UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 16-20379-Cr-Moreno

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

UNITED STATES OF AMERICA

vs.

ARMANDO SALAZAR,

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 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 P.O.C.

Record Keeping Requirements

7. 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.

8. 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.

9. 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."

10. 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.

11. 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. For example, Medicare may pay for insulin injections by an HHA when a beneficiary was determined to be unable to inject his/her own insulin and the beneficiary had no available caregiver able or willing to inject the beneficiary.

Medicare Part B

12. Medicare Part B pays for a portion of the cost of certain necessary medical services and medications that are provided and ordered by physicians, clinics, and other qualified health care providers. Medicare Part B is administered in Florida by First Coast Service Options, a company that contracted with CMS to receive, adjudicate, process, and pay Medicare Part B claims. Medicare Part B payments are made directly to the physician, clinic, or other provider of the medical services, rather than to the beneficiary.

13. Physicians, clinics, and other health care providers that provide services to Medicare beneficiaries are able to apply for and obtain a "provider number." A health care provider who has been issued a Medicare provider number is able to file claims with Medicare to obtain reimbursement for services provided to beneficiaries. A Medicare claim is required to set forth, among other things, the beneficiary's name and Medicare identification number, the services that had been performed for the beneficiary, 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 had ordered the services.

The Defendants, Co-Conspirators, and Related Companies

14. Monzon Medical Diagnostic, Corp. ("Monzon Medical") was incorporated on or about April 3, 2009, with its principal place of business in Miami-Dade County, in the Southern District of Florida.

15. Defendant **ARMANDO SALAZAR**, a resident of Miami-Dade County, held himself out as a doctor or physician assistant associated with Monzon Medical.

16. RPH Home Health Care Inc. ("RPH HH") was incorporated on or about February 10, 2009 with its principal place of business in Miami-Dade County, in the Southern District of Florida.

17. Ivan Fonseca and Ivon Fonseca are owners or operators of RPH HH.

18. Unlimited Care of Florida Inc. ("Unlimited HH") was incorporated on or about September 24, 2003 with its principal place of business in Miami-Dade County, in the Southern District of Florida.

19. Co-Conspirator A is a resident of Miami-Dade County.

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

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

ARMANDO SALAZAR,

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, including Co-Conspirator A and Ivan Fonseca, 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; and

b. to violate Title 42, United States Code, Section 1320a-7b(b)(1)(B), 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 purchasing, leasing, ordering, and arranging for and recommending purchasing, leasing, and ordering any good, facility, service, and item 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) soliciting and receiving kickbacks and bribes from co-conspirator patient recruiters and home health clinic owners in return for providing prescriptions for home health care services; and (2) submitting and causing the submission of claims to Medicare for home health services that Miami-Dade area home health agencies, including Unlimited HH and RPH HH, purportedly provided 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. **ARMANDO SALAZAR** solicited and received kickbacks and bribes from co-conspirator patient recruiters and home health agencies owners, including Co-Conspirator A and Ivan Fonseca in return for providing prescriptions for home health care services for Medicare beneficiaries.

5. **ARMANDO SALAZAR** and his co-conspirators caused Miami-Dade home health agencies, including RPH HH and Unlimited HH to submit claims to Medicare for home health services purportedly provided to Medicare beneficiaries, based upon prescriptions procured via kickbacks.

6. As a result of these claims, Medicare made payments to Miami-Dade home health agencies including RPH HH and Unlimited HH.

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. In or around June of 2012, **ARMANDO SALAZAR** solicited a kickback from Co-Conspirator A in the approximate amount of $250, in return for providing a prescription for home health services for a Medicare beneficiary.

2. On or about August 13, 2012, **ARMANDO SALAZAR** accepted a kickback from Co-Conspirator A in the amount of $150, in return for providing a prescription for home health services for a Medicare beneficiary.

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

COUNT 2
Receipt of Kickbacks in Connection with a Federal Health Care Program
(42 U.S.C. § 1320a-7b(b)(1)(B))

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

ARMANDO SALAZAR,

did knowingly and willfully solicit and receive remuneration, including kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind, as set forth below, in return for purchasing, leasing, ordering, and arranging for and recommending purchasing, leasing, and ordering any good, facility, service, and item for which payment may be made in whole and in part under a Federal health care program, that is, Medicare, as set forth below:

Count	Approximate Date	Approximate Kickback Amount
2	August 13, 2012	$150

In violation of Title 42, United States Code, Section 1320a-7b(b)(1)(B).

COUNT 3-5
Health Care Fraud
(18 U.S.C. § 1347)

1. Paragraphs 12 through 19 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 November of 2012, and continuing through in or around March of 2013, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

ARMANDO SALAZAR,

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 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 defendant to unlawfully enrich himself by, among other things: (a) submitting and causing the submission of false and fraudulent claims to Medicare; (b) soliciting and receiving kickbacks and bribes in exchange for providing prescriptions for home health care; and (c) concealing the submission of false and fraudulent claims.

The Scheme and Artifice

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

4. **ARMANDO SALAZAR** examined patients and provided prescriptions despite the fact that he was not licensed to do so by the state of Florida.

5. **ARMANDO SALAZAR** solicited and received kickback payments for creating fraudulent prescriptions.

6. **ARMANDO SALAZAR** caused the submission of false and fraudulent claims for office visits that were not performed by a licensed medical professional.

7. As a result of these false and fraudulent claims, Medicare made payments to a doctor associated with **ARMANDO SALAZAR.**

Acts in Execution or Attempted Execution of the Scheme and Artifice

8. On or about the dates set forth below as to each count, in Miami-Dade County, in the Southern District of Florida, the defendant, **ARMANDO SALAZAR,** as specified in each count below, 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 the defendant submitted and caused the submission of false and fraudulent Medicare claims, representing that a licensed medical professional had provided various services to beneficiaries.

Count	Approx. Date of Submission of Claim	Beneficiary	Service Claimed; Approx. Amount Billed
3	November 14, 2012	L.B.	Outpatient Office Visit; $250
4	November 20, 2012	H.H.	Outpatient Office Visit; $250
5	February 22, 2013	O.C.P.	Outpatient Office Visit; $250

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

FORFEITURE
(18 U.S.C. § 982(a)(7))

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 forfeiture to the United States of America of certain property in which the defendant, **ARMANDO SALAZAR**, has an interest.

2. Upon conviction of a violation of Title 18, United States Code, Sections 371, 1347, or Title 42, United States Code, Section 1320a-7b(b), 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).

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.

A TRUE BILL

[redacted]

FOREPERSON

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