREZ, JESTIL TAPIA**, and others offered and paid kickbacks and bribes to telemedicine and marketing companies in exchange for the ordering and arranging for the ordering of DME for Medicare beneficiaries.

12. **LUIS PEREZ, JESTIL TAPIA**, and others caused DME companies, including LION MEDICAL, TITAN MEDICAL, REDMED, GIANT MEDICAL, and SUPERIOR MEDICAL, to submit claims to Medicare for DME.

13. **LUIS PEREZ, JESTIL TAPIA**, and others used the kickback payments received from DME companies to benefit themselves and others, and to further the conspiracy.

Overt Acts

In furtherance of the conspiracy, and to accomplish its objects and purpose, at least one co-conspirator committed and caused to be committed, in the Southern District of Florida, at least one of the following overt acts, among others:

1. On or about January 11, 2019, **LUIS PEREZ**, through the Aptitude Account, transferred approximately $41,900 to the CRH Holdings Account.

2. On or about May 9, 2019, **LUIS PEREZ**, through the Lion Medical Account, transferred approximately $10,000 to the Mendez Digital Account.

3. On or about April 6, 2020, **LUIS PEREZ**, through the Enhanced Account, transferred approximately $50,000 to the Broad Street Lifestyles Account.

4. On or about April 29, 2020, **JESTIL TAPIA**, through the Enriched Account, transferred approximately $25,000 to the Gulf Marketing Account.

5. On or about June 8, 2020, **JESTIL TAPIA**, through the Enriched Account, transferred approximately $50,000 to the Broad Street Account.

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

COUNTS 5–9
Payment of Kickbacks in Connection with a Federal Health Care Program
(42 U.S.C. § 1320a-7b(b)(2)(A))

1. Paragraphs 1 through 17 and 25 through 42 of 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, in Broward County, in the Southern District of Florida, and elsewhere, the defendants, as specified in each count below, did knowingly and willfully offer and pay remuneration, that is, kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind, as set forth below, in return for referring an individual to a person for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole and in part under a Federal health care program, that is, Medicare:

Count	Defendant	Approx. Date of Kickback Payment	Approx. Amt. of Kickback Payment	Description of Kickback Payment
5	**LUIS PEREZ**	1/11/2019	$41,900	Wire transfer from the Aptitude Account to the CRH Holdings Account
6	**LUIS PEREZ**	5/9/2019	$10,000	Wire transfer from the Lion Medical Account to the Mendez Digital Account
7	**LUIS PEREZ**	4/6/2020	$50,000	Wire transfer from the Enhanced Account to the Broad Street Lifestyles Account
8	**JESTIL TAPIA**	4/29/2020	$25,000	Wire transfer from the Enriched Account to the Gulf Marketing Account

Count	Defendant	Approx. Date of Kickback Payment	Approx. Amt. of Kickback Payment	Description of Kickback Payment
9	**JESTIL TAPIA**	6/8/2020	$50,000	Wire transfer from the Enriched Account to the Broad Street Account

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

COUNT 10
(Theft of Government Property)
(18 U.S.C. § 641)

1. The General Allegations section of this Indictment are realleged and incorporated by reference as if fully set forth herein.

2. On or about April 21, 2020, in Broward County, in the Southern District of Florida, and elsewhere, the defendant,

LUIS PEREZ,

did knowingly and willfully steal, purloin, and convert to his own use and the use of another, money from HHS, a department of the United States, in an amount exceeding $1,000, namely, approximately $89,052 from the HHS Provider Relief Fund that was deposited into an account at Bank 1 ending in x9391 in the name of LION MEDICAL, to which **PEREZ** knew LION MEDICAL was not entitled, with the intent to deprive HHS of the use and benefit of that money.

In violation of Title 18, United States Code, Sections 641 and 2.

COUNT 11
Money Laundering
(18 U.S.C. § 1957(a))

1. The General Allegations section of this Indictment are realleged and incorporated by reference as if fully set forth herein.

