UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 18-20488

18 U.S.C. § 1347
18 U.S.C. § 982(a)(7)

CR-GAYLES
/OTAZO-REYES

UNITED STATES OF AMERICA

vs.

GILBERTO HERNANDEZ,

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 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 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 were typically made directly to a Medicare-certified HHA or provider based on claims submitted to the Medicare program for qualifying services that had been provided to eligible beneficiaries.

4. Home health care agencies, pharmacies, physicians, and other health care providers that provided services to beneficiaries were able to apply for and obtain a Medicare Identification Number or "provider number." In the application, the provider acknowledged that to be able to participate in the Medicare program, the provider must comply with all Medicare related laws and regulations. A provider who was issued a Medicare Identification Number was able to file claims with Medicare to obtain reimbursement for services provided to beneficiaries. The Medicare Identification Number uniquely identified the provider on its submissions to Medicare. A Medicare claim was required to set forth, among other things, the beneficiary's name and Medicare identification number, the services that were performed for the beneficiary, the date the services were provided, the cost of the services, and the name and identification number of the physician or other health care provider who ordered the services.

5. 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"), located in Columbia, South

Carolina. 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 contracted with SafeGuard Services, a Zone Program Integrity Contractor. SafeGuard Services safeguarded the Medicare Trust Fund by reviewing HHA providers' claims for potential fraud, waste, and/or abuse.

Part A Coverage and Regulations

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 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.

7. Medicare paid 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 based on 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 of care could commence. There were no limits to the number of episodes of home health benefits a beneficiary could receive as long as the beneficiary remained eligible.

8. In order to be reimbursed, the HHA would submit a Request for Anticipated Payment ("RAP"), and subsequently would receive a portion of their payment in advance at the beginning of the episode. At the end of a 60 day episode, the HHA submitted the final claim and received the remaining portion of the payment.

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 the actual treatment of the 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.

10. Among the written records required to document the appropriateness of home health care claims submitted under Part A of Medicare was a (i) 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.

11. Additionally, Medicare Part A regulations required HHAs to maintain medical records of every visit made by a nurse, therapist, or home health aide to a patient. 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 aide was 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 "skilled nursing progress notes" and "home health aide notes/observations."

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

13. Medicare beneficiaries were each assigned unique benefit numbers which were referred to as a Health Insurance Claim Number ("HICN").

14. Doctors who prescribed goods and services paid for by the Medicare program were issued unique identification numbers which were called National Physician Identification Numbers ("NPIN").

The Defendant and a Related Entity

15. Advance Home Care Services, Inc. ("Advance") was a corporation organized under the laws of the State of Florida and located at 15271 NW 60 Avenue, Suite 204, Miami, Florida. Advance was an HHA purportedly engaged in the business of providing home health services to Medicare beneficiaries and had a Medicare provider number and was eligible to receive reimbursement from Medicare for home health services provided to beneficiaries.

16. Defendant **GILBERTO HERNANDEZ**, a resident of Miami-Dade County, became a Vice President and fifty percent owner of Advance on or about June 27, 2014, and became the Director, President, Secretary, Registered Agent, and sole owner of Advance on or about September 23, 2014.

COUNTS 1-3
Health Care Fraud
(18 U.S.C. § 1347)

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 June 2014, through in or around May 2015, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant, **GILBERTO HERNANDEZ**, 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 a health care benefit program affecting commerce, as defined by 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.

Purpose of the Scheme and Artifice

3. It was a purpose of the scheme and artifice for the defendant and his accomplices to unjustly 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 and the receipt and transfer of fraud proceeds; and (c) diverting fraud proceeds for the personal use and benefit of themselves and others, and to further the fraud.

The Scheme and Artifice

The manner and means by which the defendant and his accomplices sought to accomplish the object and purpose of the scheme and artifice included, among other things, the following:

4. **GILBERTO HERNANDEZ** and his accomplices obtained the names and HICNs of Medicare beneficiaries so that they could submit false and fraudulent claims for home health services that were never provided to Medicare beneficiaries.

5. **GILBERTO HERNANDEZ** and his accomplices obtained the names and NPINs of physicians in order to submit false and fraudulent claims to Medicare purportedly prescribed by a licensed physician.

6. **GILBERTO HERNANDEZ** and his accomplices caused Advance to submit false and fraudulent claims to Medicare for home health services allegedly rendered to Medicare beneficiaries, when in truth and in fact, such home health services were not medically necessary and were not provided.

7. As a result of these false and fraudulent claims, Medicare made payments to Advance in the approximate amount of $3,386,162.

Acts in Execution or Attempted Execution of the Scheme and Artifice

8. On or about the dates set forth below, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant, **GILBERTO HERNANDEZ**, 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 the defendant submitted and caused the submission of false and fraudulent claims to Medicare, representing that Advance had provided various home health services to beneficiaries pursuant to physicians' POCs:

Count	Medicare Beneficiary	Approx. Date Of Claim	Medicare Claim Number	Approx. Amount Paid
1	G.M.	3/4/2015	21506300813404FLR	$ 3,397
2	R.L.	4/1/2015	21509100848004FLR	$ 3,269
3	W.B.	5/6/2015	21505400817204FLR	$ 3,269

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

FORFEITURE
(18 U.S.C. § 982 (a)(7))

1. The allegations contained in this Indictment are re-alleged 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, **GILBERTO HERNANDEZ**, has an interest.

2. Upon conviction of a violation of Title 18, United States Code, Section 1347, as alleged in this Indictment, the defendant shall forfeit to the United States of America, pursuant to Title 18, United States Code, Section 982(a)(7), any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of such offense.

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)(1).

A TRUE BILL

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BENJAMIN G. GREENBERG
UNITED STATES ATTORNEY

JAMES V. HAYES
ASSISTANT U.S. ATTORNEY