UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

UNITED STATES OF AMERICA

v.

CARIDAD LIMBERG-GONZALEZ, and
THOMAS CARPENTER

CASE NO 8:18 cr295 T17JSS

18 U.S.C. § 1347
18 U.S.C. § 1349
18 U.S.C. § 1035
18 U.S.C. § 982 (forfeiture)

INDICTMENT

The Grand Jury charges that:

GENERAL ALLEGATIONS

At times material to this Indictment:

A. The Medicare Program

1. The Medicare Program ("Medicare") was a federal health care program providing health care benefits, items and services (collectively, "services") to persons who were over the age of 65 or disabled. Medicare was administered by the United States Department of Health and Human Services ("HHS") through its agency, the Centers for Medicare & Medicaid Services ("CMS"). Individuals who received services under Medicare were referred to as Medicare "beneficiaries."

2. Medicare programs covering different types of benefits were separated into different program "parts." "Part A" of the Medicare program

covered certain eligible home health care costs for medical services provided by a home health agency ("HHA"), to beneficiaries who required home health services because of an illness or disability that caused them to be homebound. Payments for home health care medical services under Medicare Part A were typically made directly to an HHA or provider based on claims submitted to the Medicare program for qualifying services that had been provided to eligible beneficiaries, rather than to the beneficiary. "Part B" of the Medicare program covered, among other things, certain physician and outpatient services, and other health care benefits, items, and services, including visits with physicians at a physician's office or in the beneficiary's home, that were medically necessary.

3. Physicians, physician's assistants, nurse practitioners, clinics and other health care providers (such as HHAs) that provided services to Medicare beneficiaries were able to apply for and obtain "provider numbers." A health care provider who received a Medicare provider number was able to submit bills, known as "claims," to Medicare to obtain reimbursement for benefits, items, and services provided to beneficiaries. A Medicare claim was required to set forth, among other things, (i) the beneficiary's name and Medicare identification number, (ii) the name and identification number of the physician or other health care provider who ordered the benefits, items, and services, (iii)

the benefits, items, and services that were performed for or provided to the beneficiary, (iv) the date that the benefits, items, and services were provided, (v) the cost of the benefits, items, and services, and (vi) the billing codes for the benefits, items, and services.

4. CMS did not directly pay Medicare Part A claims submitted by Medicare-certified HHAs. CMS contracted with different companies to administer the Medicare Part A program throughout different parts of the United States. In the State of Florida, CMS contracted with Palmetto Government Benefits Administrators ("Palmetto"). As administrator, Palmetto was to receive, adjudicate, and pay claims submitted by HHA providers under the Part A program for home health services. Additionally, CMS separately contracted with companies in order to review HHA providers' claims data. CMS first contracted with TriCenturion, a Program Safeguard Contractor. Subsequently, on December 15, 2008, CMS contracted with SafeGuard Services, a Zone Program Integrity Contractor. Both TriCenturion and SafeGuard Services safeguarded the Medicare Trust Fund by reviewing HHA providers' claims for potential fraud, waste, and/or abuse.

5. For Florida beneficiaries, Medicare Part B's insurance concerning physician visits and related health care benefits, items, and services, was administered by First Coast Service Options, Inc. ("First

Coast"), pursuant to a contract with HHS. Among First Coast's responsibilities, it received, adjudicated, and paid the claims of authorized physicians or clinics that were seeking reimbursement for the cost of physician visits and other health care benefits, items, or services supplied or provided to Medicare beneficiaries.

B. Medicare Part A Coverage and Regulations

1. Reimbursements

6. The Medicare Part A program reimbursed 100% of the allowable charges for participating HHAs providing home health care services only if the patient qualified for home health benefits. A patient qualified for home health benefits only if the following requirements, among others, were met:

a. the patient was confined to the home, also referred to as homebound;

b. the patient was under the care of a physician who specifically determined there was a need for home health care and established the Plan of Care ("POC"); and

c. the determining physician signed a certification statement specifying that the beneficiary needed intermittent skilled nursing services, physical therapy, or speech therapy and that the beneficiary was confined to the home; that a POC

for furnishing services was established and periodically reviewed; and that the services were furnished while the beneficiary was under the care of the physician who established the POC.

