UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 15-20396 CR-KING
/TORRES

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

UNITED STATES OF AMERICA

vs.

ODETTE SANCHEZ, and
ROQUE X. GARCIA

Defendants.
_____/

INDICTMENT

The Grand Jury charges that:

GENERAL ALLEGATIONS

At all times material to this Indictment:

1. The Medicare Program ("Medicare") was a federal healthcare program providing benefits 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 benefits under Medicare where referred to as Medicare "beneficiaries."

2. The Florida Medicaid Program ("Medicaid") was a federal health care program providing benefits to low-income individuals and families. Medicaid was administered by CMS and the State of Florida Agency for Health Care Administration ("AHCA".)

3. Medicare and Medicaid were each a "health care benefit program," as defined by Title 18, United States Code, Section 24(b).

4. "Part A" of the Medicare program and the Medicaid 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 and Medicaid were typically made directly to an HHA or provider based on claims submitted to the Medicare and Medicaid program for qualifying services that had been provided to eligible beneficiaries, rather than to the beneficiary.

5. Physicians, clinics, and other health care providers, including HHAs, which provided services to Medicare beneficiaries and Medicaid recipients were able to apply for and obtain a "provider number." Health care providers that received a Medicare or Medicaid provider number were able to file claims with Medicare or Medicaid to obtain reimbursement for services provided to beneficiaries. A Medicare or Medicaid claim was required to set forth, among other things, the beneficiary's or recipient's name and Medicare or Medicaid information number, the services that were performed for the beneficiary or recipient, 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.

6. 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") to administer Part A HHA claims. As administrator, Palmetto was to receive, adjudicate, and pay, claims submitted by HHA providers under the Part A program for home health claims.

7. In the State of Florida, AHCA contracted with HP Enterprises ("HP"), formerly known as Electronic Data Systems (EDS) to administer Medicaid claims. As administrator, HP was to receive, adjudicate, and pay, claims submitted by HHA providers under the Medicaid program for home health claims.

Part A Coverage and Regulations

Reimbursements

8. The Medicare Part A program and Medicaid 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:

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.

9. Under the Medicare Part A program, 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 under the Medicare Part A program, 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" are 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.

11. Under the Medicaid program, to be reimbursed the HHA would submit, to AHCA, a request for prior authorization for home health services. Prior authorization is required before certain services are provided to recipients. The prior authorization must include the POC, the certification period covered by the POC not to exceed 60 days, and medical information related to the recipient. When the request is approved by AHCA, the approval will contain a prior authorization number for billing and reference. Only one prior authorization number will be issued per certification period. HHAs must submit a claim for payment under the Medicaid program for a prior authorized procedure after the service has been approved and provided.

Record Keeping Requirements

12. Medicare Part A and Medicaid regulations required HHAs providing services to Medicare and Medicaid 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 or Medicaid, through Palmetto and other contractors, to review the appropriateness of Medicare and Medicaid payments made to the HHA under the Part A or Medicaid program.

13. Among the written records required to document the appropriateness of home health care claims submitted under Part A of Medicare or the Medicaid program 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.

14. Medicare Part A and Medicaid regulations required provider HHAs to maintain medical records of every visit made by a nurse, therapist, and home health aide to a beneficiary.

The Defendant and Related Companies

15. Limited Home Health Care, Inc., ("Limited"), was a Florida corporation incorporated on or about August 4, 2006, and did business in Miami-Dade County, Florida, as a company that purportedly provided home health services.

16. Defendant **ODETTE SANCHEZ,** a resident of Miami-Dade County, was the owner and operator of Limited.

17. Defendant **ROQUE X. GARCIA,** a resident of Miami-Dade County, was a Florida licensed Registered Nurse and the Director of Nursing at Limited.

COUNT 1
Conspiracy to Commit Health Care Fraud and Wire Fraud
(18 U.S.C. § 1349)

1. Paragraphs 1 through 17 of the General Allegations section of this Indictment are realleged and incorporated by reference as though fully set forth herein.

