UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. _____

18 U.S.C. § 1349
18 U.S.C. § 1347
18 U.S.C. § 982

UNITED STATES OF AMERICA

vs.

MIRIAM CASTELLANOS,

Defendant.
_____/

INDICTMENT

The Grand Jury charges that:

GENERAL ALLEGATIONS

At all times relevant to this Indictment:

The Medicare Program

1. The Medicare Program ("Medicare") was a federal program that provided free or below-cost health care benefits to certain individuals, primarily the elderly, blind, and disabled. Medicare was administered by the Centers for Medicare and Medicaid Services ("CMS"), a federal agency under the United States Department of Health and Human Services ("HHS"). 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).

3. The Medicare program was divided into different "parts." "Part A" of the

Medicare program covered health services provided by hospitals, skilled nursing facilities, hospices, and home health agencies. "Part B" of the Medicare program covered, among other things, medical services provided by physicians, medical clinics, and other qualified health care providers, as well as medications rendered "incident to" such services. The Medicare Advantage Program, formerly known as "Part C" or "Medicare+Choice," is described in further detail below.

4. Medicare Part B was administered in Florida by First Coast Service Options, a company that contracted with CMS to receive, adjudicate, process, and pay certain Part B claims.

5. Payments under the Medicare Program were often made directly to the physician, medical clinic, or other qualified provider of the medical goods or services, rather than to the beneficiary. This occurred when the provider accepted assignment of the right to payment from the beneficiary. In that case, the provider submitted the claim to Medicare for payment, either directly or through a billing company.

6. Physicians, medical clinics, and other health care providers that provided services to Medicare beneficiaries were able to apply for and obtain a "provider number." A health care provider who was issued a Medicare provider number was able to file bills, known as "claims," with Medicare to obtain reimbursement for services provided to beneficiaries. The claim form was required to contain certain important information, including: (a) the Medicare beneficiary's name and Health Insurance Claim Number ("HICN"); (b) a description of the health care benefit, item, or service that was provided or supplied to the beneficiary; (c) the billing codes for the benefit, item, or service; (d) the date upon which the benefit, item, or service was provided or supplied to the beneficiary; and (e) the name of the referring physician or other

health care provider, as well as a unique identifying number, known either as the Unique Physician Identification Number ("UPIN") or National Provider Identifier ("NPI"). The claim form could be submitted in hard copy or electronically.

7. When a claim was submitted to Medicare, the provider certified that the contents of the form were true, correct, complete, and that the form was prepared in compliance with the laws and regulations governing the Medicare program. The provider further certified that the services being billed were medically necessary and were in fact provided as billed.

8. Pursuant to federal statutes and regulations, Medicare only paid for health care benefits, items or other services that were medically necessary and ordered by a licensed doctor or other licensed, qualified health care provider.

The Medicare Advantage Program

9. The Medicare Advantage Program, formerly known as "Part C" or "Medicare+Choice," provided Medicare beneficiaries with the option to receive their Medicare benefits through a wide variety of private managed care plans, including health maintenance organizations ("HMOs"), provider sponsored organizations ("PSOs"), preferred provider organizations ("PPOs"), and private fee-for-service plans ("PFFS"), rather than through the original Medicare program (Parts A and B).

10. Private health insurance companies offering Medicare Advantage plans were required to provide Medicare beneficiaries with the same services and supplies offered under Parts A and B of Medicare. To be eligible to enroll in a Medicare Advantage plan, a person must be entitled to benefits under Part A and Part B of the Medicare Program.

11. A number of companies including Blue Cross and Blue Shield of Florida ("BCBS") and their related subsidiaries and affiliates contracted with CMS to provide managed

care to Medicare Advantage beneficiaries through various plans.

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

13. These entities, including BCBS, through their respective Medicare Advantage programs, often made payments directly to physicians, medical clinics, or other health care providers, rather than to the Medicare Advantage beneficiary that received the health care benefits, items, and services. This occurred when the provider accepted assignment of the right to payment from the beneficiary.

14. To obtain payment for treatment or services provided to a beneficiary enrolled in a Medicare Advantage plan, physicians, medical clinics, and other health care providers had to submit itemized claim forms to the beneficiary's Medicare Advantage plan. The claim forms were typically submitted electronically via the internet. The claim form required certain important Indictment, including: (a) the Medicare Advantage beneficiary's name and HICN or other identification number; (b) a description of the health care benefit, item, or service that was provided or supplied to the beneficiary; (c) the billing codes for the benefit, item, or service; (d) the date upon which the benefit, item, or service was provided or supplied to the beneficiary; and (e) the name of the referring physician or other health care provider, as well as a unique identifying number, known either as the Unique Physician Identification Number ("UPIN") or National Provider Identifier ("NPI").

15. When a provider submitted a claim form to a Medicare Advantage program, the provider party certified that the contents of the form were true, correct, complete, and that the form was prepared in compliance with the laws and regulations governing the Medicare program. The submitting party also certified that the services being billed were medically

necessary and were in fact provided as billed.

16. The private health insurance companies offering Medicare Advantage plans were paid a fixed rate per beneficiary per month by the Medicare program, regardless of the actual number or type of services the beneficiary receives. These payments by Medicare to the insurance companies were known as "capitation" payments. Thus, every month, CMS paid the health insurance companies a pre-determined amount for each beneficiary who was enrolled in a Medicare Advantage plan, regardless of whether or not the beneficiary utilized the plan's services that month. CMS determined the per-patient capitation amount using actuarial tables, based on a variety of factors, including the beneficiary's age, sex, severity of illness, and county of residence. CMS adjusted the capitation rates annually, taking into account each patient's previous illness diagnoses and treatments. Beneficiaries with more illnesses or more serious conditions would rate a higher capitation payment than healthier beneficiaries.

