UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 18-20535

18 U.S.C. § 371
18 U.S.C. § 1349
18 U.S.C. § 1347
18 U.S.C. § 2
18 U.S.C. § 982(a)(7)

CR-ALTONAGA/GOODMAN

UNITED STATES OF AMERICA

vs.

JULIETTE ANAIS TAMAYO,

Defendant.
_____/

FILED by _____ D.C.
JUN 21 2018
STEVEN M. LARIMORE
CLERK U. S. DIST. CT.
S. D. of FLA. - MIAMI

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 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.

5. Part B of the Medicare program was a medical insurance program that covered, among other things, certain physician and outpatient services, and other health care benefits, items and services.

6. For Florida beneficiaries, Medicare Part B's insurance coverage for physician and outpatient services and related health care benefits, items, and services was administered by First Coast Services Options, Inc. ("First Coast"), pursuant to a contract with HHS.

7. 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." 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.

Part A Coverage and Regulations

Reimbursements

8. 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.

9. 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 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 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.

10. 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.

Record Keeping Requirements

11. 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 to review the appropriateness of Medicare payments made to the HHA under the Part A program.

12. 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.

Part B Coverage and Regulations

13. The Medicare Part B program generally would pay a substantial portion of the cost of the physician or outpatient services or related health care benefits, items, and services that were

medically necessary and ordered by licensed doctors or other licensed, qualified health care providers.

14. 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.

15. Under Medicare's rules and regulations, physician and outpatient services and related health care benefits, items, or services must be medically necessary and ordered by a licensed doctor or other licensed, qualified health care provider in order to be reimbursed by Medicare.

The Defendant, Co-Conspirators, and Related Companies

16. Sunshine Medical Care Group, Inc., located at 2990 W. Flagler Street, Suite 406, Miami, Florida, was a domestic corporation with its principal place of business in Miami-Dade County, in the Southern District of Florida, that previously did business under the name Sunshine Medical and Pain Management, Inc. ("Sunshine"). Sunshine was incorporated October 2009.

17. Elite Home Care, LLC ("Elite"), located at 1200 NW 78 Avenue, #114, Doral, Florida, was incorporated on or about May 12, 2008, with its principal place of business in Miami-Dade County, in the Southern District of Florida.

18. Care First Home Health Corp. ("Care First"), located at 8242 NW 103 Street, Hialeah Gardens, Florida, was incorporated on or about February 20, 2008, with its principal place of business in Miami-Dade County, in the Southern District of Florida.

19. Defendant **JULIETTE ANAIS TAMAYO**, a resident of Miami-Dade County, was an operator of Sunshine beginning in or around October 2009.

20. Individual 1 was a resident of Miami-Dade County.

21. Physician 1, a resident of Miami-Dade County, was employed as a physician at Sunshine from on or about February 4, 2013, through on or about June 27, 2017.

22. Physician 2, a resident of Miami-Dade County, was employed as a physician at Sunshine from on or about December 26, 2014, through on or about November 18, 2016.

23. Ricardo Vento, a resident of Miami-Dade County, was a Medicare beneficiary.

COUNT 1
Conspiracy to Defraud the United States and to Pay and Receive Health Care Kickbacks (18 U.S.C. § 371)

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

2. From in or around February 2013, through in or around June 2017, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

JULIETTE ANAIS TAMAYO,

did willfully, that is, with the intent to further the objects of the conspiracy, and knowingly combine, conspire, confederate, and agree with Individual 1, Physician 1, Physician 2, Richard Vento, and others, known and unknown to the Grand Jury:

a. to defraud the United States by impairing, impeding, obstructing, and defeating through deceitful and dishonest means, the lawful government functions of the United States Department of Health and Human Services in its administration and oversight of the Medicare program, in violation of Title 18, United States Code, Section 371, and to commit certain offenses against the United States; that is,

b. to violate Title 42, United States Code, Section 1320a-7b(b)(1)(A), by knowingly and willfully soliciting and receiving 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 an item and service for which payment may be made in whole and in part under a federal health care program, that is, Medicare; and

c. to violate Title 42, United States Code, Section 1320a-7b(b)(2)(A), by knowingly and willfully offering and paying remuneration, including kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind, to any person to induce such person to refer an individual to a person for the furnishing and arranging for the furnishing of an 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 defendant and her co-conspirators to unlawfully enrich themselves by: (a) offering, paying, soliciting and receiving kickbacks and bribes in return for beneficiary information to be used to submit claims to Medicare; and (b) submitting and causing the submission of claims to Medicare for home health care services that Miami-Dade area home health agencies purported to provide to those beneficiaries.

MANNER AND MEANS OF THE CONSPIRACY

The manner and means by which the defendant and her co-conspirators sought to accomplish the objects and purpose of the conspiracy included, among others, the following:

4. **JULIETTE ANAIS TAMAYO** solicited and received kickbacks and bribes from co-conspirator patient recruiters and home health agency owners, including Individual 1 and Ricardo Vento, in return for providing prescriptions for home health care services for Medicare beneficiaries.

5. **JULIETTE ANAIS TAMAYO** offered and paid kickbacks and bribes to Physician 1, Physician 2, and others, to ensure that they wrote prescriptions for home health services that the defendant sold to patient recruiters and other co-conspirators.

6. **JULIETTE ANAIS TAMAYO** and her co-conspirators caused various Miami-Dade home health agencies to submit claims to Medicare for home health services purportedly provided to Medicare beneficiaries.