7. HHAs were reimbursed under the Home Health Prospective Payment System ("PPS"). Under PPS, Medicare paid Medicare-certified HHAs a predetermined base payment for each 60 days that care was needed. This 60-day period was called an "episode of care." The base payment was adjusted depending upon the health condition and care needs of the beneficiary. This adjustment was done through the Outcome and Assessment Information Set ("OASIS"), which was a patient assessment tool for measuring and detailing the patient's condition. If a beneficiary was still eligible for care after the end of the first episode of care, a second episode could commence. There were no limits to the number of episodes of home health benefits a beneficiary could receive as long as the beneficiary continued to qualify for home health benefits.

8. In order to be reimbursed, the HHA would submit a Request for Anticipated Payment ("RAP") and subsequently receive a portion of its payment in advance of services being rendered. At the end of a 60-day episode, when the final claim was submitted, the remaining portion of the

payment would be made. As explained in more detail below, "Outlier Payments" were additional PPS payments based on visits in excess of the norm. Palmetto paid Outlier Payments to HHA providers under PPS where the providers' RAP submissions established that the cost of care exceeded the established Health Insurance Prospective Payment System ("HIPPS") code threshold dollar amount.

2. Record Keeping Requirements

9. Medicare Part A regulations required HHAs providing services to Medicare patients to maintain complete and accurate medical records reflecting the medical assessment and diagnoses of their patients, as well as records documenting actual treatment of the patients to whom services were provided and for whom claims for reimbursement were submitted by the HHAs. These medical records were required to be sufficient to permit Medicare, through Palmetto and other contractors, to review the appropriateness of Medicare payments made to the HHA under the Part A program.

10. Among the written records required to document the appropriateness of home health care claims submitted under Part A of Medicare was a POC that included the physician order for home health care, diagnoses, types of services/frequency of visits, prognosis/rehabilitation

potential, functional limitations/activities permitted, medications/treatments/nutritional requirements, safety measures/discharge plans, goals, and the physician's signature. Also required was a signed certification statement by an attending physician certifying that the patient was confined to his or her home and was in need of the planned home health services, and an OASIS.

11. Medicare Part A regulations required provider HHAs to maintain medical records of every visit made by a nurse, therapist, and home health aide to a beneficiary. The record of a nurse's visit was required to describe, among other things, any significant observed signs or symptoms, any treatment and drugs administered, any reactions by the patient, any teaching and the understanding of the patient, and any changes in the patient's physical or emotional condition. The home health nurse, therapist and aide were required to document the hands-on personal care provided to the beneficiary as the services were deemed necessary to maintain the beneficiary's health or to facilitate treatment of the beneficiary's primary illness or injury. These written medical records were generally created and maintained in the form of "clinical notes" and "home health aide notes/observations."

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

agencies, registries, or groups (nursing groups), which would bill the certified HHA. The HHA would, in turn, bill Medicare for all services provided to beneficiaries by the subcontractor. The HHA's professional supervision over subcontracted-for services required the same quality controls and supervision as required of its own salaried employees.

C. Medicare Part B Coverage and Regulations

13. Medicare, through First Coast, would generally pay a substantial portion of the cost of physician visits or related health care benefits, items, and services that were medically necessary.

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

15. Under Medicare rules and regulations, physician visits and other related health care benefits, items or other services, must have been medically necessary and rendered by a licensed doctor or other licensed, qualified health care provider in order to be reimbursed by Medicare.

16. The Medicare Part B program would pay for benefits, items, and services furnished by physician's assistants and nurse practitioners in one of two ways. The physician's assistant and nurse practitioner could obtain a Medicare provider number and bill the Medicare Part B program directly for benefits, items, and services they rendered.