Professional Treatment Medical Center, Inc.

17. Professional Treatment Medical Center, Inc. ("Professional") was a Florida corporation with a place of business located in Miami-Dade County, Florida. Professional was purportedly a medical clinic that provided Medicare Advantage beneficiaries with various medical items and services.

The Defendant

18. Defendant **MIRIAM CASTELLANOS**, a resident of Miami-Dade County, was the President and Owner of Professional.

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

1. Paragraphs 1 through 18 of the General Allegations section of this Indictment are

realleged and incorporated by reference as if fully set forth herein.

2. From in or around January 2011, and continuing through in or around July 2012, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

MIRIAM CASTELLANOS,

did knowingly and willfully combine, conspire, confederate and agree with others known and unknown to the Grand Jury, to violate Title 18, United States Code, Section 1347, that is, 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 BCBS, 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.

PURPOSE OF THE CONSPIRACY

3. It was the purpose of the conspiracy for the defendant and her co-conspirators to unlawfully enrich themselves by, among other things: (a) submitting and causing the submission of false and fraudulent claims to a health care benefit program; (b) concealing the submission of false and fraudulent claims to a health care benefit program; (c) concealing the receipt of the fraud proceeds; and (d) diverting the fraud proceeds for her personal use and benefit, and the use and benefit of others, and to further the fraud.

MANNER AND MEANS OF THE CONSPIRACY

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

4. From in or around January 2011, and continuing through in or around July 2012, **MIRIAM CASTELLANOS** caused the submission of numerous false and fraudulent claims to

BCBS on behalf of Professional Treatment Medical Center, Inc., in an approximate amount of $2,906,987, seeking reimbursement for the cost of services that were not provided as claimed.

5. As a result of such false and fraudulent claims, **MIRIAM CASTELLANOS** caused BCBS to deposit approximately $1,473,504 into Professional Treatment Medical Center, Inc.'s corporate bank accounts.

6. **MIRIAM CASTELLANOS** used the proceeds of the health care fraud for her personal use and benefit, and to further the fraud.

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

COUNTS 2-9
Health Care Fraud
(18 U.S.C. § 1347)

1. Paragraphs 1 through 18 of the General Allegations section of this Indictment are realleged and incorporated by reference as if fully set forth herein.

2. From in or around January 2011, and continuing through in or around July 2012, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

MIRIAM CASTELLANOS,

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 BCBS, 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 the purpose of the scheme and artifice for the defendant and her

accomplices to unlawfully enrich themselves by, among other things: (a) submitting and causing the submission of false and fraudulent claims to a health care benefit program; (b) concealing the submission of false and fraudulent claims to a health care benefit program; (c) concealing the receipt of the fraud proceeds; and (d) diverting the fraud proceeds for her personal use and benefit, and the use and benefit of others, and to further the fraud.

The Scheme and Artifice

The allegations contained in paragraphs 4 through 6 of the Manner and Means section of Count 1 of this 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

On or about the dates specified as to each count below, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant, 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 BCBS, 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 BCBS seeking the identified dollar amounts, and representing that Professional Treatment Medical Center, Inc. provided medical items and services to Medicare Advantage beneficiaries pursuant to physicians' orders and prescriptions:

Count	Medicare Beneficary	Approx. Date of Service	BCBS Claim Number	Services Claimed; Approx. Amount Claimed
2	S.H.	03/19/2011	Q100000231542283	Injection, Octreotide, Depot, 1MG (J2353); $4200
3	T.G.	04/04/2011	Q100000233492362	Injection, Octreotide, Depot, 1MG (J2353); $3500
4	R.N.	04/07/2011	Q100000234097592	Injection, Octreotide, Depot, 1MG (J2353); $3500
5	S.H.	04/25/2011	Q100000236684275	Injection, Octreotide, Depot, 1MG (J2353); $4200
6	D.D.	05/02/2011	Q100000242632844	Injection, Octreotide, Depot, 1MG (J2353); $3500
7	D.D.	05/23/2011	Q100000245803447	Injection, Octreotide, Depot, 1MG (J2353); $3500
8	W.J.	06/10/2011	Q100000248312290	Injection, Octreotide, Depot, 1MG (J2353); $3500
9	T.G.	06/27/2011	Q100000250557848	Injection, Octreotide, Depot, 1MG (J2353); $3500

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

FORFEITURE
(18 U.S.C. § 982)

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 America of certain property in which the defendant, **MIRIAM CASTELLANOS,** has an interest.

2. Upon conviction of any violation of Title 18, United States Code, Sections 1347 and 1349, as alleged in Counts 1 through 9 of this Indictment, the defendant shall forfeit to the United States all of her respective right, title and interest of any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of such violation, pursuant to Title 18, United States Code, Section 982(a)(7).

3. The property subject to forfeiture includes, but is not limited to, the sum of $1,473,504 in United States currency, which amount is equal in value to the gross proceeds traceable to the commission of the violations alleged in this Indictment, which the United States will seek as a forfeiture money judgment as part of the defendant's sentence.

All pursuant to Title 18, United States Code, Section 982(a)(7); and the procedures set forth at Title 21, United States Code, Section 853, as made applicable through Title 18, United States Code, Section 982(b)(1).

A TRUE BILL

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FOREPERSON

/s/ Kenneth Nodal

WIFREDO A. FERRER
UNITED STATES ATTORNEY

FOR

CHRISTOPHER J. CLARK
ASSISTANT UNITED STATES ATTORNEY