UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 18-20559-CR-WILLIAMS/TORRES

18 U.S.C. § 371
18 U.S.C. § 982

UNITED STATES OF AMERICA

vs.

RICARDO VENTO,

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 1320-7b(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. Payments for home health care medical services were typically made directly to a Medicare-certified HHA or provider based on claims submitted to the Medicare program for qualifying services that had been provided to eligible beneficiaries.

4. "Part B" of the Medicare program covered outpatient hospital services and professional services provided by physicians and other providers; it also covered certain drugs provided "incident to" a physician's service and durable medical equipment.

5. Physicians, clinics, and other health care providers that provided services to Medicare beneficiaries were able to apply for and obtain a "provider number." A health care provider who has been 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 Medicare Part A Program

6. 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.

Reimbursements

7. 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

8. 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.

9. Among the written records required to document the appropriateness of home health care claims submitted under Part A of Medicare were: (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.

10. Additionally, Medicare Part A regulations required HHAs to maintain medical records of every visit made by a nurse, therapist, or home health aide to a patient. 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 teaching and the understanding of the patient, and any changes in the patient's physical or emotional condition. The home health aide was 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 "skilled nursing progress notes" and "home health aide notes/observations."

11. 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.

12. In order to receive Medicare reimbursements, HHAs were required to complete a Provider/Supplier Enrollment Application, also known as Form CMS-855A, as well as provide supporting documentation. HHAs were required to provide truthful and accurate information in the application, and an authorized official was required to certify that all information provided in the application was true, correct, and complete.

The Medicare Part B Program

13. Medicare Part B was administered in Florida by First Coast Service Options, a company that contracted with CMS to receive, adjudicate, process, and pay certain Part B claims.

14. Payments under the Medicare Program were often made directly to the physician, medical clinic, or other qualified provider of the medical goods or services, rather than to the beneficiary. This occurred when the provider accepted assignment of the right to payment from the beneficiary. In that case, the provider submitted the claim to Medicare for payment, either directly or through a billing company.

15. Physicians, medical clinics, and other health care providers that provided services to Medicare beneficiaries were able to apply for and obtain a "provider number." A health care provider who was issued a Medicare provider number was able to file bills, known as "claims," with Medicare to obtain reimbursement for services provided to beneficiaries. The claim form was required to contain certain important information, including: (1) the Medicare beneficiary's name and Health Insurance Claim Number (HICN); (b) a description of the health care benefit, item, or service that was provided or supplied to the beneficiary; (c) the billing codes for the benefit, item, or service; (d) the date upon which the benefit, item, or service was provided or supplied to the beneficiary; and (e) the name of the referring physician or other health care provider, as well as a

unique identifying number, known either as the Unique Physician Identification Number (UPIN) or National Provider Identifier (NPI). The claim form could be submitted in hard copy or electronically.

16. When a claim was submitted to Medicare, the provider certified that the contents of the form were true, correct, complete, and that the form was prepared in compliance with the laws and regulations governing the Medicare program. The provider further certified that the services being billed were medically necessary and were in fact provided as billed.

17. Pursuant to federal statutes and regulations, Medicare only paid for health care benefits, items or other services that were medically necessary and ordered by a licensed doctor or other licensed, qualified health care provider.

The Defendant and Relevant Entities

18. Sunshine Medical Care Group, Inc. ("Sunshine Medical") was a Florida corporation, located at 3990 W. Flagler Street, Suite 406, Miami, Florida, that purportedly operated as a medical clinic that provided services to patients, including Medicare beneficiaries.

19. Elite Home Care, LLC ("Elite") was a Florida corporation, located at 1200 NW 78 Avenue, #114, Doral, Florida, that purportedly provided home health care and physical therapy services to eligible Medicare beneficiaries.

20. Defendant **RICARDO VENTO** was a resident of Miami-Dade County.

CONSPIRACY TO SOLICIT AND RECEIVE HEALTH CARE KICKBACKS
(18 U.S.C. § 371)

From in or around February of 2013, through in or around September of 2015, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

RICARDO VENTO,

did willfully, that is, with the intent to further the object of the conspiracy, and knowingly combine, conspire, confederate, and agree with others, known and unknown to the United States Attorney, 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 any item and service for which payment may be made in whole and in part by a Federal health care program, that is, Medicare.

Purpose of the Conspiracy

21. It was the purpose of the conspiracy for the defendant and his co-conspirators to unlawfully enrich themselves by, among other things: (1) soliciting and receiving kickbacks and bribes in return for referring Medicare beneficiaries to Sunshine Medical and Elite to serve as patients, and (2) submitting and causing the submission of claims to Medicare for health services that Sunshine Medical and Elite 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 object and purpose of the conspiracy included, among other things, the following:

22. **RICARDO VENTO** received kickbacks from co-conspirators in exchange for referring Medicare beneficiaries to serve as patients at Sunshine Medical and Elite.

23. **RICARDO VENTO** and his co-conspirators caused Sunshine Medical and Elite to submit claims to Medicare for health services purportedly provided to Medicare beneficiaries.

24. As a result of the submission of these claims, **RICARDO VENTO** and his co-conspirators caused Medicare to make overpayments to Sunshine Medical and Elite for health services purportedly provided to Medicare beneficiaries.

Overt Acts

In furtherance of the conspiracy, and to accomplish its object and purpose, at least one of the co-conspirators 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 May 2015, **RICARDO VENTO** received a cash kickback in exchange for his referral of patient I.F. to Sunshine Medical.

2. In or around September 2013, **RICARDO VENTO** received a cash kickback in exchange for his referral of patient S.G. to Sunshine Medical.

3. In or around July 2015, **RICARDO VENTO** received a cash kickback in exchange for his referral of patient R.A. to Sunshine Medical.

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

FORFEITURE
(18 U.S.C. § 982)

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

2. Upon conviction of violation of Title 18, United States Code, Section 371, as alleged in this Information, the defendant shall forfeit to the United States any property, real or personal, which 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). The property subject to forfeiture is $16,200, which the United States will seek as a forfeiture money judgment.

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 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).

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, made applicable by Title 18, United States Code Section 982(b)(1).

BENJAMIN G. GREENBERG
UNITED STATES ATTORNEY
SOUTHERN DISTRICT OF FLORIDA

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

By: _____
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