UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 12-20230 CR-UNGARO/TORRES

18 U.S.C. § 1349
18 U.S.C. § 1347
18 U.S.C. § 371
42 U.S.C. § 1320a-7b(b)(1)(A)
18 U.S.C. § 2
18 U.S.C. § 982

UNITED STATES OF AMERICA

vs.

YANURIS LIMA,
SERVANDO RAYA,
JOSE GUERRA,
YUMIDIA NARANJO,
ODALYS FERNANDEZ, and
KELVIN SOTO,

Defendants.
_____/

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. 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. 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.

Part A Coverage and Regulations

Reimbursements

5. 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

6. 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.

7. 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.

8. 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."

9. 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.

10. 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 Defendants and Related Companies

11. Ideal Home Health, Inc. (hereinafter "Ideal") was incorporated on April 7, 2005 and did business in Miami-Dade County, purportedly providing skilled nursing services and home health aide services to Medicare beneficiaries that required home health services. In August of 2006, Ideal began providing services to Medicare beneficiaries. In or around November of 2006, Ideal became a Medicare certified HHA and submitted claims directly to Medicare under Medicare Provider Number 108338.

12. Defendant **YANURIS LIMA** was the owner of Y. Lima LLC, a corporation organized under the laws of the State of Florida which purportedly did business at 2460 SW 15th Street Miami, Florida 33145

13. Defendant **SERVANDO RAYA** was employed as a Home Health Aide by Ideal.

14. Defendant **YUMIDIA NARANJO** was employed as a Home Health Aide by Ideal.

15. Defendant **JOSE GUERRA** was a resident of Miami-Dade County.

16. Defendant **KELVIN SOTO** was a Registered Nurse (R.N.) employed by Ideal. As an R.N. in the home health field, it was his duty to provide skilled nursing services to patients and maintain proper documentation of all treatments provided to patients.

17. Defendant **ODALYS FERNANDEZ** was a Registered Nurse (R.N.) employed by Ideal. As an R.N. in the home health field, it was her duty to provide skilled nursing services to patients and maintain proper documentation of all treatments provided to patients.

COUNT 1
Conspiracy to Commit Health Care Fraud
(18 U.S.C. § 1349)

1. Paragraphs 1 through 11 and paragraphs 16 and 17 of the General Allegations section of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

2. From on or about August 17, 2007, and continuing through on or about March 19, 2009, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendants,

KELVIN SOTO and
ODALYS FERNANDEZ,

did knowingly and willfully combine, conspire, confederate and agree with Elizabeth Sanz and others known and unknown to the Grand Jury, to violate Title 18, United States Code, Section 1347, that is, to 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.

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; (b) paying and accepting kickbacks and bribes to Medicare beneficiaries in exchange for the use of their Medicare beneficiary numbers as the bases of claims filed for home health care; and (c) concealing the submission of false and fraudulent claims.

MANNER AND MEANS OF THE CONSPIRACY

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

4. **KELVIN SOTO** and **ODALYS FERNANDEZ** falsified and caused Medicare beneficiaries to falsify "Weekly Visit / Time Record" sheets which indicated that they provided skilled nursing services to Medicare beneficiaries two times per day, seven days per week when, in truth and in fact, they did not provide skilled nursing services with such frequency.

5. **KELVIN SOTO** and **ODALYS FERNANDEZ** falsified "Skilled Nursing Progress Note" sheets wherein they falsely represented that they administered insulin injections and provided various other medical services to Medicare beneficiaries on particular dates when, in truth and in fact, they did not provide such services.

6. **KELVIN SOTO** and **ODALYS FERNANDEZ** caused Ideal to submit false and fraudulent claims to Medicare for home health benefits by falsely representing, among other things, that home health services had been provided to home health eligible Medicare beneficiaries.

7. As a result of the false and fraudulent claims, **KELVIN SOTO** and **ODALYS**

FERNANDEZ caused Medicare to make payments to Ideal.

