UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 16-20412 CR-GAYLES

18 U.S.C. § 371
18 U.S.C. § 1349
18 U.S.C. § 982(a)(7)

MAGISTRATE JUDGE
TURNOFF

UNITED STATES OF AMERICA

vs.

JOANNA CARPIO and
LEONIE DORCE,

Defendants.

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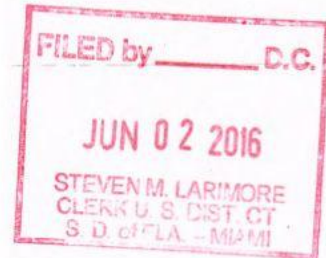

INDICTMENT

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 paid for insulin injections by an HHA if 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 paid for a portion of the cost of certain necessary medical services and medications that were provided and ordered by physicians, clinics, and other qualified health care providers. Medicare Part B was 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 were 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 provided services to Medicare beneficiaries are able to apply for and obtain a "provider number." A health care provider who was issued 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 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, Related Companies and Individuals

14. Pacific Medical & Rehabilitation Center, Inc. ("Pacific Medical") was incorporated on or about May 1, 2004, with its principal place of business in Miami-Dade County, in the Southern District of Florida.

15. City Center Rehab Corp ("City Center") was incorporated on or about November 14, 2009.

16. Marlys Tabares, a resident of Miami-Dade County, was an owner and operator of Pacific Medical and City Center.

17. Steven Lee Bolanos, a resident of Miami-Dade County, was an owner and operator of Pacific Medical and City Center.

18. Defendant **JOANNA CARPIO**, a resident of Miami-Dade County, was an employee and office manager of Pacific Medical and City Center.

19. Defendant **LEONIE DORCE**, a resident of Miami-Dade County, was an Advanced Registered Nurse Practitioner (ARNP) licensed to write prescriptions in the state of Florida. She practiced at City Center.

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

1. Paragraphs 1 through 18 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 June of 2009, and continuing through in or around October of 2015, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

JOANNA CARPIO,

did willfully, that is, with the intent to further the objects of the conspiracy, and knowingly combine, conspire, confederate and agree with others known and unknown to the Grand Jury, including Marlys Tabares and Steven Bolanos, 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 her co-conspirators to unlawfully enrich themselves by: (1) soliciting and receiving kickbacks and bribes from co-conspirator patient recruiters, home health clinic owners, medical device suppliers and other service providers in return for dispensing prescriptions for medical services and supplies; and (2) submitting and causing the submission of claims to Medicare for home health services, medical devices, and services.

MANNER AND MEANS OF THE CONSPIRACY

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

4. **JOANNA CARPIO,** Marlys Tabares, and Steven Bolanos, solicited and received kickbacks and bribes from patient recruiters and home health agencies owners, in return for providing prescriptions for home health care for Medicare beneficiaries.

5. **JOANNA CARPIO,** Marlys Tabares, and Steven Bolanos, solicited and received kickbacks and bribes from a number of medical service providers, including companies that provided genetic testing, toxicology screening, durable medical equipment, in return for providing prescriptions or referral forms for those services to Medicare beneficiaries.

6. **JOANNA CARPIO** and her co-conspirators caused Miami-Dade County home health agencies and other service providers to submit claims to Medicare for home health services and other medical services purportedly provided to Medicare beneficiaries, based upon prescriptions for which the co-conspirators were paid kickbacks and bribes.

7. As a result of these claims, Miami-Dade County home health agencies and other medical service providers received payments from Medicare.

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 October 21, 2013, **JOANNA CARPIO** wrote handwritten notes on a patient sign-in sheet to keep track of kickback payments.

2. On or about April 9, 2014, **JOANNA CARPIO** pre-filled a prescription/referral form for a pharmacy, which was used to obtain a kickback.

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

COUNT 2
Conspiracy to Commit Health Care Fraud and Wire Fraud
(18 U.S.C. § 1349)

1. Paragraphs 1 through 19 of the General Allegations section of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

2. Beginning in or around June of 2009, and continuing through in or around October of 2015, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendants,

JOANNA CARPIO and
LEONIE DORCE,

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 Marlys Tabares, Stephen Bolanos, and others, known and unknown to the Grand Jury, to commit offenses against the United States, that is:

a. to knowingly and willfully 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 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, in violation of Title 18, United States Code, Section 1347; and

b. to knowingly and with the intent to defraud, devise and intend to devise a scheme and artifice to defraud and for obtaining money and property by means of materially false and fraudulent pretenses, representations, and promises, knowing the pretenses, representations and promises were false and fraudulent when made, and for the purpose of executing the scheme and artifice, did knowingly transmit and cause to be transmitted by means of wire communication in interstate and foreign commerce, any writings, signs, signals, pictures or sounds, in violation of Title 18, United States Code, Section 1343.

PURPOSE OF THE CONSPIRACY

3. It was a 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 Medicare; and (b) concealing the submission of false and fraudulent claims to Medicare.

MANNER AND MEANS

The manner and means by which the defendants and their co-conspirators sought to accomplish the objects and purpose of the conspiracy included, among other things:

4. **JOANNA CARPIO, LEONIE DORCE,** and their co-conspirators caused the submission of false and fraudulent claims, via interstate wire, which falsely and fraudulently represented that Pacific and City Center provided or referred services that were medically necessary and performed or referred by a properly-licensed medical professional on the date indicated.

5. **JOANNA CARPIO, LEONIE DORCE,** and their co-conspirators falsified and caused the falsification of prescriptions for home health services and other medical services and supplies which were not medically necessary.

6. **JOANNA CARPIO, LEONIE DORCE,** and their co-conspirators caused Miami-Dade home health agencies and other medical service and equipment providers to submit false and fraudulent claims for home health services and other medical services and supplies, which were not medically necessary and not properly prescribed.

7. As a result of these claims, Miami-Dade County home health agencies and other medical service and equipment providers received payment from Medicare.

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

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 each defendant, **JOANNA CARPIO** and **LEONIE DORCE**, has an interest.

2. Upon conviction of a violation of Title 18, United States Code, Section 371 or 1349, as alleged in this Indictment, each 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, Sections 982(a)(7) and the procedures set forth in Title 21, United States Code, Section 853.

A TRUE BILL

FOREPERSON

WIFREDO A. FERRER
UNITED STATES ATTORNEY

JOSEPH BEEMSTERBOER

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

for KATHERINE PAYERLE
TRIAL ATTORNEY
CRIMINAL DIVISION, FRAUD SECTION
U.S. DEPARTMENT OF JUSTICE