UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

22-60156-CR-MIDDLEBROOKS/HUNT
Case No. _____

18 U.S.C. § 371
18 U.S.C. § 1035(a)(2)
18 U.S.C. § 2
18 U.S.C. § 982(a)(7)

UNITED STATES OF AMERICA

vs.

LUCIA MIRANDA ORO TABOADA,

Defendant.
_____/

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.

4. Medicare "providers" included physicians, DME companies, independent clinical laboratories, and other health care providers who provided items and 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 and 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: (a) the contents of the forms were true, correct, and complete; (b) the forms were prepared in compliance with the laws and regulations governing Medicare; and (c) 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 Enrollment Application in Medicare 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.

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 Defendant, Related Entities, and Relevant Persons

18. Nero Med Tech LLC d/b/a Nero Med Tech Supplies LLC ("NERO"), 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. NERO had a listed place of business in Broward County, Florida, and held an account at Bank 1 ending in x3752 ("Nero Account").

19. Trinity Med Supplies LLC ("TRINITY"), 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. TRINITY had a listed place of business in Broward County, Florida.

20. Company 1, a limited liability company formed under the laws of Florida, was purportedly a marketing company with a listed place of business in Palm Beach County, Florida.

21. Defendant **LUCIA MIRANDA ORO TABOADA**, a resident of Palm Beach County, Florida, was the listed owner of NERO and signatory on the Nero Account.

22. Conspirator 1, a resident of Broward County, Florida, was a beneficial owner of NERO and TRINITY.

23. Conspirator 2, a resident of Palm Beach County, Florida, was a beneficial owner of NERO and TRINITY, and an officer of Company 1.

COUNT 1
Conspiracy to Defraud the United States
(18 U.S.C. § 371)

1. The General Allegations section of this Indictment is re-alleged and incorporated by reference as though fully set forth herein.

2. From in or around February 2020, and continuing through in or around May 2021, in Broward County, in the Southern District of Florida, and elsewhere, the defendant,

LUCIA MIRANDA ORO TABOADA,

did knowingly and willfully, that is, with the intent to further the object of the conspiracy, combine, conspire, confederate, and agree with Conspirator 1, Conspirator 2, and others known and unknown to the Grand Jury, to defraud the United States by impairing, impeding, obstructing, and defeating through deceitful and dishonest means, the lawful government functions of HHS and CMS in their administration and oversight of Medicare.

Purpose of the Conspiracy

3. It was a purpose of the conspiracy for the defendant and her co-conspirators to unlawfully enrich themselves by, among other things: (a) falsifying and submitting, and causing the falsification and submission of, a Medicare Enrollment Application concealing the true ownership of TRINITY and NERO; (b) offering, and paying kickbacks and bribes for the referral of Medicare beneficiaries and doctors' orders for DME; (c) submitting and causing the submission of false and fraudulent claims to Medicare through TRINITY and NERO that were based on kickbacks and bribes, not medically necessary, and not eligible for reimbursement by Medicare; (d) concealing and causing the concealment of false and fraudulent claims to Medicare; and (e) diverting fraud proceeds for her personal use and benefit, the use and benefit of others, and to further the fraud.

Manner and Means of the Conspiracy

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

4. Conspirator 1 and Conspirator 2 acquired beneficial ownership interests in NERO and TRINITY.

5. Conspirator 1 falsified and caused the falsification of a Medicare Enrollment Application, corporate records, and other documents to conceal the true ownership and management of TRINITY.

6. Conspirator 1 and Conspirator 2 recruited **LUCIA MIRANDA ORO TABOADA** as an employee of TRINITY and as the nominee owner of NERO in order to conceal the identities of the beneficial owners, including Conspirator 1 and Conspirator 2.

7. **LUCIA MIRANDA ORO TABOADA** falsified and caused the falsification of a Medicare Enrollment Application, corporate records, and other documents to conceal the true ownership and management of NERO.

8. **LUCIA MIRANDA ORO TABOADA** submitted and caused the submission of a false and fraudulent Medicare Enrollment Application to Medicare to enroll NERO as a DME provider.