2. On or about May 1, 2020, in Broward County, in the Southern District of Florida, and elsewhere, the defendant,

LUIS PEREZ,

did knowingly engage and attempt to engage in a monetary transaction affecting interstate commerce, by, through, and to a financial institution, in criminally derived property of a value greater than $10,000, and such property having been derived from specified unlawful activity, knowing that the property involved in the monetary transaction was derived from some form of unlawful activity, that is, a transfer of $85,000 from an account at Bank 1 ending in x0830 held in the name of **PEREZ**, to a luxury car dealership.

It is further alleged that the specified unlawful activity is theft of government property, in violation of Title 18, United States Code, Section 641.

In violation of Title 18, United States Code, Sections 1957(a) and 2.

FORFEITURE ALLEGATIONS

1. The allegations of this Indictment are hereby re-alleged and by this reference fully incorporated herein for the purpose of alleging forfeiture to the United States of certain property in which any of the defendants, **LUIS PEREZ** and **JESTIL TAPIA**, have an interest.

2. Upon conviction of a violation of Title 18, United States Code, Sections 1347, 1349, and/or Title 42, United States Code, Section 1320a-7b, as alleged in this Indictment, the defendant so convicted shall forfeit to the United States any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense, pursuant to Title 18, United States Code, Section 982(a)(7).

3. Upon conviction of a violation of Title 18, United States Code, Section 641, as alleged in this Indictment, the defendant, **LUIS PEREZ**, shall forfeit to the United States any

property, real or personal, which constitutes or is derived from proceeds traceable to such offense, pursuant to Title 18, United States Code, Section 981(a)(1)(C).

4. Upon conviction of a violation of Title 18, United States Code, Section 1957, as alleged in this Indictment, the defendant, **LUIS PEREZ**, shall forfeit to the United States any property, real or personal, involved in such offense, and any property traceable to such property, pursuant to Title 18, United States Code, Section 982(a)(1).

All pursuant to Title 18, United States Code, Sections 982(a)(7), 981(a)(1)(C), and 982(a)(1), and the procedures set forth in Title 21, United States Code, Section 853, as incorporated by Title 28, United States Code, Section 2461(c) and Title 18, United States Code, Section 982(b)(1).

A TRUE BILL

[redacted]

GRAND JURY FOREPERSON

JUAN ANTONIO GONZALEZ
UNITED STATES ATTORNEY

LORINDA I. LARYEA, ACTING CHIEF
CRIMINAL DIVISION, FRAUD SECTION
U.S. DEPARTMENT OF JUSTICE

PATRICK J. QUEENAN
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CRIMINAL DIVISION, FRAUD SECTION
U.S. DEPARTMENT OF JUSTICE

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

UNITED STATES OF AMERICA

v.

LUIS M. PEREZ, et al.

_____/
Defendants.

CASE NO.:

CERTIFICATE OF TRIAL ATTORNEY*

Superseding Case Information:

New Defendant(s) (Yes or No)
Number of New Defendants
Total number of New Counts

Court Division (select one)

☐ Miami ☐ Key West ☐ FTP
☑ FTL ☐ WPB

I do hereby certify that:

1. I have carefully considered the allegations of the indictment, the number of defendants, the number of probable witnesses and the legal complexities of the Indictment/Information attached hereto.
2. I am aware that the information supplied on this statement will be relied upon by the Judges of this Court in setting their calendars and scheduling criminal trials under the mandate of the Speedy Trial Act, Title 28 U.S.C. §3161.
3. Interpreter: (Yes or No) No
   List language and/or dialect:
4. This case will take 5 days for the parties to try.
5. Please check appropriate category and type of offense listed below:

(Check only one)		(Check only one)	
I	☑ 0 to 5 days	☐	Petty
II	☐ 6 to 10 days	☐	Minor
III	☐ 11 to 20 days	☐	Misdemeanor
IV	☐ 21 to 60 days	☑	Felony
V	☐ 61 days and over		

6. Has this case been previously filed in this District Court? (Yes or No) No
   If yes, Judge Case No.
7. Has a complaint been filed in this matter? (Yes or No) No
   If yes, Magistrate Case No.
8. Does this case relate to a previously filed matter in this District Court? (Yes or No) No
   If yes, Judge Case No.
9. Defendant(s) in federal custody as of
10. Defendant(s) in state custody as of
11. Rule 20 from the District of
12. Is this a potential death penalty case? (Yes or No) No
13. Does this case originate from a matter pending in the Northern Region of the U.S. Attorney's Office prior to August 8, 2014 (Mag. Judge Shaniek Maynard? (Yes or No) No
14. Does this case originate from a matter pending in the Central Region of the U.S. Attorney's Office prior to October 3, 2019 (Mag. Judge Jared Strauss? (Yes or No) No