17. In the alternative, benefits, items, and services furnished by physician's assistants and nurse practitioners could be billed using what was commonly referred to as "incident to" billing. In order to bill in this manner, the benefits, items, and services furnished by physician's assistants and nurse practitioners must have met certain conditions: (i) the benefits, items, and services were an integral, although incidental, part of a physician's personal professional services in the course of diagnosis or treatment of an injury or illness; (ii) the benefits, items, and services were of kinds commonly furnished in physician's offices; (iii) the benefits, items, and services were included on the physician's bill; and (iv) the benefits, items, and services were rendered under the physician's direct supervision. Direct supervision meant the physician was present in the office suite and immediately available to provide assistance and direction throughout the time the physician's assistants and nurse practitioners were performing services. If these criteria were met, the Medicare Part B program allowed the benefits, items, and services furnished

by physician's assistants and nurse practitioners to be billed using the supervising physician's provider number.

18. The Medicare Part B program generally paid more for benefits, items, and services billed under a supervising physician's provider number using "incident to" billing than it paid for the same benefits, items, and services billed directly under the provider number of a physician's assistant or nurse practitioner.

D. Defendants and Relevant Entities

19. Foundation Consultant Services, Inc., which did business under the name Foundational Health ("Foundational Health"), was a Florida corporation established in or around March 2010, that had a purported principal place of business at 5535 Memorial Highway, Tampa, Florida 33634.

20. Defendant **CARIDAD LIMBERG-GONZALEZ** was an owner and operator of Foundational Health, and was listed in its corporate records as an officer and registered agent of the corporation.

21. Accurate Health Services, Corp. ("Accurate Health") was an HHA that purported to provide home health services to eligible Medicare beneficiaries.

22. Defendant **THOMAS CARPENTER** was a medical doctor licensed to practice medicine in the State of Florida. He served as the medical director of Foundational Health.

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

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

2. From in or around at least May 2011, and continuing through in or around October 2016, in Hillsborough County, in the Middle District of Florida, and elsewhere, the defendants,

CARIDAD LIMBERG-GONZALEZ and
THOMAS CARPENTER,

did knowingly and willfully combine, conspire, confederate, and agree with each other and others known and unknown to the Grand Jury, to commit the following offenses against the United States:

a. health care fraud, in violation of 18 U.S.C. § 1347; and

b. wire fraud, in violation of 18 U.S.C. § 1343.

MANNER AND MEANS OF THE CONSPIRACY

3. 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:

a. **CARIDAD LIMBERG-GONZALEZ** owned and operated Foundational Health, and established bank accounts in the name of Foundational Health.

b. **CARIDAD LIMBERG-GONZALEZ** and **THOMAS CARPENTER** signed documents enrolling Foundational Health with Medicare as a provider so that Foundational Health could submit claims to, and receive payments from, Medicare. In the documents, **CARIDAD LIMBERG-GONZALEZ** and **THOMAS CARPENTER** promised to abide by Medicare laws, and promised that they would not knowingly present or cause to be presented false or fraudulent claims for payment by Medicare, and would not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

c. **THOMAS CARPENTER** also signed documents re-assigning to Foundational Health his right to bill, and receive payments from, Medicare. These documents allowed Foundational Health to submit claims

and receive payment for Medicare Part B services that **THOMAS CARPENTER** rendered.

d. **CARIDAD LIMBERG-GONZALEZ, THOMAS CARPENTER**, and other co-conspirators submitted and caused the submission of claims, via interstate wire transmissions, that falsely and fraudulently represented various health care benefits, items, and services, primarily physician visits, were personally furnished by **THOMAS CARPENTER** or were furnished incident to **THOMAS CARPENTER's** professional service by physician's assistants, nurse practitioners and other medical service personnel under his direct supervision. In fact, **THOMAS CARPENTER** had not rendered any services, and the services were in fact rendered by physician's assistants, nurse practitioners and other medical service personnel, but were not incident to **THOMAS CARPENTER's** professional services, and **THOMAS CARPENTER** was at the time away from the practice.

e. **CARIDAD LIMBERG-GONZALEZ, THOMAS CARPENTER**, and other co-conspirators made false and fraudulent claims to Medicare in excess of approximately $1.5 million, of which Medicare paid in excess of approximately $500,000.

f. **CARIDAD LIMBERG-GONZALEZ, THOMAS CARPENTER**, and other co-conspirators also falsified, altered, and fabricated, and caused the falsification, alteration, and fabrication, of medical records, including plans of care and face-to-face encounter forms, that were used to support home health care claims that were medically unnecessary, not eligible for Medicare reimbursement and/or not provided. **THOMAS CARPENTER** routinely signed the documents without regard to the truth or falsity of the documents, and without regard to the medical necessity of the treatments described in the documents.