9. In exchange for serving as the nominee owner of NERO, **LUCIA MIRANDA ORO TABOADA** received a salary deriving from the reimbursements for DME billed to Medicare by NERO.

10. **LUCIA MIRANDA ORO TABOADA,** Conspirator 1, Conspirator 2, and others, through and on behalf of NERO and TRINITY, paid and caused to be paid kickbacks and bribes to patient recruiters and marketers in exchange for referring beneficiaries and doctors' orders for DME to NERO and TRINITY.

11. **LUCIA MIRANDA ORO TABOADA,** Conspirator 1, Conspirator 2, and others, through and on behalf of NERO and TRINITY, negotiated the kickback and bribe arrangements, and disguised the true nature and source of these kickbacks and bribes as being for other purported services, such as "logistical management" or "brand awareness" services, and further concealed such payments by entering into sham contracts.

12. Conspirator 2 and others, through and on behalf of NERO, TRINITY, and Company 1, offered and paid, and caused to be paid, illegal kickbacks and bribes to telemedicine 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.

13. **LUCIA MIRANDA ORO TABOADA**, Conspirator 1, Conspirator 2, and others submitted, and caused the submission of, false and fraudulent claims to Medicare on behalf of NERO, totaling approximately $759,755, for DME that was not medically necessary and not eligible for reimbursement. As a result of these false and fraudulent claims, NERO received payment from Medicare in the approximate amount of $410,568.

14. **LUCIA MIRANDA ORO TABOADA**, Conspirator 1, Conspirator 2, and others submitted, and caused the submission of, false and fraudulent claims to Medicare on behalf of TRINITY, totaling approximately $1,037,975, for DME that was not medically necessary and not eligible for reimbursement. As a result of these false and fraudulent claims, TRINITY received payment from Medicare in the approximate amount of $552,155.

15. **LUCIA MIRANDA ORO TABOADA**, Conspirator 1, Conspirator 2, and other co-conspirators used the fraud proceeds to benefit themselves and others, and to further the fraud.

Overt Acts

In furtherance of the conspiracy, and to accomplish its object 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 June 23, 2020, **LUCIA MIRANDA ORO TABOADA** caused the submission of a Medicare Enrollment Application (CMS Form 855S), falsely certifying that, as of on or about June 22, 2020, **ORO TABOADA** was the sole owner and person with managing control of NERO, when in fact Conspirator 1 and Conspirator 2 were the beneficial owners and managers of NERO.

2. On or about June 26, 2020, **LUCIA MIRANDA ORO TABOADA** executed a signature card at Bank 1 adding herself as a signatory on the Nero Account.

3. On or about September 9, 2020, **LUCIA MIRANDA ORO TABOADA** issued a check from the Nero Account in the amount of $10,000 to Company 1.

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

COUNT 2
False Statements Relating to Health Care Matters
(18 U.S.C. § 1035(a)(2))

1. The General Allegations section of this Indictment is re-alleged and incorporated by reference as though fully set forth herein.

2. On or about June 23, 2020, in Broward County, in the Southern District of Florida, and elsewhere, the defendant,

LUCIA MIRANDA ORO TABOADA,

in a matter involving a health care benefit program, that is, Medicare, did knowingly and willfully make and use a materially false writing and document, knowing the same to contain a materially false, fictitious, and fraudulent statement and entry, in connection with the delivery of and payment for health care benefits, items, and services, that is, the defendant signed and submitted to Medicare a Medicare Enrollment Application (CMS Form 855S) certifying that she was the sole owner and managing employee of NERO, when, in truth and in fact, as the defendant then and there well knew, she was not the sole owner and managing employee of NERO.

In violation of Title 18, United States Code, Sections 1035(a)(2) 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 the defendant, **LUCIA MIRANDA ORO TABOADA**, has an interest.

2. Upon conviction of a violation of a Federal health care offense, that is, Title 18, United States Code, Section 1035, as alleged in this Indictment, the defendant 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).

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

A TRUE BILL

[redacted]

GRAND JURY FOREPERSON

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