By: _____

PATRICK J. QUEENAN
DOJ Trial Attorney
Court ID No. A5502715

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

PENALTY SHEET

Defendant's Name: **LUIS M. PEREZ**

Case No:

Count #: 1

Title 18, United States Code, Section 1349

Conspiracy to Commit Health Care Fraud and Wire Fraud

* **Max. Term of Imprisonment: 20 years**
* **Mandatory Min. Term of Imprisonment (if applicable): N/A**
* **Max. Supervised Release: 3 years**
* **Max. Fine: $250,000 or twice the gross gain or loss from the offense**

Counts #: 2 – 3

Title 18, United States Code, Section 1347

Health Care Fraud

* **Max. Term of Imprisonment: 10 years as to each count**
* **Mandatory Min. Term of Imprisonment (if applicable): N/A**
* **Max. Supervised Release: 3 years**
* **Max. Fine: $250,000 or twice the gross gain or loss from the offense**

Count #: 4

Title 18, United States Code, Section 371

Conspiracy to Defraud the United States and to Pay and Receive Health Care Kickbacks

* **Max. Term of Imprisonment: 5 years**
* **Mandatory Min. Term of Imprisonment (if applicable): N/A**
* **Max. Supervised Release: 3 years**
* **Max. Fine: $250,000 or twice the gross gain or loss from the offense**

***Refers only to possible term of incarceration, supervised release and fines. It does not include restitution, special assessments, parole terms, or forfeitures that may be applicable.**

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

PENALTY SHEET

Defendant's Name: LUIS M. PEREZ

Case No:

Counts #: 5 – 7

Title 42, United States Code, Section 1320a-7b(b)(2)(A)

Payment of Kickbacks in Connection with a Federal Health Care Program

* **Max. Term of Imprisonment: 10 years as to each count**
* **Mandatory Min. Term of Imprisonment (if applicable): N/A**
* **Max. Supervised Release: 3 years**
* **Max. Fine: $250,000 or twice the gross gain or loss from the offense**

Count #: 10

Title 18, United States Code, Section 641

Theft of Government Property

* **Max. Term of Imprisonment: 10 years**
* **Mandatory Min. Term of Imprisonment (if applicable): N/A**
* **Max. Supervised Release: 3 years**
* **Max. Fine: $250,000**

Count #: 11

Title 18, United States Code, Section 1957(a)

Money Laundering

* **Max. Term of Imprisonment: 10 years**
* **Mandatory Min. Term of Imprisonment (if applicable): N/A**
* **Max. Supervised Release: 3 years**
* **Max. Fine: $250,000 or twice the amount of criminally derived property involved**

***Refers only to possible term of incarceration, supervised release and fines. It does not include restitution, special assessments, parole terms, or forfeitures that may be applicable.**

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

PENALTY SHEET

Defendant's Name: **JESTIL TAPIA**

Case No:

Count #: 4

Title 18, United States Code, Section 371

Conspiracy to Defraud the United States and to Pay and Receive Health Care Kickbacks

*** Max. Term of Imprisonment: 5 years**
*** Mandatory Min. Term of Imprisonment (if applicable): N/A**
*** Max. Supervised Release: 3 years**
*** Max. Fine: $250,000 or twice the gross gain or loss from the offense**

Counts #: 8 – 9

Title 42, United States Code, Section 1320a-7b(b)(2)(A)

Payment of Kickbacks in Connection with a Federal Health Care Program

*** Max. Term of Imprisonment: 10 years as to each count**
*** Mandatory Min. Term of Imprisonment (if applicable): N/A**
*** Max. Supervised Release: 3 years**
*** Max. Fine: $250,000 or twice the gross gain or loss from the offense**

***Refers only to possible term of incarceration, supervised release and fines. It does not include restitution, special assessments, parole terms, or forfeitures that may be applicable.**