UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 14-20317 CR-COOKE/TORRES

18 U.S.C. § 1349
18 U.S.C. § 1347
18 U.S.C. § 2
18 U.S.C.§ 371
42 U.S.C. § 1320a-7b(b)(1)(A)
18 U.S.C. § 982(a)(7)

UNITED STATES OF AMERICA
vs.

MIGUEL ESPINOSA
and
LUIS BUZZI,

Defendants.
_____/

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 information, 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.

FEHBP Program Overview

17. The Federal Employees Health Benefits Program ("FEHBP") was a health care benefit program, as defined in Title 18, United States Code, Section 24(b), created to provide health benefits to federal employees. The United States Office of Personnel Management manages the FEHBP and contracts with various insurance companies to offer these benefits. FEHBP reimburses the various insurance companies it contracts with for the money the insurance companies pay out for health benefits for federal employees.

18. Blue Cross/Blue Shield of Florida ("Blue Cross") was one of the various insurance companies contracted by the Office of Personnel Management to offer health benefits to federal employees under the FEHBP. In addition to being a provider for FEHBP, Blue Cross was a

mutual insurance company (member-owned) health care benefit program licensed under the State of Florida to provide health insurance benefits to individuals and businesses in the State of Florida, including employees of the State of Florida.

Lord's Medical & Rehab Center, Inc.

19. Lord's Medical & Rehab Center, Inc. ("Lord's Medical") was a Florida corporation with a place of business in Miami-Dade County. Lord's Medical was a medical clinic that purportedly provided Medicare Advantage, private insurance, and FEHBP beneficiaries with various medical items and services.

The Defendants

20. Defendant **MIGUEL ESPINOSA** was a resident of Broward County.

21. Defendant **LUIS BUZZI** was a resident of Miami-Dade County.

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

1. Paragraphs 1 through 21 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 2010, and continuing through in or around September 2011, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendants,

MIGUEL ESPINOSA
and
LUIS BUZZI,

did knowingly and willfully combine, conspire, confederate and agree with Janet Farigola, and 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 programs, 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 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 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 their 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 defendants and their co-conspirators sought to accomplish the purpose of the conspiracy included, among others, the following:

4. **MIGUEL ESPINOSA** and **LUIS BUZZI** accepted kickbacks from Lord's Medical in exchange for recruiting Medicare Advantage beneficiaries, while knowing that Lord's Medical would in turn bill BCBS for medical services purportedly rendered to the recruited Medicare Advantage beneficiaries.

5. **MIGUEL ESPINOSA, LUIS BUZZI,** Janet Farigola, and their co-conspirators caused the submission of numerous false and fraudulent claims to BCBS on behalf of Lord's Medical, in an approximate amount of $5,497,047 seeking reimbursement for the cost of services that were not medically necessary and not provided.

6. As a result of the submission of these claims, BCBS made payments to Lord's

Medical in the approximate amount of $2,346,416.

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

COUNTS 2-10
Health Care Fraud
(18 U.S.C. § 1347 and 2)

1. Paragraphs 1 through 21 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 February 2010, and continuing through in or around July 2011, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

MIGUEL ESPINOSA
and
LUIS BUZZI,

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, 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 defendants and their 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 their personal use and benefit, and the use and benefit of others, and to further the fraud.

The Scheme and Artifice

4. 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

5. On or about the dates specified as to each count below, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendants, 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 defendants submitted and caused the submission of false and fraudulent claims to Medicare and BCBS seeking the identified dollar amounts, and representing that Lord's provided medical items and services to Medicare Advantage beneficiaries pursuant to physicians' orders and prescriptions:

Count	Medicare Beneficiary	Defendant	Approx. Date Claim Received	BCBS Claim Number	Services Claimed; Approx. Amount Claimed
2	D.M.	**MIGUEL ESPINOSA**	02/04/2011	F100000224863315	Injection, Pyridoxine HCL, 100 MG (J3415); $900
3	D.M.	**MIGUEL ESPINOSA**	02/04/2011	F100000224863315	Injection, Thiamine HCL, 100 MG (J3411); $500
4	D.M.	**MIGUEL ESPINOSA**	02/04/2011	F100000224865290	Injection, Pyridoxine HCL, 100 MG (J3415); $900

Count	Medicare Beneficiary	Defendant	Approx. Date Claim Received	BCBS Claim Number	Services Claimed; Approx. Amount Claimed
5	C.Q.	**LUIS BUZZI**	02/10/2011	F100000225676974	Injection, Thiamine HCL, 100 MG (J3411); $500
6	C.Q.	**LUIS BUZZI**	02/10/2011	F100000225676974	Injection, Pyridoxine HCL, 100 MG (J3415); $900
7	C.Q.	**LUIS BUZZI**	02/14/2011	F100000226117137	Injection, Pyridoxine HCL, 100 MG (J3415); $900
8	M.T.	**MIGUEL ESPOINOSA**	03/07/2011	F100000229260970	Injection, Thiamine HCL, 100 MG (J3415); $500
9	M.T.	**MIGUEL ESPOINOSA**	03/08/2011	F100000229404993	Injection, Pyridoxine HCL, 100 MG (J3415); $900
10	M.T.	**MIGUEL ESPOINOSA**	03/08/2011	F100000229404993	Injection, Pyridoxine HCL, 100 MG (J3415); $900

In violation of Title 18, United States Code, Section 1347.