7. **JULIETTE ANAIS TAMAYO** and her co-conspirators, including Individual 1, Physician 1, Physician 2, and Ricardo Vento, caused Medicare to pay various Miami-Dade home health care agencies, including Elite and Care First, based upon claims for home health services purportedly provided to Medicare beneficiaries.

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 June 30, 2014, **JULIETTE ANAIS TAMAYO** submitted, and caused the submission of, a Medicare enrollment application for Sunshine certifying that she would abide by the laws and regulations of the Medicare program.

2. On or about June 23, 2015, **JULIETTE ANAIS TAMAYO** submitted, and caused the submission of, a Medicare enrollment application for Sunshine certifying that she would abide by the laws and regulations of the Medicare program.

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

COUNT 2
Conspiracy to Commit Health Care Fraud and Wire Fraud
(18 U.S.C. § 1349)

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 2013, through in or around June 2017, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

JULIETTE ANAIS TAMAYO,

did willfully, that is, with the intent to further the objects of the conspiracy, and knowingly, combine, conspire, confederate, and agree with Physician 1, Physician 2, Individual 1, Ricardo Vento, and others, known and unknown to the Grand Jury to commit certain 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, 1347; and

b. to knowingly and with the intent to defraud, devise and intend to devise a scheme and artifice to defraud, and for obtaining money and property by means of materially false and fraudulent pretenses, representations, and promises, knowing that the pretenses, representations, and promises were false and fraudulent when made, and did knowingly transmit and cause to be transmitted, by means of wire communication in interstate and foreign commerce, writings, signs, signals, pictures, and sounds for the purpose of executing such scheme and artifice, in violation of Title 18, United States Code, Section 1343.

Purpose of the Conspiracy

3. It was a purpose of the conspiracy for **JULIETTE ANAIS TAMAYO** and her co-conspirators to unlawfully enrich themselves by, among other things: (a) submitting and causing the

submission of false and fraudulent claims to Medicare based on kickbacks and bribes; (b) submitting and causing the submission of false and fraudulent claims to Medicare for services that were medically unnecessary, not eligible for Medicare reimbursement, and never provided; (c) concealing the submission of false and fraudulent claims to Medicare; (d) concealing the receipt and transfer of fraud proceeds; and (e) 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 **JULIETTE ANAIS TAMAYO** and her co-conspirators sought to accomplish the objects and purpose of the conspiracy included, among other things, the following:

4. **JULIETTE ANAIS TAMAYO** signed certifications falsely affirming that Sunshine would comply with all of the Medicare Program's rules and regulations, which include a prohibition against violating the federal anti-kickback statute.

5. Individual 1, Ricardo Vento, and other co-conspirators paid and caused the payment of kickbacks and bribes to **JULIETTE ANAIS TAMAYO** in return for referrals of Medicare beneficiaries to Elite, Care First, and other HHAs for medically unnecessary health care services.

6. **JULIETTE ANAIS TAMAYO** accepted kickbacks and bribes, including in the form of cash, from Individual 1 and Ricardo Vento in return for arranging for referrals of Medicare beneficiaries to Elite, Care First, and other HHAs for medically unnecessary health care services.

7. **JULIETTE ANAIS TAMAYO** paid kickbacks and bribes to Physician 1 and Physician 2 in return for false and fraudulent medical records, including falsified prescriptions for home health care services, for Medicare beneficiaries referred to Elite, Care First, and other HHAs.

8. **JULIETTE ANAIS TAMAYO** submitted, and caused the submission of, false and fraudulent claims to Medicare for Part A and Part B services, via wire transmissions, that were not rendered and were not medically necessary.

9. **JULIETTE ANAIS TAMAYO** and her co-conspirators caused Medicare to make approximately $3.6 million in payments to Sunshine, Elite and First Care for health care services that were medically unnecessary, never provided, and procured through the payment of kickbacks and bribes.

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

COUNTS 3-4
Health Care Fraud
(18 U.S.C. § 1347)

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

2. From in or around February 2013, through in or around June 2017, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

JULIETTE ANAIS TAMAYO,

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 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.

Purpose of the Scheme and Artifice

3. It was a purpose of the scheme and artifice for the defendant and her accomplices to unlawfully enrich themselves by, among other things, submitting false and fraudulent claims to Medicare through Elite for services that were medically unnecessary, that were not eligible for Medicare reimbursement, and that were never provided.

Manner and Means of the Scheme and Artifice

4. The allegations contained in the Manner and Means section of Count 2 of the Indictment are 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 set forth below, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant, **JULIETTE ANAIS TAMAYO,** 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, 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 that the defendant submitted and caused the submission of false and fraudulent Medicare claims, seeking the identified dollar amounts, representing that the services were medically necessary services to Medicare beneficiaries:

Count	Approximate Date	Beneficiary	Services Billed	Amount Paid	Claim Number
3	March 25, 2014	Ricardo Vento	Home health episode	$5,099.88	21408401614407FLR
4	August 11, 2014	Ricardo Vento	Home health episode	$5,099.88	21422301976207FLR

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 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, **JULIETTE ANAIS TAMAYO,** has an interest.

2. Upon conviction of a violation alleged in Counts 1 through 4 of this Indictment, 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).

A TRUE BILL

FOREPERSON

BENJAMIN G. GREENBERG
UNITED STATES ATTORNEY
SOUTHERN DISTRICT OF FLORIDA

JOSEPH BEEMSTERBOER
DEPUTY CHIEF
CRIMINAL DIVISION, FRAUD SECTION
U.S. DEPARTMENT OF JUSTICE

DREW BRADYLYONS
TRIAL ATTORNEY
CRIMINAL DIVISION, FRAUD SECTION
U.S. DEPARTMENT OF JUSTICE