2. Beginning on or about May 11, 2009, and continuing through on or about September 6, 2012, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendants,

ODETTE SANCHEZ and
ROQUE X. GARCIA,

did willfully, that is, with the intent to further the objects of the conspiracy, and knowingly combine, conspire, confederate and agree with each other, and others known and unknown to the Grand Jury, to commit offenses against the United States of America, 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 Medicaid, 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; and

b. to knowingly and with 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 the pretenses, representations, and promises were false and fraudulent when made, and for the purpose of executing the scheme and artifice, did knowingly transmit and cause to be transmitted by means of wire communication in interstate commerce, certain writings, signs, signals, and sounds, in violation of Title 18, United States Code, Section 1343.

PURPOSE OF THE CONSPIRACY

3. It was a purpose of the conspiracy for defendants and their co-conspirators to unlawfully enrich themselves by, among other things: (a) submitting and causing the submission of false and fraudulent claims to Medicare and Medicaid; and (b) concealing the submission of false and fraudulent claims to Medicare and Medicaid.

MANNER AND MEANS OF THE CONSPIRACY

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

4. **ODETTE SANCHEZ, ROQUE X. GARCIA,** and their co-conspirators created and caused the creation of false and fraudulent OASIS forms which stated that Medicare and Medicaid beneficiaries were qualified to receive home health services, when in fact, they were not qualified to receive home health services.

5. **ODETTE SANCHEZ, ROQUE X. GARCIA,** and their co-conspirators caused Limited to submit false and fraudulent claims to Medicare and Medicaid seeking payment for home health services that were not medically necessary, not properly prescribed by a licensed physician, and not actually provided to Medicare and Medicaid beneficiaries.

6. As a result of these false and fraudulent claims, Limited received payment from Medicare and Medicaid.

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

COUNTS 2-5
Health Care Fraud
(18 U.S.C. § 1347)

1. Paragraphs 1 through 17 of the General Allegations section of this Indictment are realleged and incorporated by reference as though fully set forth herein.

2. Beginning on or about May 11, 2009, and continuing through on or about September 6, 2012, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendants,

ODETTE SANCHEZ and
ROQUE X. GARCIA,

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 Medicaid, 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 defendants and their accomplices to unlawfully enrich themselves by, among other things: (a) submitting and causing the submission of false and fraudulent claims to Medicare and Medicaid; and (b) concealing the submission of false and fraudulent claims to Medicare and Medicaid.

The Scheme and Artifice

4. The allegations contained in paragraphs 4 through 6 of the Manner and Means section of Count 1 of the Indictment are realleged 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 as to each count, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendants, **ODETTE SANCHEZ** and **ROQUE X. GARCIA,** 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 Medicaid, 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 defendants caused the submission of false and fraudulent Medicare claims by Limited, as further described below, representing that these home health agencies had provided various home health services to beneficiaries pursuant to physicians' P.O.C.s:

Count	Medicare Beneficiary	Approx. Date of Submission of Claim	Medicare Claim Number	Service Claimed; Approx. Amount Claimed
2	B.B.	3/21/2011	201108402268405FLR	Home Health Services; $2,253
3	E.P.	10/5/2011	21127801697905FLR	Home Health Services; $3,025
4	R.O.	12/14/2011	21134801151607FLR	Home Health Services; $1,637

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

FORFEITURE ALLEGATIONS
(18 U.S.C. § 982)

1. The allegations of this Indictment are realleged and incorporated by reference as though fully set forth herein for the purpose of alleging criminal forfeiture to the United States of America of certain property in which one or more of the defendants, **ODETTE SANCHEZ** and **ROQUE X. GARCIA,** has an interest.

2. Upon conviction of a violation of, or a conspiracy to violate, Title 18, United States Code, Section 1347, and 1343 as alleged in this Indictment, the defendant shall forfeit to the United States of America any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense, pursuant to Title 18, United States Code, Section 982(a)(7).

3. The property subject to forfeiture includes approximately $7,278,452 in United States currency, which sum represents the value of the gross proceeds traceable to the commission of the health care offenses alleged in this Indictment.

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 incorporated by Title 18, United States Code, Section 982(b).

A TRUE BILL

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FOREPERSON

_____
WIFREDO A. FERRER
UNITED STATES ATTORNEY

_____
HAGERENESH SIMMONS
SPECIAL ASSISTANT U.S. ATTORNEY