COUNT 11
Conspiracy to Receive Health Care Kickbacks
(18 U.S.C. § 371)

1. Paragraphs 1 through 21 of the General Allegations section of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

2. From in or around January 2010, and continuing through in or around September 2011, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

MIGUEL ESPINOSA
and
LUIS BUZZI,

did willfully, that is with the intent to further the object of the conspiracy, and knowingly combine, conspire, confederate and agree with Janet Farigola and others known and unknown to the Grand Jury to commit an offense against the United States, that is, to violate Title 42, United States Code, Section 1320a-7b(b)(1)(A), by knowingly and willfully soliciting and receiving any 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 any item or 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 the purpose of the conspiracy for the defendants and their co-conspirators to unlawfully enrich themselves by: (1) soliciting and receiving kickbacks and bribes for referring Medicare Advantage beneficiaries to Lord's Medical so that their Medicare Beneficiary number would serve as the bases of claims for medical items and services, and (2) by submitting and causing the submission of claims to Medicare and BCBS for medical items and services that Lord's Medical Rehab, Inc. purported to provide to those beneficiaries.

MANNER AND MEANS OF THE CONSPIRACY

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

4. **MIGUEL ESPINOSA and LUIS BUZZI**, accepted kickbacks in return for referring Medicare Beneficiaries to Lord's Medical for various medical items and services.

5. **MIGUEL ESPINOSA, LUIS BUZZI**, Janet Farigola, and their co-conspirators caused Lord's Medical to submit claims to Medicare for various medical items and services purportedly rendered to the recruited beneficiaries.

6. **MIGUEL ESPINOSA, LUIS BUZZI**, Janet Farigola and their co-conspirators caused Medicare and BCBS to pay Lord's Medical based upon various items and Medicare services purportedly provided to the recruited beneficiaries.

OVERT ACTS

In furtherance of the conspiracy, and to accomplish its object 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 April 6, 2011, **MIGUEL ESPINOSA** received approximately $30,989 via Lord's Medical check no. 1005, in return for referring patients to Lord's Medical.

2. On or about April 7, 2011, **LUIS BUZZI** received approximately $18,846 via Lord's Medical check no. 1099, in return for referring patients to Lord's Medical.

3. On or about April 28, 2011, **MIGUEL ESPINOSA** received approximately $11,969 via Lord's Medical check no. 1077 in return for referring patients to Lord's Medical.

4. On or about April 28, 2011, **LUIS BUZZI** received approximately $28,931 via Lord's Medical check no. 1083 in return for referring patients to Lord's Medical.

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

COUNTS 12-21
Receipt of Kickbacks in Connection with a Federal Health Care Program (42 U.S.C. § 1320a-7b(b)(1)(A))

1. Paragraphs 1 through 23 of the General Allegations section of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

2. On or about the dates enumerated below as to each count, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendants,

MIGUEL ESPINOSA
and
LUIS BUZZI,

As specified in each count below, did knowingly and willfully solicit and receive any remuneration, that is, kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind, including by check, in return for referring an individual to a person for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole and in part under a Federal health care program, as set forth below:

Count	Defendant	Approximate Date	Approximate Kickback Amount
12	**MIGUEL ESPINOSA**	04/06/2011	$30,898
13	**MIGUEL ESPINOSA**	04/19/2011	$10,700
14	**MIGUEL ESPINOSA**	04/28/2011	$11,969
15	**MIGUEL ESPINOSA**	06/07/2011	$18,273
16	**MIGUEL ESPINOSA**	06/07/2011	$6,833
17	**LUIS BUZZI**	04/08/2011	$18,846
18	**LUIS BUZZI**	04/08/2011	$18,846
19	**LUIS BUZZI**	05/03/2011	$21,978
20	**LUIS BUZZI**	05/04/2011	$28,931

21	**LUIS BUZZI**	05/12/2011	$20,858

In violation of Title 42, United States Code, Section 1320a-7b(b)(1)(A) and Title 18, United States Code, Section 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 America of certain property in which defendants, **MIGUEL ESPINOSA** and **LUIS BUZZI**, have an interest.

2. Upon conviction of any violation of Title 18, United States Code, Sections 1347 or 1349, as alleged in Counts 1 through 11 of this Indictment, the defendants shall forfeit to the United States all of their respective right, title, and interest in any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of such violations, pursuant to Title 18, United States Code, Section 982(a)(7).

3. The property subject to forfeiture includes, but is not limited to, the following: The sum of $2,346,416 in United States currency, which amount is equal 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 by Title 18, United States Code, Section 982(b)(1).

A TRUE BILL

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FOREPERSON

WIFREDO A. FERRER
UNITED STATES ATTORNEY

CHRISTOPHER J. CLARK
ASSISTANT UNITED STATES ATTORNEY