UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

UNITED STATES OF AMERICA

v.

OSMALDO GOMEZ AGUILA

CASE NO 8:15 CR 200 T 35 TGW

18 U.S.C. § 1347
18 U.S.C. § 1028A
18 U.S.C. § 982 (forfeiture)

INDICTMENT

The Grand Jury charges that:

GENERAL ALLEGATIONS

At all times material to this Indictment:

A. The Medicare Program

1. The Medicare Program ("Medicare") was a federal health care program providing health care benefits, items and services (collectively, "services") 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 services under Medicare were referred to as Medicare "beneficiaries."

2. Medicare was a "health care benefit program," as defined by Title 18, United States Code, Section 24(b).

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

4. 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 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 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.

B. Medicare Part A Coverage and Regulations

1. 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:

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.

7. 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.

8. 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. As explained in more detail below, "Outlier Payments" were 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.

2. 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 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, 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 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.

11. 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 teaching 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."

3. Special Outlier Provision

12. Medicare regulations allowed certified home health agencies to subcontract home health care services to nursing companies, registries, or groups (nursing groups), which would, in turn, bill the certified home health agency. That certified home health agency would then bill Medicare for all services provided to the patient by the subcontractor. The HHA's professional supervision over arranged-for services required the same quality controls and supervision of its own employees.

13. For insulin-dependent diabetic beneficiaries, Medicare paid for insulin injections by an HHA when a beneficiary was determined to be unable to inject his or her own insulin and the beneficiary had no available care-giver able and willing to inject the beneficiary. Additionally, for beneficiaries for whom occupational or physical therapy was medically necessary, Medicare paid for such therapy provided by an HHA. The basic requirements that a physician

certify that a beneficiary is confined to the home or homebound and in need of home health services, as certified by a physician, was a continuing requirement for Medicare to pay for such home health benefits.

14. While payment for each episode of care was adjusted to reflect the beneficiary's health condition and needs, Medicare regulations contained an "outlier" provision to ensure appropriate payment for those beneficiaries who had the most extensive care needs, which may result in an Outlier Payment to the HHA. These Outlier Payments were additions or adjustments to the payment amount based on an increased type or amount of medically necessary care. Adjusting payments through Outlier Payments to reflect the HHA's cost in caring for each beneficiary, including the sickest beneficiaries, ensured that all beneficiaries had access to home health services for which they were eligible.

C. Defendants and Relevant Entities

15. Balance Home Health, Inc. ("Balance") was a Florida corporation incorporated on or about August 3, 2009, that had a purported principal place of business at 8405 North Himes Avenue, Suite 217, Tampa, Hillsborough County, Florida. Balance was an HHA that purported to provide home health services to eligible Medicare beneficiaries. Effective on or about June 21, 2011, Balance became authorized to use Medicare provider number ending 9696 to submit claims to Medicare for HHA-related benefits and services.

16. Defendant OSMALDO GOMEZ AGUILA became Balance's vice-president on or about September 2, 2014. On or about October 22, 2014, he became Balance's sole officer, director and registered agent.

17. OSMALDO GOMEZ AGUILA maintained sole signatory authority on a bank account for Balance with Bank of America, account number ending 9191.

18. OSMALDO GOMEZ AGUILA maintained sole signature authority on a bank account for Balance with Bank of America, account number ending 9703.

19. OSMALDO GOMEZ AGUILA was a resident of Hillsborough County, Florida or Miami-Dade County, Florida.

COUNTS 1 through 7
(Health Care Fraud)
(18 U.S.C. § 1347)

1. Paragraphs 1 through 19 of the General Allegations section of this Indictment are realleged and incorporated by reference as though fully set forth herein.

2. Beginning in or around January 2015 and continuing through in or around March 2015, in the Middle District of Florida, and elsewhere, the defendant,

OSMALDO GOMEZ AGUILA,

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 Medicare, a health care benefit program affecting commerce, as defined by Title 18, United States Code, Section 24(b), 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, Medicare, that is, the defendant, through Balance, caused the submission of false and fraudulent claims to Medicare, seeking reimbursement for the cost of home health services.

Purpose of the Scheme and Artifice

3. It was a purpose of the scheme and artifice for Defendant OSMALDO GOMEZ AGUILA to unlawfully enrich himself and others 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 (c) diverting fraud proceeds for the personal use and benefit of himself and others.

Manner and Means of the Scheme and Artifice

The manner and means by which Defendant OSMALDO GOMEZ AGUILA sought to accomplish the purpose of the scheme and artifice included, among others, the following:

4. OSMALDO GOMEZ AGUILA caused Balance to submit false and fraudulent claims to Medicare seeking payment for home health services that were not medically necessary and not provided to Medicare beneficiaries.

