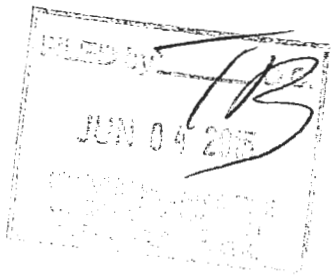
UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 15-20407 CR-COOKE

/TORRES

18 U.S.C. § 371
42 U.S.C. § 1320a-7b(b)(2)(A)
18 U.S.C. § 1956(h)
18 U.S.C. § 1956(a)(1)(B)(i)
18 U.S.C. § 2
18 U.S.C. § 982



UNITED STATES OF AMERICA

vs.

LUIS TOLEDO,

Defendant.
_____/

INDICTMENT

The Grand Jury charges that:

GENERAL ALLEGATIONS

At all times material to this Indictment:

The Medicare Program

1. The Medicare Program ("Medicare") was a federally funded program that provided free or below-cost health care benefits to certain individuals, primarily the elderly, blind, and disabled. The benefits available under Medicare were governed by federal statutes and regulations. The United States Department of Health and Human Services ("HHS"), through its agency, the Centers for Medicare and Medicaid Services ("CMS"), oversaw and administered Medicare. 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) and a Federal health care program, as defined by Title 42, United States Code, Section 1320a-7b(f).

3. Medicare programs covering different types of benefits were separated into different program "parts." "Part A" of the Medicare program covered certain eligible home health care costs for medical services provided by a home health agency ("HHA"), also referred to as a "provider," to persons who already qualified for Medicare and who additionally required home health services because of an illness or disability that caused them to be homebound.

4. CMS did not directly pay Medicare Part A claims submitted by Medicare-certified HHAs. CMS contracted with different private 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"). As administrator, Palmetto was to receive, adjudicate and pay claims submitted by HHA providers under the Part A program for home health claims. Additionally, CMS separately contracted with companies in order to review HHA providers' claims data. CMS first contracted with TriCenturion, a Program Safeguard Contractor. Subsequently, on December 15, 2008, CMS contracted with SafeGuard Services, a Zone Program Integrity Contractor. Both TriCenturion and SafeGuard Services safeguarded the Medicare Trust Fund by reviewing HHA providers' claims for potential fraud, waste, and/or abuse.

5. 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 provider number of the physician or other health care provider who ordered the services.

Part A Coverage and Regulations

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 the patient:

a. was confined to the home, also referred to as homebound;

b. was under the care of a physician who specifically determined there was a need for home health care and established the Plan of Care ("P.O.C."); and

c. the determining physician signed a certification statement specifying that the beneficiary needed intermittent skilled nursing, physical therapy, speech therapy, or a continued need for occupational therapy; the beneficiary was confined to the home; that a P.O.C. 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 P.O.C.

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.

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 the actual treatment of patients to whom services were provided and for whom claims for reimbursement were submitted by the HHA. These medical records were required to be sufficiently complete 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 were a: (i) P.O.C. that included the physician order, diagnoses, types of services/frequency of visits, prognosis/rehab potential, functional limitations/activities permitted, medications/treatments/nutritional requirements, safety measures/discharge plans, goals, and the physician's signature; and (ii) 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.

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 instruction provided to the patient 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."

12. Medicare regulations allowed Medicare certified HHAs to subcontract home health care services to nursing companies, therapy staffing services agencies, registries, or groups (nursing groups), which would bill the certified home health agency. The Medicare certified HHA would, in turn, bill Medicare for all services rendered to the patient. The HHA's professional supervision over subcontracted-for services required the same quality controls and supervision as of its own salaried employees.

Special Outlier Provision

13. Medicare regulations allowed certified HHAs to subcontract home health care services to nursing companies, registries, or groups (nursing groups), which would, in turn, bill the certified home health agency. The certified HHA 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. However, Medicare regulations prohibited one HHA merely serving as a billing mechanism for another agency.

14. 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 caregiver 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 requirement that the beneficiary be confined to the home or be homebound was a continuing requirement for a Medicare beneficiary to receive home health benefits.

15. 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.

The Defendant and Related Companies

16. Renovation Health Care, LLC ("Renovation HC") was incorporated on or about March 8, 2007, with its principal place of business in Miami-Dade County, in the Southern District of Florida.

17. Renovation of Life Dialysis Center Corp. ("Renovation of Life Dialysis") was incorporated on or about November 24, 2009, with its principal place of business in Miami-Dade County, in the Southern District of Florida.

18. Defendant **LUIS TOLEDO**, a resident of Miami-Dade County, was an operator of Renovation HC.

19. Countywide Consulting, Inc. ("Countywide Consulting") was a Florida corporation, incorporated on or about August 3, 2011, with its principal place of business in Miami-Dade County, in the Southern District of Florida.

