IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

v.

(1) DAVID ORLANDO GARZA,

Defendant.

Criminal No.

INDICTMENT

Count 1: 18 U.S.C. § 371: Conspiracy to Defraud the United States and to Pay and Receive Health Care Kickbacks;

Counts 2-4: 42 U.S.C. § 1320a-7b (b)(2) and 18 U.S.C. § 2: Offering to Pay and Paying Illegal Health Care Kickbacks and Aiding and Abetting.

INDICTMENT SA20CR0402JKP

The Grand Jury charges:

General Allegations

At all times material to this Indictment, unless otherwise specified:

The Defendant and Related Entities

1. Defendant David Orlando **GARZA** was a resident of Benavides, Texas, and the principal owner of Adventia Healthcare Associates, Incorporated ("Adventia").

2. Adventia was a company registered in Benavides, Texas, and officed in San Antonio, Texas. Adventia provided home health services to patients in San Antonio, Laredo, and the surrounding areas.

3. "Home health" is used herein to refer to outpatient medical services where providers go to patients' homes to administer services. Home health services are generally utilized by individuals who have a medical condition for which they require assistance for therapy, nursing services, and/or daily activities (e.g., washing, dressing, feeding themselves, transporting

themselves). They are frequently used for short time periods by patients who have recently had a surgery or other in-patient hospital stay. A patient must be initially certified by a medical practitioner as needing home health before a home health services company will be allowed to bill an insurance provider for the services.

The Medicare Program

4. The Medicare Program ("Medicare") was a federally funded and administered healthcare program providing benefits to individuals who were sixty-five (65) years of age or older, or disabled. The program was administrated through the Centers for Medicare and Medicaid Services ("CMS"), a federal agency within the United States Department of Health and Human Services. Medicare was paid for primarily through federal income and payroll taxes. This program is referred to collectively herein as "Medicare". Medicare was a "healthcare benefit program" as defined by Title 18, United States Code, Section 24(b) and a "Federal health care program" as defined by 42 U.S.C. Section 1320a-7b(f).

5. Medicare was subdivided into multiple Parts. Medicare Part A covered health services provided by hospitals, skilled nursing facilities, hospices, and home health agencies. Medicare Part B covered physician services and outpatient care. Parts A and B were known as the "original fee-for-service" Medicare program, in which Medicare paid health care providers fees for services rendered to beneficiaries.

6. Individuals who qualified for Medicare benefits were commonly referred to as Medicare "beneficiaries." Each beneficiary was given a unique Medicare identification number that was used to process bills linked to that beneficiary.

7. Medicare paid for reasonable and necessary medical services provided to individuals and families who are deemed eligible. Medical service providers were required to be registered with Medicare in order to receive reimbursements. Healthcare providers that provided

services to Medicare beneficiaries were referred to as Medicare "providers." Service providers enrolled with Medicare received a unique provider number with which to identify themselves when submitting Medicare claims.

8. To participate in Medicare, providers were required to submit an application in which they agreed to comply with all Medicare-related laws and regulations. Per the provider agreement with Medicare, providers had a duty to become educated with and knowledgeable of the contents and procedures of the Medicare program. Providers were given access to Medicare manuals and service bulletins describing billing procedures, rules, and regulations.

9. The Federal Anti-Kickback Statute is a law prohibiting service providers from paying or receiving money in return for inducing the referral of a patient or service being paid for by Federal funds, including the Medicare program. To receive Medicare funds, enrolled providers agreed to, and were required to abide by, the Anti-Kickback Statute and other laws and regulations.

10. To receive payment from Medicare, providers submitted or caused the submission of claims to Medicare, either directly or through a billing company. When submitting, or causing claims to be submitted, under the provider's unique personal identification number, a provider is certifying that the services were properly rendered and were medically necessary. Medicare pays claims submitted by providers through automatic deposits and by checks issued to the provider.

11. A Medicare claim for reimbursement was required to set forth, among other things, the beneficiary's name and unique Medicare identification number, the service provided to the beneficiary, the date the service was provided, the cost of the service, and the name and unique provider identification number of the physician or health service provider who prescribed or ordered the service.

12. Adventia was a registered Medicare provider, with a unique National Provider Identification number. Adventia's Medicare enrollment application listed David Orlando **GARZA** as the Chief Financial Officer of Adventia.

The Medicaid Program

13. The Texas Medicaid program ("Medicaid") was a federal and state funded health care program providing benefits to individuals and families who met specified financial and other eligibility requirements, and certain other individuals who lacked adequate resources to pay for medical care. CMS was responsible for overseeing the Medicaid program in participating states, including Texas. Individuals who received benefits under the Medicaid program were similarly referred to as "beneficiaries."

