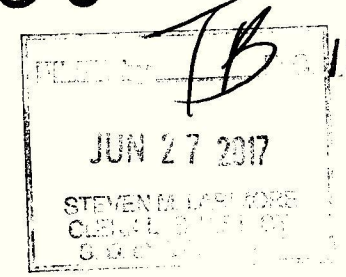
UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 17-20439 CR-WILLIAMS
TORRES

18 U.S.C. § 1347
18 U.S.C. § 2
18 U.S.C. § 982(a)(7)



UNITED STATES OF AMERICA,

vs.

JESUS ESCOBAR MONTERO,

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 ("POC"); 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 POC.

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 was: (i) a POC that included the physician's 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 HHAs to maintain medical records of every visit made by a nurse, therapist, or 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. Medicare beneficiaries were each assigned unique benefit numbers which were referred to as a Health Insurance Claim Number ("HICN").

12. Doctors who prescribed goods and services paid for by the Medicare program were issued unique identification numbers which were called National Physician Identification Numbers ("NPIN").

The Defendant and Related Company

13. Better Care Home Health Services, Inc. ("Better Care") was a corporation organized under the laws of the State of Florida and located at 4577 N. Nob Hill Road, Suite 207, Sunrise, FL. Better Care was an HHA purportedly engaged in the business of providing home health services to Medicare beneficiaries.

14. Defendant **JESUS ESCOBAR MONTERO**, a resident of Miami-Dade County, became the registered agent and Director, President, and Secretary of Better Care on or about June 1, 2015.

COUNTS 1-4
Health Care Fraud
(18 U.S.C. § 1347)

1. The General Allegations section of this Indictment is re-alleged and incorporated by reference as though fully set forth herein.

2. From in or around May of 2015, through in or around November of 2015, in Miami-Dade and Broward Counties, in the Southern District of Florida, and elsewhere, the defendant,

JESUS ESCOBAR MONTERO,

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 the purpose of the scheme and artifice for the defendant to unjustly enrich himself 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; (c) concealing the receipt and transfer of fraud proceeds; and (d) diverting fraud proceeds for his personal use and benefit and to further the fraud.

The Scheme and Artifice

4. **JESUS ESCOBAR MONTERO** and his accomplices obtained the names and HICNs of Medicare beneficiaries and NPINs of physicians in order to submit false and fraudulent claims for home health services purportedly prescribed by a licensed physician that were never provided to Medicare beneficiaries.

5. **JESUS ESCOBAR MONTERO** and his accomplices caused Better Care to submit false and fraudulent claims to Medicare for home health services purportedly rendered to Medicare beneficiaries, when in truth and in fact, such home health services were not medically necessary and were not provided.

7. As a result of these false and fraudulent claims, Medicare made payments to Better Care in the approximate amount of over $900,000.

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 and Broward Counties, in the Southern District of Florida, and elsewhere, the defendant, **JESUS ESCOBAR MONTERO**, 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 claims to Medicare, representing that Better Care had provided various home health services to beneficiaries pursuant to physicians' orders and prescriptions:

Count	Beneficiary	Approx. Date Of Claim	Claim Number	Approx. Amount Paid
1	C.S.	7/14/2015	21519500805204FLR	$3,468
2	R.L.	7/14/2015	21519500789804FLR	$3,468
3	C.W.	7/22/2015	21520300651104FLR	$3,468
4	L.H.	7/27/2015	21520801180904FLR	$3,468

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 certain property in which the defendant, **JESUS ESCOBAR MONTERO**, has an interest.

2. Upon conviction of a violation of Title 18, United States Code, Section 1347, as alleged in this Indictment, the defendant shall forfeit to the United States, 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 such offense.

3. The property to be forfeited includes, but is not limited to, a sum equal in value to the gross proceeds traceable to the commission of the offenses alleged in this Indictment, approximately over $900,000, which the United States will seek as a forfeiture money judgment as part of the defendant's sentence.

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

and Title 28, United States Code, Section 2461(c).

All pursuant to Title 18, United States Code, Section 982(a)(7), Title 28, United States Code, 2461(c), 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)(1).

A TRUE BILL

FC

BENJAMIN G. GREENBERG
ACTING UNITED STATES ATTORNEY

JOSEPH BEEMSTERBOER
DEPUTY CHIEF
CRIMINAL DIVISION, FRAUD SECTION
U.S. DEPARTMENT OF JUSTICE

DAVID A. SNIDER
TRIAL ATTORNEY
CRIMINAL DIVISION, FRAUD SECTION
U.S. DEPARTMENT OF JUSTICE

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

UNITED STATES OF AMERICA

v.

JESUS ESCOBAR MONTERO,

Defendant.
_____ /

CASE NO. _____

CERTIFICATE OF TRIAL ATTORNEY*

Superseding Case Information:

Court Division: (Select One)

_X_ Miami _____ Key West
___ FTL _____ WPB ___FTP

New Defendant(s) Yes ___ No ___
Number of New Defendants _____
Total number of counts _____

I do hereby certify that:

1. I have carefully considered the allegations of the indictment, the number of defendants, the number of probable witnesses and the legal complexities of the Indictment/Information attached hereto.

2. I am aware that the information supplied on this statement will be relied upon by the Judges of this Court in setting their calendars and scheduling criminal trials under the mandate of the Speedy Trial Act, Title 28 U.S.C. Section 3161.

3. Interpreter: (Yes or No) Yes
List language and/or dialect Spanish

4. This case will take 2-3 days for the parties to try.

5. Please check appropriate category and type of offense listed below:

	(Check only one)		(Check only one)	
I	0 to 5 days	X	Petty	
II	6 to 10 days		Minor	
III	11 to 20 days		Misdem.	
IV	21 to 60 days		Felony	X
V	61 days and over			

6. Has this case been previously filed in this District Court? (Yes or No) No
If yes:
Judge: Case No. _____
(Attach copy of dispositive order)
Has a complaint been filed in this matter? (Yes or No) No
If yes:
Magistrate Case No. _____
Related Miscellaneous numbers: _____
Defendant(s) in federal custody as of _____
Defendant(s) in state custody as of _____
Rule 20 from the District of _____
Is this a potential death penalty case? (Yes or No) No

7. Does this case originate from a matter pending in the Northern Region of the U.S. Attorney's Office prior to October 14, 2003? Yes ___ No X

8. Does this case originate from a matter pending in the Central Region of the U. S. Attorney's Office prior to September 1, 2007? Yes ___ No X

DAVID A. SNIDER
DOJ TRIAL ATTORNEY
Court ID No. A5502260

*Penalty Sheet(s) attached

REV 5/3/17

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

PENALTY SHEET

Defendant's Name: **JESUS ESCOBAR MONTERO**

Case No:

Counts #: 1 – 4

Health Care Fraud

Title 18, United States Code, Section 1347

***Max Penalty**: Ten (10) years' imprisonment as to each count

Count #:

***Max Penalty**:

Count #:

*Max Penalty:

Count #:

*Max Penalty:

***Refers only to possible term of incarceration, does not include possible fines, restitution, special assessments, parole terms, or forfeitures that may be applicable.**