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

COUNTS 2-10
Health Care Fraud
(18 U.S.C. § 1347)

1. Paragraphs 1 through 11 and paragraphs 16 and 17 of the General Allegations section of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

2. From on or about August 17, 2007, and continuing through on or about March 19, 2009, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendants,

KELVIN SOTO
and ODALYS FERNANDEZ,

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 a purpose of the scheme and artifice for the defendants and their accomplices to unlawfully enrich themselves by, among other things: (a) submitting and causing the submission of false and fraudulent claims to Medicare; (b) paying and accepting kickbacks and bribes for referring Medicare beneficiaries so that their Medicare beneficiary numbers would serve as the bases of claims filed for home health care; and (c) concealing the submission of false and fraudulent claims.

claims.

The Scheme and Artifice

4. The allegations contained in paragraphs 4 through 7 of the Manner and Means section of Count 1 of this Indictment are realleged and incorporated by reference as though fully set forth herein as a description of the scheme and artifice.

Acts in Execution or Attempted Execution of the Scheme and Artifice

5. On or about the dates set forth below as to each count, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendants as specified below, 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 defendants submitted and caused the submission of false and fraudulent Medicare claims, as further described below, representing that Ideal had provided various home health services to beneficiaries pursuant to physicians' P.O.C.s:

Count	Defendant	Medicare Beneficiary	Approx. Date of Submission of Claim	Medicare Claim Number	Services Claimed; Approx. Amount Claimed
2	**ODALYS FERNANDEZ**	K.D.	09/21/2007	20726403422205	Skilled Nursing, Home Health Aide, Occupational Therapy, Physical Therapy; $20,430

Count	Defendant	Medicare Beneficiary	Approx. Date of Submission of Claim	Medicare Claim Number	Services Claimed; Approx. Amount Claimed
3	**ODALYS FERNANDEZ**	E.G.	09/28/2007	20727101442105	Skilled Nursing, Home Health Aide; $18,000
4	**ODALYS FERNANDEZ**	R.A.	10/17/2007	20729003859505	Skilled Nursing, Home Health Aide; $18,000
5	**ODALYS FERNANDEZ**	K.D.	12/3/2007	20733705373005	Skilled Nursing, Home Health Aide; $13,500
6	**ODALYS FERNANDEZ**	C.P.	02/29/2008	20806000952705	Skilled Nursing, Home Health Aide, Physical Therapy; $12,110
7	**KELVIN SOTO**	E.D.	08/04/2008	20821704734105	Skilled Nursing, Home Health Aide; $14,600
8	**KELVIN SOTO**	L.B.	03/19/2009	20907821760408	Skilled Nursing, Home Health Aide; $14,600
9	**KELVIN SOTO**	F.B.	03/19/2009	20907848298708	Skilled Nursing, Home Health Aide; $14,600
10	**KELVIN SOTO**	R.D.	03/19/2009	20907855305708	Skilled Nursing, Home Health Aide; $14,600

In violation of Title 18, United States Code, Sections 1347 and 2.

COUNT 11
Conspiracy to Receive Health Care Kickbacks
(18 U.S.C. § 371)

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. Beginning on or about July 5, 2007, and continuing through on or about February 27, 2009, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendants,

YANURIS LIMA,

SERVANDO RAYA,
YUMIDIA NARANJO,
JOSE GUERRA,

did willfully, that is, with the intent to further the object of the conspiracy, and knowingly combine, conspire, confederate and agree with Elizabeth Sanz and others known and unknown to the Grand Jury, to commit an offense 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 any kickback and bribe, directly and indirectly, overtly and covertly, 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 by a Federal health care program, that is, Medicare.

PURPOSE OF THE CONSPIRACY

3. It was the purpose of the conspiracy for the defendants and their co-conspirators to unlawfully enrich themselves by: (1) paying and accepting kickbacks and bribes for referring Medicare beneficiaries so that their Medicare beneficiary numbers would serve as the bases of claims filed for home health care; and (2) submitting 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 defendants and their co-conspirators sought to accomplish the object and purpose of the conspiracy included, among others, the following:

1. **YANURIS LIMA, SERVANDO RAYA, YUMIDIA NARANJO** and **JOSE GUERRA** accepted kickbacks in return for recruiting Medicare beneficiaries to be placed at Ideal.