14. Medicaid covered the costs of medical services and products ranging from routine preventive medical care for children to institutional care for the elderly and disabled. Medicaid covered the costs of medical care if, among other requirements, they were medically necessary and ordered by a physician. Home health services were covered by the Medicaid program.

15. Medicaid was partially funded by Federal tax dollars and is therefore a "health care benefit program" as defined by 18 U.S.C. Section 24(b), and as that term is used in 18 U.S.C. Section 1347. Medicaid was also a "Federal health care program" as defined by 42 U.S.C. Section 1320a-7b(f).

16. Adventia was an enrolled Medicaid provider.

COUNT ONE

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

13. Paragraphs One through Sixteen of this Indictment are realleged and incorporated by reference as though fully set forth herein.

14. From in or around November of 2017, through in or around October of 2018, in the Western District of Texas, and elsewhere, the Defendant,

David Orlando GARZA,

did knowingly and willfully combine, conspire, confederate, and agree with others, known and unknown to the Grand Jury, to commit offenses against the United States, that is,

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 and the State of Texas in their administration and oversight of Medicare and Medicaid;

b. to violate Title 42, United States Code, Section 1320a-7b(b)(1), by knowingly and willfully soliciting and receiving remuneration, specifically, kickbacks and bribes, directly and indirectly, overtly and covertly, in return for referring individuals and services for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole or in part by Medicare or Medicaid; and for the purchasing, leasing, ordering and arranging for and recommending the purchasing, leasing and ordering of any good, item, and service for which payment may be made in whole and in part by a Federal health care program, that is, Medicare and Medicaid.

c. to violate Title 42, United States Code, Section 1320a-7b(b)(2), by knowingly and willfully paying and offering to pay any remuneration, specifically, kickbacks and bribes, directly and indirectly, overtly and covertly, to any person to induce such person to refer any individual to Adventia for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole or in part by Medicare; and for the purchasing, leasing, ordering and arranging for and recommending the purchasing, leasing and ordering of any good, item and service for which payment may be made in whole and in part by a Federal health

care program, that is, Medicare and Medicaid.

Purpose of the Conspiracy

15. It was a purpose of the conspiracy for defendant GARZA to unlawfully enrich himself and others, known and unknown to the Grand Jury, by paying kickbacks and bribes in exchange for having patients referred to Adventia for the provision of home health services, at least some of which was billed to the Medicare and Medicaid programs.

Manner and Means of the Conspiracy

16. The manner and means by which GARZA, and others sought to accomplish the purpose and object of the conspiracy included, among other things, the following:

17. During the specified time period, GARZA engaged individuals to perform marketing and promotional services to increase Adventia's client base. As the owner of a registered Medicare and Medicaid provider, as well as the principal supervisor of the individuals performing these services, GARZA was personally aware of the Anti-Kickback Statute and its prohibition on compensating individuals on a per-referral basis for services to be paid for by Federal funds. GARZA required marketers to sign and initial employment documentation while working for Adventia which stated that the marketer was aware of the Anti-Kickback Statute.

18. Despite this, GARZA agreed with at least one individual (the "CW") during this time period to pay on a per-patient basis for any referral from CW who was successfully enrolled to receive home health services from Adventia. This arrangement began no later than November of 2017, and continued until in or about October of 2018.

19. During this time period, the CW did not perform any legitimate marketing services, in that CW did not attempt to promote or advertise Adventia to patients, case managers, or doctors. Rather, the CW used a network of health-care industry contacts who provided the CW with the

names and insurance information of individuals who could potentially qualify for home health services. These sources provided this information with the understanding that they would be paid a kickback in return by the CW. Defendant David Orlando GARZA was aware that CW was using the kickback funds paid to CW by Adventia to maintain and illegally compensate his contact network.

20. After receiving the personal and insurance information of individuals, the CW would forward these details to staff at Adventia. Adventia would then attempt to enroll the individual for home health services.

21. When the enrollment was successful, Adventia would then bill the individual's insurance provider for home health services, and remit a portion of that payment to the CW as a kickback payment. The services for at least some of the patients referred in this manner were billed to Medicare and Medicaid.

22. During this time period, the CW personally agreed with Defendant David Orlando GARZA that the CW was to be paid $300 for each successfully referred patient with Medicare insurance, and $200 for each successfully referred patient with non-Medicare insurance, including Medicaid.

23. The CW maintained a list of patients referred to Adventia, and sent this list on a monthly basis to staff at Adventia. David Orlando GARZA instructed his staff to total the amount due to CW based upon the formula described in Paragraph 22, and then pay him via the Adventia payroll.

