UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 14-20263

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

CR-MIDDLEBROOKS

MAGISTRATE JUDGE
GARBER

UNITED STATES OF AMERICA

vs.

ISRAEL BENIGNO GIL,

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 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." The benefits available under Medicare were governed by federal statutes and regulations.

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. Title 42, United States Code, Section 1320a-7b(b) prohibited Medicare beneficiaries from knowingly and willfully receiving any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, related to any goods and services for which payment may have been made in whole or in part under a Federal health care program such as Medicare.

4. 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 beneficiaries who 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.

5. Home health care agencies, pharmacies, physicians, and other health care providers that provided services to beneficiaries were able to apply for and obtain a Medicare Identification Number or "provider number." In the application, the provider acknowledged that to be able to participate in the Medicare program, the provider must comply with all Medicare related laws and regulations. A provider who was issued a Medicare Identification Number was able to file claims with Medicare to obtain reimbursement for services provided to beneficiaries. The Medicare Identification Number uniquely identified the provider on its submissions to Medicare. A Medicare claim was required to set forth, among other things, the beneficiary's name and Medicare identification number, the services that were 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 ordered the services.

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"), located in Columbia, South Carolina. 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 contracted with SafeGuard Services, a Zone Program Integrity Contractor. SafeGuard Services safeguarded the Medicare Trust Fund by reviewing HHA providers' claims for potential fraud, waste, and/or abuse.

Part A Coverage and Regulations

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 ("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.

8. Medicare paid certified HHAs a predetermined base payment for each 60 days that care was needed. This 60-day period was called an "episode of care." The base payment was adjusted based on the health condition and care needs of the beneficiary. This adjustment was done through the Outcome and Assessment Information Set ("OASIS"), which was a patient assessment tool for measuring and detailing the patient's condition. If a beneficiary was still eligible for care after the end of the first episode of care, a second episode of care could commence. There were no limits to the number of episodes of home health benefits a beneficiary could receive as long as the beneficiary remained eligible.

9. In order to be reimbursed, the HHA would submit a Request for Anticipated Payment ("RAP") and subsequently received a portion of their payment in advance at the beginning of the episode. At the end of a 60 day episode, the HHA submitted the final claim and received the remaining portion of the payment.

Record Keeping Requirements

10. 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 the 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.

11. Among the written records required to document the appropriateness of home health care claims submitted under Part A of Medicare was a (i) POC 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.

12. 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."

13. Medicare regulations allowed Medicare certified HHAs to subcontract home health care services to nursing companies, 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.

14. 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.

15. The Defendant, **ISRAEL BENIGNO GIL,** a resident of Miami-Dade County, Florida, was a Medicare beneficiary due to his age and purported disability.

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

1. Paragraphs 1 through 15 of the General Allegations section of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

2. On or about the dates enumerated below as to each count, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

ISRAEL BENIGNO GIL,

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

Count	Approximate Date	Approximate Kickback Amount
1	03/4/2011	$1,000
2	05/26/2011	$400

In violation of Title 42, United States Code, Section 1320a-7b(b)(1)(B), and Title 18, United States Code, Section 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, **ISRAEL BENIGNO GIL,** has an interest.

2. Upon conviction of any violation of 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).

3. The property subject to forfeiture includes a money judgment in the amount of the value of the gross proceeds traceable to the commission of the health care offenses alleged in this Indictment.

4. If any of the property described above, as a result of any act or omission of any of the defendants:

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;

it is the intent of the United States of America to seek forfeiture of substitute property pursuant to Title 21, United States Code, Section 853(p).

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

_____
FOREPERSON

WIFREDO A. FERRER
UNITED STATES ATTORNEY

ROBERT T. WATSON
ASSISTANT U.S. ATTORNEY