UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 18-20558-CR-MORENO/LOUIS

18 U.S.C. § 1349
18 U.S.C. § 982

UNITED STATES OF AMERICA

vs.

BERTO ARIAS CARRASCO,

Defendant.
_____/

INFORMATION

The United States Attorney charges that:

GENERAL ALLEGATIONS

At all times material to this Information:

The Medicare Program

1. The Medicare Program ("Medicare") was a federally funded program that provided free or below-cost health care benefits to certain 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 and 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 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"), also referred to as a "provider," to persons who already qualified for Medicare and who additionally required home health services because of an illness or disability that caused them to be homebound.

4. CMS did not directly pay Medicare Part A claims submitted by Medicare-certified HHAs. CMS contracted with different private 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 claims. 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. Physicians, clinics and other health care providers, including HHAs, that provided services to Medicare beneficiaries were able to apply for and obtain a "provider number." In its enrollment application, a provider was required to disclose to Medicare any person or company who held an ownership interest of 5% or more or who had managing control of the provider. A health care provider that received a Medicare provider number was able to file claims with Medicare to obtain reimbursement for services provided to beneficiaries. A Medicare claim was required to set forth, among other things, the beneficiary's name and Medicare information number, the services that were performed for the beneficiary, the date that the services were

provided, the cost of the services, and the name and provider number of the physician or other health care provider who ordered the services.

6. By becoming a participating provider in Medicare, enrolled providers agreed to abide by the policies and procedures, rules, and regulations governing reimbursement, including the Federal Anti-Kickback Statute. To receive Medicare funds, enrolled providers, together with their authorized agents, employees, and contractors, were required to abide by all provisions of the Social Security Act, the regulations promulgated under the Act, and applicable policies, procedures, rules, and regulations issued by CMS and its authorized agents and contractors. Health care providers were given and provided with online access to Medicare manuals and services bulletins describing proper billing procedures and billing rules and regulations.

Part A Coverage and Regulations

Reimbursements

7. 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 patient:

(a) was confined to the home, also referred to as homebound;

(b) 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, physical therapy, speech therapy, or a continued need for occupational therapy; 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.

Record Keeping Requirements

8. 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 the actual treatment of patients to whom services were provided and for whom claims for reimbursement were submitted by the HHA. These medical records were required to be sufficiently complete to permit Medicare, through Palmetto and other contractors, to review the appropriateness of Medicare payments made to the HHA under the Part A program.

9. Among the written records required to document the appropriateness of home health care claims submitted under Part A of Medicare were: (i) a POC that included the physician order, diagnoses, types of services/frequency of visits, prognosis/rehab potential, functional limitations/activities permitted, medications/treatments/nutritional requirements, safety measures/discharge plans, goals, and the physician's signature; and (ii) 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.

10. 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 instruction provided to the patient 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."

11. Medicare regulations allowed Medicare 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 home health agency. The Medicare certified HHA would, in turn, bill Medicare for all services rendered to the patient. The HHA's professional supervision over subcontracted-for services required the same quality controls and supervision as of its own salaried employees.

12. Medicare paid for insulin injections by an HHA when a beneficiary was determined to be unable to inject his/her own insulin and the beneficiary had no available caregiver able or willing to inject the beneficiary. The basic requirement that the beneficiary be confined to the home or be homebound was a continuing requirement for a Medicare beneficiary to receive home health benefits.

The Defendant, Related Companies, and Individuals

13. New Life Home HealthCare Inc. ("New Life Home Health") was a Florida corporation, incorporated on or about October 11, 2004, located at 12260 SW 8th Street, Suite 230, Miami, Florida. It purported to provide home health care services to eligible Medicare beneficiaries.

14. Defendant **BERTO ARIAS CARRASCO** was a resident of Miami-Dade County.

15. Rafael Arias, a resident of Miami-Dade County, was the owner of numerous home health agencies that purported to provide home health care services to eligible Medicare beneficiaries, including New Life Home Health.

16. Aylen Gonzalez, a resident of Miami-Dade County, was a patient recruiter.

17. Rafael Cabrera, a resident of Miami-Dade County, laundered money for home health agencies owned by Rafael Arias.

CONSPIRACY TO COMMIT HEALTH CARE FRAUD
(18 U.S.C. § 1349)

From in or around August 2008, through in or around July 2013, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

BERTO ARIAS CARRASCO,

did willfully, that is, with the intent to further object of the conspiracy, and knowingly combine, conspire, confederate, and agree with Rafael Arias, Aylen Gonzalez, Rafael Cabrera, and others, known and unknown to the United States Attorney, to commit certain offenses against the United States, that is to 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 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.

Purpose of the Conspiracy

It was a purpose of the conspiracy for the defendant and his co-conspirators to unlawfully enrich themselves by, among other things: (a) submitting and causing the submission of false and

fraudulent claims to Medicare; (b) concealing the submission of false and fraudulent claims to Medicare; (c) concealing the receipt and transfer of fraud proceeds; and (d) diverting fraud proceeds for their 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 his co-conspirators sought to accomplish the object and purpose of the conspiracy included, among other things:

18. **ARIAS CARRASCO** and his co-conspirators operated New Life Home Health. Even though New Life Home Health was, in fact, owned by Rafael Arias, Rafael Arias recruited **ARIAS CARRASCO** to falsely and fraudulently represent himself as the owner of this agency.

19. In or around February 2012, **ARIAS CARRASCO** signed and caused to be submitted Medicare enrollment documents on behalf of New Life Home Health in which he falsely and fraudulently identified himself as an actual owner of the agency and failed to disclose the ownership interest and managing control of Rafael Arias.

20. As part of these enrollment documents, **ARIAS CARRASCO** certified to Medicare that he would abide by the Medicare laws, regulations, and program instructions applicable to New Life Home Health, including the Federal Anti-Kickback Statute.

21. As a result of the submission of these false and fraudulent enrollment documents, Medicare allowed New Life Home Health to submit claims for services purportedly rendered to eligible Medicare beneficiaries.

22. **ARIAS CARRASCO** and Rafael Arias paid and caused to be paid bribes and kickbacks to Aylen Gonzalez and other co-conspirators in exchange for referring Medicare beneficiaries to New Life Home Health.

23. **ARIAS CARRASCO** and Rafael Arias issued and caused to be issued checks from New Life Home Health to co-conspirators, including Rafael Cabrera, for purposes of cashing these checks in order to obtain funds to pay bribes and kickbacks.

24. **ARIAS CARRASCO** submitted and caused to be submitted false and fraudulent claims to Medicare seeking payment for home health care services purportedly provided to beneficiaries who had been referred in exchange for bribes and kickbacks, many of whom did not qualify for or need home health care services.

25. As a result of such false and fraudulent claims, **ARIAS CARRASCO** and his co-conspirators caused Medicare to make payments exceeding $15 million.

26. **ARIAS CARRASCO** and his co-conspirators diverted the fraud proceeds for the personal use and benefit of themselves and to further the fraud.

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

FORFEITURE
(18 U.S.C. § 982)

1. The allegations contained in this Information are realleged and incorporated by reference as though fully set forth herein for the purpose of alleging forfeiture to the United States of certain property in which the defendant, **BERTO ARIAS CARRASCO,** has an interest.

2. Upon conviction of the violation alleged in this Information, the defendant shall forfeit to the United States, pursuant to Title 18, United States Code, Section 982(a)(7), all property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of such violation.

All pursuant to Title 18, United States Code, Section 982(a)(7), and the procedures set forth in Title 21, United States Code, Section 853, as made applicable by Title 18, United States Code, Section 982(b).

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