24. In order to conceal the illegal nature of these kickback payments, David Orlando GARZA instructed his staff to list CW as a W-2 employee who was being paid an hourly rate. In actuality, the CW never tracked or submitted any hours worked to Adventia. Rather, the hours

listed on CW's paystubs were calculated by taking the total amount due to the CW for each month's referrals, and dividing this amount by his purported hourly rate in order to fabricate the number of hours listed on his payroll paperwork.

Overt Acts

25. In furtherance of the conspiracy, and to accomplish its object and purpose, the Defendant committed and caused to be committed, in the Western District of Texas, and elsewhere, the following overt acts:

a. In or around November of 2017, David Orlando GARZA and the CW agreed to engage in a kickback conspiracy where Adventia would pay the CW $300 per Medicare patient, and $200 per non-Medicare patient.

b. Beginning no later than December of 2017, David Orlando GARZA instructed his office staff to track and verify the enrollment of patients referred to Adventia by the CW. David Orlando GARZA further instructed his staff to total up the number of patients referred by CW, and calculate a payment amount at the rate described in paragraph

c. Beginning no later than December of 2017, David Orlando GARZA instructed his office staff to pay CW as a W-2 employee, with the purported number of hours worked being calculated by dividing the amount due for kickback payments by the CW's fictional hourly wage.

d. On or about December 4, 2017, David Orlando GARZA authorized and instructed that a kickback of approximately $1,116.70 be paid to the CW via a check from Adventia.

e. On or about January 15, 2018, David Orlando GARZA authorized and instructed that a kickback of approximately $1,600 be paid to the CW via a check from Adventia.

f. On or about October 15, 2018, David Orlando GARZA authorized and instructed that a kickback of approximately $660 be paid to the CW via a check from Adventia.

g. Between in or about November of 2017 and in or about October of 2018, the CW used a portion of their kickback payments from Adventia to pay other health care industry contacts illegal kickbacks.

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

COUNTS TWO – FOUR
Offering to Pay and Paying Illegal Health Care Kickbacks and Aiding and Abetting
(42 U.S.C. § 1320a-7b(b)(2) and 18 U.S.C. § 2)

26. Paragraphs One through Twenty-Nine of this Indictment are realleged and incorporated by reference as though fully set forth herein

27. On or about the dates specified below, in the Western District of Texas, the Defendant,

David Orlando GARZA,

aided and abetted by others known to the Grand Jury, knowingly and willfully, offered to pay and paid any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for referring patients to Adventia for the furnishing of home health services, payment for which would be made in whole or in part by a Federal health care program, specificall Medicare or Medicaid:

Count	Date	Amount
2	12/4/2017	$1,116.70
3	1/15/2018	$1,600
4	10/15/2018	$669.24

All in violation of Title 42, United States Code § 1320a-7b(b)(2).

Notice of United States of America's Demand for Forfeiture
[*See* Fed. R. Crim. P. 32.2]

I.
Health Care Fraud Violations and Forfeiture Statute
[Title 18 U.S.C. 371 and Title 42 U.S.C. § 1320a-7b(b)(2), subject to forfeiture pursuant to Title 18 U.S.C. 982(a)(7)]

This Notice of Demand for Forfeiture includes but is not limited to the property described below.

28. As a result of the foregoing criminal violations set forth in Counts One to Four, the United States of America gives notice to Defendant David Orlando GARZA of its intent to seek the forfeiture of any forfeitable property upon conviction and as part of sentencing pursuant to Fed. R. Crim. P. 32.2 and Title 18 U.S.C. § 982(a)(7), which states:

> **(a)(7)** The court, in imposing sentence on a person convicted of a Federal health care offense, shall order the person to forfeit property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.

II.
Money Judgment

Money Judgment: An amount of money which represents the proceeds obtained directly or indirectly as a result of the violations set forth above for which Defendant is liable.

III.
Substitute Assets

If any of the property described above as being subject to forfeiture for the violations set forth above, 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;

it is the intent of the United States of America to seek forfeiture of any other property of the Defendant, up to the value of said money judgment, as substitute assets pursuant to Title 21 U.S.C. 853(p) and Fed. R. Crim. P. 32.2(e)(1).

A TRUE BILL.

[redacted]

FOREPERSON OF THE GRAND JURY

By:
JOHN F. BASH
UNITED STATES ATTORNEY

JUSTIN CHUNG Digitally signed by JUSTIN CHUNG Date: 2020.08.26 09:49:52 -05'00'

JUSTIN CHUNG
Assistant United States Attorney
U.S. Attorney's Office, WDTX
601 NW Loop 410, Suite 600
San Antonio, Texas 78216