2. **YANURIS LIMA, SERVANDO RAYA, YUMIDIA NARANJO** and **JOSE**

GUERRA caused Ideal to submit claims to Medicare for home health services purportedly rendered to Medicare beneficiaries.

3. **YANURIS LIMA, SERVANDO RAYA, YUMIDIA NARANJO** and **JOSE GUERRA** caused Medicare to pay Ideal, based upon home health services alleged to have been rendered 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. On or about October 18, 2007, **SERVANDO RAYA** deposited check no. 1131 drawn on Ideal's corporate account in the approximate amount of $2,800.

2. On or about February 4, 2008, **YANURIS LIMA** cashed check no. 1735 drawn on Ideal's corporate account in the approximate amount of $2,700.

3. On or about July 15, 2008, **JOSE GUERRA** cashed check no. 2940 drawn on Ideal's corporate account in the approximate amount of $2,100.

4. On or about September 15, 2008, **SERVANDO RAYA** deposited check no. 3373 drawn on Ideal's corporate account in the approximate amount of $1,500.

5. On or about October 30, 2008, **YUMIDIA NARANJO** cashed check no. 3728 drawn on Ideal's corporate account in the approximate amount of $5,000.

6. On or about November 7, 2008, **YANURIS LIMA** cashed check no. 3874 drawn on Ideal's corporate account in the approximate amount of $7,450.

7. On or about January 9, 2009, **JOSE GUERRA** cashed check no. 4435 drawn on

Ideal's corporate account which was made out to **JOSE GUERRA** in the approximate amount of $4,800.

8. On or about February 13, 2009, **YUMIDIA NARANJO** cashed check no. 4636 drawn on Ideal's corporate account in the approximate amount of $5,950.

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

COUNTS 12-21
Receipt of Kickbacks in Connection with a Federal Health Care Program (42 U.S.C. § 1320a-7b(b)(1)(A))

On or about the dates enumerated below as to each count, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendants as specified below, did knowingly and willfully solicit and receive remuneration, including any kickback and bribe, by check, directly and indirectly, overtly and covertly, in return for referring an individual to a person for the furnishing and arranging for the furnishing of an item and service, 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	Defendant	Approximate Date	Approximate Kickback Amount
12	**SERVANDO RAYA**	02/18/2008	$2,500
13	**YANURIS LIMA**	06/12/2008	$4,400
14	**YANURIS LIMA**	06/14/2008	$3,000
15	**YANURIS LIMA**	06/15/2008	$2,000
16	**YANURIS LIMA**	06/15/2008	$4,200
17	**SERVANDO RAYA**	09/29/2008	$1,500
18	**YUMIDIA NARANJO**	11/17/2008	$6,000
19	**YUMIDIA NARANJO**	11/17/2008	$7,000

Count	Defendant	Approximate Date	Approximate Kickback Amount
20	**JOSE GUERRA**	12/11/2008	$6,320
21	**JOSE GUERRA**	12/15/2008	$8,200

In violation of Title 42, United States Code, Section 1320a-7b(b)(1)(A) and Title 18, United States Code, Section 2.

FORFEITURE
(18 U.S.C. § 982 (a)(7))

1. The allegations contained in this Indictment are realleged 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 defendants, **YANURIS LIMA, SERVANDO RAYA, YUMIDIA NARANJO, JOSE GUERRA, ODALYS FERNANDEZ** and **KELVIN SOTO** have an interest.

2. Upon conviction of any violation of Title 18 United States Code Sections 1347 or 1349 or Title 42 United States Code Section 1320a-7(b), as alleged in Counts 1 through 12 of this Indictment, the defendants, **YANURIS LIMA, SERVANDO RAYA, YUMIDIA NARANJO, JOSE GUERRA, ODALYS FERNANDEZ** and **KELVIN SOTO**, 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, Sections 982 (a)(7) and 981 (a)(1)(c).

All pursuant to Title 28, United States Code, Section 2461; Title 18, United States Code, Sections 981 (a)(1)(C) and 982 (a)(7); and Title 21, United States Code, Section 853.

A TRUE BILL

_____
FOREPERSON

WIFREDO A. FERRER
UNITED STATES ATTORNEY

DANIEL BERNSTEIN
ASSISTANT U.S. ATTORNEY