g. **CARIDAD LIMBERG-GONZALEZ** provided the falsified, altered and fabricated documents that **THOMAS CARPENTER** had signed to Accurate Health, which used the documents to submit false and fraudulent claims to Medicare, via interstate wire transmissions, seeking payment for home health care and other services purportedly provided to beneficiaries when, in fact, such services were medically unnecessary, not eligible for Medicare reimbursement and/or not provided.

h. As a result of these false and fraudulent claims, Accurate Health received payment from Medicare in excess of $700,000.

i. **CARIDAD LIMBERG-GONZALEZ, THOMAS CARPENTER**, and other co-conspirators used the proceeds from the false

and fraudulent claims for their own use, the use of others, and to further the fraud.

j. **CARIDAD LIMBERG-GONZALEZ, THOMAS CARPENTER**, and other co-conspirators performed acts, and made statements, to promote and achieve the objects of the conspiracy and to hide and conceal the purposes of the conspiracy and the acts committed in furtherance thereof.

All in violation of 18 U.S.C. § 1349.

COUNTS TWO - FIVE
Health Care Fraud
(18 U.S.C. § 1347)

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

2. From in or around at least May 2011, and continuing through in or around October 2016, in Hillsborough County, in the Middle District of Florida, and elsewhere, the defendants,

CARIDAD LIMBERG-GONZALEZ and
THOMAS CARPENTER,

and those acting in concert with them, in connection with the delivery of and payment for health care benefits, items, and services, did knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud Medicare, a health care benefit program affecting commerce, as defined by 18

U.S.C. § 24(b), 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, Medicare.

MANNER AND MEANS OF THE SCHEME AND ARTIFICE

3. The allegations contained in the Manner and Means section of Count One of the Indictment are re-alleged and incorporated by reference as though fully set forth herein.

ACTS IN EXECUTION OR ATTEMPTED EXECUTION OF THE SCHEME AND ARTIFICE

4. On or about the dates set forth as to each count below, in the Middle District of Florida, and elsewhere, **CARIDAD LIMBERG-GONZALEZ** and **THOMAS CARPENTER**, in connection with the delivery of and payment for health care benefits, items, and services, did knowingly and willfully execute, and attempt to execute, the above-described scheme and artifice to defraud a health care benefit program affecting commerce, 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 that they submitted and caused the submission of false and fraudulent Medicare claims seeking reimbursement for the cost of health care benefits, items, and services,

primarily home health care services and physician visits, that were medically unnecessary, not eligible for Medicare reimbursement and/or not provided.

Count	Medicare Beneficiary	Document Control Number	Purported Date of Service	Type of Claim	Bill Code; Type of Bill; Approx. Amount Claimed
Two	J.M.E.	591014168220660	6/2/2014	Part B	99214; Established patient office visit, 25 min; $200
Three	J.M.E.	21424002977107FLR	8/6/2014	Part A	322; HHA Interim First Claim; $2,304
Four	F.G.	21509300644407FLR	3/24/2015	Part A	322; HHA Interim First Claim; $2,527
Five	F.G.	590914247862710	3/31/2015	Part B	G0181; Physician supervision of a patient receiving services provided by a home health agency; $200

In violation of 18 U.S.C. §§ 1347 and 2.

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

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

2. On or about September 3, 2014, in Hillsborough County, in the Middle District of Florida, and elsewhere, the defendants,

CARIDAD LIMBERG-GONZALEZ and THOMAS CARPENTER,

and those acting in concert with them, in any matter involving a health care benefit program, knowingly and willfully made a materially false, fictitious, and fraudulent statement and representation, and made and used a materially false, fictitious, and fraudulent writing and document, knowing the same to contain a materially false, fictitious, and fraudulent statement and entry, in connection with the delivery and payment for health care benefits, items, and services, that is, **THOMAS CARPENTER** signed a document titled "Face to Face Encounter Verification Documentation" for beneficiary J.M.E. stating he or a physician's assistant or nurse practitioner working with him had a face-to-face encounter with the beneficiary on June 2, 2014, and certifying that the beneficiary was under his care, when, in truth and in fact, as the defendant then and there well knew, J.M.E. had not had a face-to-face-encounter with **THOMAS CARPENTER** or a physician's assistant or nurse practitioner on June 2, 2014, and the beneficiary was not under **THOMAS CARPENTER**'s care, in violation of 18 U.S.C. §§ 1035(a)(2) and 2.