20. EZ Marketing Services, Inc. ("EZ Marketing") was a Florida corporation, incorporated on or about August 3, 2011, with its principal place of business in Miami-Dade County, in the Southern District of Florida.

21. Emilio Amador, a resident of Miami-Dade County, was the operator of Countywide Consulting and EZ Marketing.

22. Co-Conspirator A was a resident of Miami-Dade County.

COUNT 1
Conspiracy to Defraud the United States and Pay and Receive Health Care Kickbacks (18 U.S.C. § 371)

1. Paragraphs 1 through 22 of the General Allegations section of this Indictment are realleged and incorporated by reference as though fully set forth herein.

2. From in or around December 2009, and continuing through in or around at least April 2013, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

LUIS TOLEDO,

did willfully, that is, with the intent to further the objects of the conspiracy, and knowingly combine, conspire, confederate and agree with Emilio Amador, Co-Conspirator A, and others known and unknown to the Grand Jury to commit certain 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 Department of Health and Human Services in its administration and

oversight of the Medicare program, in violation of Title 18, United States Code, Section 371;

b. to violate Title 42, United States Code, Section 1320a-7b(b)(2)(A), by knowingly and willfully offering and paying any remuneration, including kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind, to any person to induce such person to refer 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, that is, Medicare; and

c. 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 an item and 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 defendant and his co-conspirators to unlawfully enrich themselves by: (1) offering, paying, soliciting, and receiving kickbacks and bribes in return for referring Medicare beneficiaries to Renovation HC to serve as patients; and (2) submitting and causing the submission of claims to Medicare for home health services that Renovation HC purported to provide to those beneficiaries.

MANNER AND MEANS OF THE CONSPIRACY

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

4. **LUIS TOLEDO** paid checks to Countywide Consulting and EZ Marketing, each under the control of co-conspirator Emilio Amador, so that Emilio Amador could deposit the checks, withdraw corresponding amounts of cash, and return cash to **LUIS TOLEDO**, which **LUIS TOLEDO** used to pay kickbacks to patient recruiters who referred Medicare beneficiaries to Renovation HC.

5. **LUIS TOLEDO** and his co-conspirators offered and paid kickbacks to co-conspirator patient recruiters, including Emilio Amador and Co-Conspirator A, in return for referring Medicare beneficiaries to Renovation HC to serve as patients.

6. **LUIS TOLEDO** and his co-conspirators, including Emilio Amador and Co-Conspirator A, caused Renovation HC to submit claims to Medicare for home health services purportedly provided to the recruited Medicare beneficiaries.

7. **LUIS TOLEDO** caused Medicare to pay Renovation HC based upon Home Health Services purportedly provided to the recruited beneficiaries.

OVERT ACTS

In furtherance of the conspiracy, and to accomplish its objects 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 9, 2012, **LUIS TOLEDO** paid Emilio Amador through Renovation HC check number 4066, drawn on Renovation HC's corporate bank account ending in 5558 at Wachovia Bank and made payable to EZ Marketing, in the approximate amount of $8,105, for the purpose of receiving cash in return to pay co-conspirator patient recruiters.

2. On or about April 9, 2012, **LUIS TOLEDO** paid Emilio Amador through Renovation HC check number 4072, drawn on Renovation HC's corporate bank account ending in

5558 at Wachovia Bank and made payable to Countywide Consulting, in the approximate amount of $4,180, for the purpose of receiving cash in return to pay co-conspirator patient recruiters.

3. On or about July 2, 2012, **LUIS TOLEDO** paid Emilio Amador through Renovation HC check number 4187, drawn on Renovation HC's corporate bank account ending in 5558 at Wachovia Bank and made payable to Countywide Consulting, in the approximate amount of $4,585, for the purpose of receiving cash in return to pay co-conspirator patient recruiters.

4. On or about July 2, 2012, **LUIS TOLEDO** paid Emilio Amador through Renovation HC check number 4188, drawn on Renovation HC's corporate bank account ending in 5558 at Wachovia Bank and made payable to EZ Marketing, in the approximate amount of $3,280, for the purpose of receiving cash in return to pay co-conspirator patient recruiters.

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

COUNTS 2-3
Payment of Kickbacks in Connection with a Federal Health Care Program
(42 U.S.C. § 1320a-7b(b)(2)(A) & 18 U.S.C. § 2)

1. Paragraphs 1 through 22 of the General Allegations section of this Indictment are realleged 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 defendant,

LUIS TOLEDO,

did knowingly and willfully offer and pay any remuneration, that is, kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind, including by check, as set forth below, to a person to induce such person to refer 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 by a Federal health care program, that is, Medicare, as set forth below:

Count	Approximate Date	Approximate Kickback Amount
2	November 16, 2010	$1,000
3	April 18, 2013	$11,000

In violation of Title 42, United States Code, Section 1320a-7b(b)(2)(A) and Title 18, United States Code, Section 2.

