

FILED by TB D.C.

Jun 11, 2015

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
15-20430-CR-LENARD/GOODMAN

Case No. _____

18 U.S.C. § 371

18 U.S.C. § 982

UNITED STATES OF AMERICA

vs.

ALFREDO RAMOS,

Defendant.

INFORMATION

The United States Attorney charges that:

GENERAL ALLEGATIONS

At all times material to this Information:

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.

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. Medicare paid 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. 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.

The Defendant and Related Entities

12. Professional Medical Home Health LLC (“Professional Home Health”) was a Florida limited liability corporation incorporated on or about August 3, 2006, that did business in Miami-Dade County, Florida, as an HHA that purportedly provided home health care services to eligible Medicare beneficiaries. On or about December 30, 2008, Professional Home Health obtained its Medicare provider number, which authorized Professional Home Health to submit claims to Medicare for HHA-related benefits and services.

13. USA Home Care Solution Agency, Corp. (“USA Home Care”) was a Florida limited liability corporation incorporated on or about June 30, 2004, that did business in Miami-Dade County, Florida, as an HHA that purportedly provided home health care services to eligible Medicare beneficiaries. On or about March 15, 2008, USA Home Care obtained its Medicare provider number, which authorized USA Home Care to submit claims to Medicare for HHA-related benefits and services.

14. Longcare Home Health Corporation (“Longcare Home Health”) was a Florida limited liability corporation incorporated on or about September 16, 2005. that did business in Miami-Dade County, Florida, as an HHA that purportedly provided home health care services to eligible Medicare beneficiaries. On or about September 22, 2006. Longcare Home Health obtained its Medicare provider number, which authorized Longcare Home Health to submit claims to Medicare for HHA-related benefits and services.

15. ATA Management Services, Inc. (“ATA Management”) was a limited liability

corporation organized under the laws of the State of Florida, which purportedly did business at 1116 Southwest 117 Court, Miami, Florida, 33184.

16. Defendant **ALFREDO RAMOS**, a resident of Miami-Dade County, was the President and Director of ATA Management.

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

From in or around at least November 2010, and continuing through in or around at least April 2014, the exact dates being unknown to the United States Attorney, at Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

ALFREDO RAMOS,

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, 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; and to commit certain offenses 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 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

17. 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 in return for

referring Medicare beneficiaries to Professional Home Health, USA Home Care, and Longcare Home Health to serve as patients; and (2) submitting and causing the submission of claims to Medicare for home health services that the co-conspirators 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:

18. **ALFREDO RAMOS** solicited and received kickbacks from co-conspirators at Professional Home Health, USA Home Care, and Longcare Home Health in exchange for referring Medicare beneficiaries to Professional Home Health, USA Home Care, and Longcare Home Health for home health services.

19. **ALFREDO RAMOS** and his co-conspirators caused Professional Home Health, USA Home Care, and Longcare Home Health to submit claims to Medicare for home health services purportedly rendered to the recruited Medicare beneficiaries.

20. **ALFREDO RAMOS** and his co-conspirators caused monies to be paid by Medicare to Professional Home Health, USA Home Care, and Longcare Home Health based upon the claims for home health services purportedly rendered to the recruited Medicare 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 February 29, 2012, **ALFREDO RAMOS** deposited check number 3499, drawn on the corporate account of Professional Home Health in the approximate amount

of \$2,000, into his personal bank account at Bank of America.

2. On or about May 10, 2012, **ALFREDO RAMOS** deposited check number 6120, drawn on the corporate account of USA Home Care in the approximate amount of \$4,000, into an account held in the name of ATA Management, a company he controlled.

3. On or about March 14, 2013, **ALFREDO RAMOS** deposited check number 2650, drawn on the corporate account of Longcare Home Health in the approximate amount of \$4,200, into an account held in the name of ATA Management, a company he controlled.

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

CRIMINAL FORFEITURE
(18 U.S.C. § 982)

1. The allegations contained in this Information are re-alleged and incorporated by reference as though fully set forth herein for the purposes of alleging forfeiture to the United States of America of certain property in which the defendant **ALFREDO RAMOS** has an interest.


2. Upon conviction of the offense charged in this Information, the defendant shall forfeit to the United States all of his right, title and interest in 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. If any of the property described above, as a result of any act or omission of the defendant:

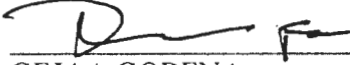
- a. cannot be located upon the exercise of due diligence;
- b. has been transferred or sold to, or deposited with, a third party;
- c. has been placed beyond the jurisdiction of the court;
- d. has been substantially diminished in value; or

e. has been commingled with other property which cannot be divided without difficulty,

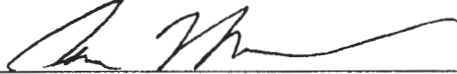
the United States of America shall be entitled to forfeiture of substitute property pursuant to Title 21, United States Code, Section 853(p), as incorporated by Title 18, United States Code, Section 982(b)(1).



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