5. As a result of these false and fraudulent claims, OSMALDO GOMEZ AGUILA caused Medicare to make payments to Balance in the approximate sum of at least $674,681.

6. OSMALDO GOMEZ AGUILA diverted the fraud proceeds for the personal use and benefit of himself and to further the fraud.

Acts in Execution or Attempted Execution of the Scheme and Artifice

7. On or about the dates set forth as to each count below, in the Middle District of Florida, and elsewhere, OSMALDO GOMEZ AGUILA, 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 he submitted and caused the submission of false and fraudulent Medicare claims seeking reimbursement for the cost of home health care services that were not prescribed by doctors or provided to Medicare beneficiaries as claimed:

Count	Medicare Beneficiary	Document Control Number	Purported Date of Service	Bill Code; Type of Bill; Approximate Amount Claimed
1	Individual A	21503401409507FLR	01/06/2015	322; HHA Interim First Claim; $2,454

Count	Medicare Beneficiary	Document Control Number	Purported Date of Service	Bill Code; Type of Bill; Approximate Amount Claimed
2	Individual B	21503503228507FLR	01/08/2015	322; HHA Interim First Claim; $2,415
3	Individual C	21503503228207FLR	01/08/2015	322; HHA Interim First Claim; $2,126
4	Individual D	21503301053707FLR	01/14/2015	322; HHA Interim First Claim; $2,126
5	Individual E	21503503229507FLR	01/22/2015	322; HHA Interim First Claim; $2,454
6	Individual F	21504101147207FLR	01/28/2015	322; HHA Interim First Claim; $2,305
7	Individual G	21504004290807FLR	01/29/2015	322; HHA Interim First Claim; $1,990

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

COUNTS 8 through 14
(Aggravated Identity Theft)
(18 U.S.C. § 1028A)

8. On or about the dates listed below, in the Middle District of Florida, during and in relation to a felony violation enumerated in Title 18, United States Code, Section 1028A(c)(5), specifically,

a. health care fraud in violation of Title 18, United States Code, Section 1347,

as set forth in the Counts of this Indictment below, the defendant,

OSMALDO GOMEZ AGUILA,

aiding and abetting, and aided and abetted by, others known and unknown to the Grand Jury, did knowingly transfer, possess, and use, without lawful authority, the means of identification of another person as defined by Title 18, United States Code, Section 1028(d)(7), specifically, the means of identification of real people, as set forth below:

Counts	Means of Identification of	On or About Date	Related Count
8	Individual D	02/02/2015	4
9	Individual A	02/03/2015	1
10	Individual C	02/04/2015	3
11	Individual E	02/04/2015	5
12	Individual B	02/04/2015	2
13	Individual G	02/09/2015	7
14	Individual F	02/10/2015	6

All in violation of Title 18, United States Code, Sections 1028A and 2.

FORFEITURE

1. The allegations contained in Counts 1 through 7 of this indictment are incorporated by reference for the purpose of alleging forfeitures pursuant to Title 18, United States Code, Section 982.

2. Upon conviction of a violation of Title 18, United States Code, Section 1347, as alleged in Counts 1 through 7 of this Indictment, the defendant OSMALDO GOMEZ AGUILA 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 the offense.

3. The property to be forfeited includes, but is not limited to, the following:

a. A forfeiture money judgment of at least $674,681.

b. The contents of Bank of America account number ending 9703 in the name of Balance.

c. The contents of Bank of America account number ending 9191 in the name of Balance.

4. If any of the property described 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,

the United States of America shall be entitled to forfeiture of substitute property under the provisions of Title 21, United States Code, Section 853(p), as incorporated by Title 18, United States Code, Section 982(b)(1).

A TRUE BILL.

FOREPERSON

A. LEE BENTLEY, III
United States Attorney

By: _____
ROBERT A. MOSAKOWSKI
Assistant United States Attorney
Chief, Economic Crimes Section

By: _____
GEJAA GOBENA
Deputy Chief
Criminal Division, Fraud Section
U.S. Department of Justice

By: _____
TIMOTHY P. LOPER
Trial Attorney
Criminal Division, Fraud Section
U.S. Department of Justice

UNITED STATES DISTRICT COURT
Middle District of Florida
Tampa Division

THE UNITED STATES OF AMERICA

vs.

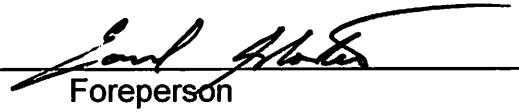
OSMALDO GOMEZ AGUILA

INDICTMENT

Violations:

18 U.S.C. §§ 1347 and 1028A

A true bill,



Foreperson

Filed in open court this 9th day

of June 2015.

Clerk

Bail $_____