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

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

2. On or about February 19, 2014, in Hillsborough County, in the Middle District of Florida, and elsewhere, the defendants,

CARIDAD LIMBERG-GONZALEZ and
THOMAS CARPENTER,

and those acting in concert with them, in any matter involving a health care benefit program, knowingly and willfully made a materially false, fictitious, and fraudulent statement and representation, and made and used a materially false, fictitious, and fraudulent writing and document, knowing the same to contain a materially false, fictitious, and fraudulent statement and entry, in connection with the delivery and payment for health care benefits, items, and services, that is, **THOMAS CARPENTER** signed a document titled "Face to Face Encounter Verification Documentation" for beneficiary F.G. stating he or a physician's assistant or nurse practitioner working with him had a face-to-face encounter with the beneficiary on March 31, 2014, and certifying that the beneficiary was under his care, when, in truth and in fact, as the defendant then and there well knew, F.G. had not had a face-to-face-encounter with

THOMAS CARPENTER or a physician's assistant or nurse practitioner as of the date **THOMAS CARPENTER** signed the document, and the beneficiary was not under **THOMAS CARPENTER**'s care, in violation of 18 U.S.C. §§ 1035(a)(2) and 2.

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

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

2. On or about February 19, 2014, in Hillsborough County, in the Middle District of Florida, and elsewhere, the defendants,

CARIDAD LIMBERG-GONZALEZ and
THOMAS CARPENTER,

and those acting in concert with them, in any matter involving a health care benefit program, knowingly and willfully made a materially false, fictitious, and fraudulent statement and representation, and made and used a materially false, fictitious, and fraudulent writing and document, knowing the same to contain a materially false, fictitious, and fraudulent statement and entry, in connection with the delivery and payment for health care benefits, items, and services, that is, **THOMAS CARPENTER** signed a document titled "Home Health Certification and Plan of Care" for beneficiary F.G. stating that the

beneficiary was under his care and that he would periodically review the plan, when, in truth and in fact, as the defendant then and there well knew, F.G. was not under **THOMAS CARPENTER's** care and **THOMAS CARPENTER** was not going to periodically review the plan, in violation of 18 U.S.C. §§ 1035(a)(2) and 2.

FORFEITURE

1. All of the allegations contained above are hereby realleged and incorporated by reference for the purpose of alleging forfeitures pursuant to 18 U.S.C. § 982.

2. Upon conviction of a violation of 18 U.S.C. §§ 1347 and 1349, as alleged in Counts One through Five of this Indictment, or a violation of 18 U.S.C. § 1035, as alleged in Counts Six through Eight of this Indictment, the defendants **CARIDAD LIMBERG-GONZALEZ** and **THOMAS CARPENTER** shall forfeit to the United States of America, pursuant to 18 U.S.C. § 982(a)(7), any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.

3. The property to be forfeited includes, but is not limited to, a forfeiture money judgment of at least $554,998.

4. If any of the property, as a result of any act or omission of the defendant:

a. cannot be located upon the exercise of due diligence;

b. has been transferred or sold to, or deposited with, a third party;

c. has been placed beyond the jurisdiction of the court;

d. has been substantially diminished in value; or

e. has been commingled with other property which cannot be divided without difficulty,

the United States of America shall be entitled to forfeiture of substitute property under the provisions of 21 U.S.C. § 853(p), as incorporated by 18 U.S.C. § 982(b)(1).

A TRUE BILL,

FOREPERSON

MARIA CHAPA LOPEZ
United States Attorney

By: _____
JAY G. TREZEVANT
Assistant United States Attorney
Chief, Economic Crimes Section

By: _____
JOSEPH BEEMSTERBOER
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