COUNT 4
Conspiracy to Commit Money Laundering
(18 U.S.C. § 1956(h))

1. Paragraphs 1 through 22 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 August 2011, and continuing through in or around at least April 2013, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

LUIS TOLEDO,

did willfully, that is, with the intent to further the object of the conspiracy, and knowingly combine, conspire, confederate, and agree with Emilio Amador, and with others known and unknown to the Grand Jury, to knowingly conduct and attempt to conduct a financial transaction affecting interstate commerce, which financial transaction involved the proceeds of specified unlawful activity, knowing that the property involved in the financial transaction represented the proceeds of some form of unlawful activity, and knowing that such transaction was designed, in whole and in part, to conceal and disguise the nature, the location, the source, the ownership, and the control of the proceeds of specified unlawful activity, in violation of Title 18, United States Code, Section 1956(a)(l)(B)(i).

It is further alleged that the specified unlawful activity is conspiracy to pay and receive health care kickbacks, in violation of Title 18, United States Code, Section 371.

All in violation of Title 18, United States Code, Section 1956(h).

COUNTS 5-8
Money Laundering
(18 U.S.C. § 1956(a)(1)(B)(i) & 18 U.S.C. § 2)

1. Paragraphs 1 through 22 of the General Allegations section of this Indictment are realleged and incorporated by reference as though fully set forth herein.

2. On or about the date specified below, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

LUIS TOLEDO,

did knowingly conduct and attempt to conduct a financial transaction affecting interstate commerce, which transaction involved the proceeds of specified unlawful activity, knowing that the property involved in the financial transaction represented the proceeds of some form of unlawful activity, and knowing that the transaction was designed in whole and in part to conceal and disguise the nature, the location, the source, the ownership, and the control of the proceeds of the specified unlawful activity, as set forth below:

Count	Approximate Transaction Date	Description of Financial Transaction
5	April 9, 2012	The delivery of check no. 4066, drawn on the corporate account of Renovation HC ending in 5558 at Wachovia Bank and made payable to EZ Marketing, in the approximate amount of $8,105.
6	April 9, 2012	The delivery of check no. 4072, drawn on Renovation HC's corporate bank account ending in 5558 at Wachovia Bank and made payable to Countywide Consulting, in the approximate amount of $4,180.
7	July 2, 2012	The delivery of check no. 4187, drawn on the corporate account of Renovation HC ending in 5558 and made payable to Countywide Consulting, in the approximate amount of $4,585.

Count	Approximate Transaction Date	Description of Financial Transaction
8	July 2, 2012	The delivery of check no. 4188, drawn on the corporate account of Renovation HC ending in 5558 and made payable to EZ Marketing, in the approximate amount of $3,280.

It is further alleged that the specified unlawful activity is conspiracy to pay and receive health care kickbacks, in violation of Title 18, United States Code, Section 371.

In violation of Title 18, United States Code, Sections 1956(a)(1)(B)(i) and 2.

CRIMINAL FORFEITURE
(18 U.S.C. § 982)

1. The allegations contained in this Indictment are re-alleged 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 the defendant, **LUIS TOLEDO**, has an interest.

2. Upon conviction of a violation of Title 42, United States Code, Sections 1320a-7b(b)(1)(A) or 1320a-7b(b)(2)(A), or a conspiracy to commit such violation, in a violation of Title 18, United States Code, Section 371, as alleged in this Indictment, the defendant shall forfeit to the United States 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. Upon conviction of a violation of Title 18, United States Code, Sections 1956, as alleged in this Indictment, the defendant shall forfeit to the United States any property, real or personal, involved in the offense, or any property traceable to such property, pursuant to Title 18, United States Code, Section 982(a)(1).

4. The property which is subject to forfeiture includes, but is not limited to, a sum of money equal in value to the property, real or personal, that constitutes or is derived, directly or

indirectly, from gross proceeds traceable to the commission of the alleged Federal healthcare offenses, or the alleged federal money laundering offenses, or any property traceable thereto, which the United States will seek as a forfeiture money judgment against the defendant.

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

A TRUE BILL

FOREPERSON

WIFREDO A. FERRER
UNITED STATES ATTORNEY

GEJAA GOBENA
DEPUTY CHIEF
CRIMINAL DIVISION, FRAUD SECTION
U.S. DEPARTMENT OF JUSTICE

KELLY GRAVES
TRIAL ATTORNEY
CRIMINAL DIVISION, FRAUD SECTION
U.S. DEPARTMENT OF JUSTICE