UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 12-20290 CR-ALTONAGA

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

MAGISTRATE JUDGE SIMONTON

FILED by D.C.
APR 26 2012
STEVEN M. LARIMORE
CLERK U. S. DIST. CT
S. D. of FLA. – MIAMI

UNITED STATES OF AMERICA

vs.

RODOLFO NIETO, JR.,

Defendant.
_____/

Certified to be a true and correct copy of the document on file
Steven M. Larimore, Clerk,
U.S. District Court
Southern District of Florida
By _____ Deputy Clerk
Date 4/26/12

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 federal health care program providing benefits to persons who were over the age of 65 or disabled. Medicare was administered by the United States Department of Health and Human Services ("HHS") through its agency, the Centers for Medicare & Medicaid Services ("CMS"). Individuals who received benefits under Medicare were referred to as Medicare "beneficiaries."

2. Medicare was a "health care benefit program," as defined by Title 18, United States Code, Section 24(b).

3. "Part A" of the Medicare program covered certain eligible home health care costs

for medical services provided by a home health agency ("HHA"), 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 under Medicare Part A were typically made directly to an HHA or provider based on claims submitted to the Medicare program for qualifying services that had been provided to eligible beneficiaries, rather than to the beneficiary.

4. 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 identification number of the physician or other health care provider who ordered the services.

5. CMS did not directly pay Medicare Part A claims submitted by Medicare-certified HHAs. CMS contracted with different 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") to administer Part A HHA claims. As administrator, Palmetto was to receive, adjudicate and pay claims submitted by HHA providers under the Part A program for home health claims.

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:

a. the patient was confined to the home, also referred to as homebound;

b. the patient 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 services, physical therapy, or speech therapy and that 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.

7. HHAs were reimbursed under the Home Health Prospective Payment System ("PPS"). Under PPS, Medicare paid Medicare-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 could commence. There were no limits to the number of episodes of home health benefits a beneficiary could receive as long as the beneficiary continued to qualify for home health benefits.

8. In order to be reimbursed, the HHA would submit a Request for Anticipated Payment ("RAP") and subsequently receive a portion of its payment in advance of services being

rendered. At the end of a 60-day episode, when the final claim was submitted, the remaining portion of the payment would be made. As explained in more detail below, "Outlier Payments" were additional PPS payments based on visits in excess of the norm. Palmetto paid Outlier Payments to HHA providers under PPS where the providers' RAP submissions established that the cost of care exceeded the established Health Insurance Prospective Payment System ("HIPPS") code threshold dollar amount.

Record Keeping Requirements

9. 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 actual treatment of the patients to whom services were provided and for whom claims for reimbursement were submitted by the HHAs. These medical records were required to be sufficient to permit Medicare, through Palmetto and other contractors, to review the appropriateness of Medicare payments made to the HHA under the Part A program.

10. Among the written records required to document the appropriateness of home health care claims submitted under Part A of Medicare was a POC that included the physician order for home health care, diagnoses, types of services/frequency of visits, prognosis/ rehabilitation potential, functional limitations/activities permitted, medications/treatments/ nutritional requirements, safety measures/discharge plans, goals, and the physician's signature. Also required was 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, and an OASIS.

11. 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 teaching 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."

Special Outlier Provision

12. Medicare regulations allowed certified home health agencies to subcontract home health care services to nursing companies, registries, or groups (nursing groups), which would, in turn, bill the certified home health agency. That certified home health agency would then bill Medicare for all services provided to the patient by the subcontractor. The HHA's professional supervision over arranged-for services required the same quality controls and supervision of its own employees. However, Medicare regulations prohibit one home health agency merely serving as a billing mechanism for another agency.

13. For insulin-dependent diabetic beneficiaries, Medicare paid for insulin injections by an HHA when a beneficiary was determined to be unable to inject his or her own insulin and the beneficiary had no available care-giver able and willing to inject the beneficiary. Additionally, for beneficiaries for whom occupational or physical therapy was medically necessary, Medicare paid for such therapy provided by an HHA. The basic requirements that a physician certify that a beneficiary is confined to the home or homebound and in need of home

health services, as certified by a physician, was a continuing requirement for Medicare to pay for such home health benefits.

14. While payment for each episode of care was adjusted to reflect the beneficiary's health condition and needs, Medicare regulations contained an "outlier" provision to ensure appropriate payment for those beneficiaries who had the most extensive care needs, which may result in an Outlier Payment to the HHA. These Outlier Payments were additions or adjustments to the payment amount based on an increased type or amount of medically necessary care. Adjusting payments through Outlier Payments to reflect the HHA's cost in caring for each beneficiary, including the sickest beneficiaries, ensured that all beneficiaries had access to home health services for which they were eligible.

NANY Home Health, Inc.

15. NANY Home Health, Inc. ("NANY HH") was a Florida corporation incorporated on or about February 8, 1995, that did business in Miami-Dade County, Florida, as an HHA that purported to provide home health care and physical therapy services to eligible Medicare beneficiaries. NANY HH was owned and operated by Roberto Gonzalez, Olga Gonzalez, Fabian Gonzalez and other co-conspirators.

16. On or about February 2, 2002, NANY HH obtained Medicare provider number 10-7732, authorizing NANY HH to submit claims to Medicare for HHA-related benefits and services.

17. From on or about January 1, 2006, through on or about November 15, 2009, NANY HH submitted approximately $60 million in claims to the Medicare program for home health services that it purportedly provided to approximately 1474 beneficiaries. As a result of the submission of these claims, Medicare, through Palmetto GBA, paid approximately $40

million to NANY HH.

RONAT Home Health Care, Inc.

18. RONAT Home Health Care, Inc. ("RONAT") was a Florida corporation incorporated on or about September 30, 2004, that did business in Miami-Dade County, Florida, as a "staffing agency" that purported to provide home health care and physical therapy services to eligible Medicare beneficiaries. RONAT was located at 12855 SW 136th Avenue, Suite 210, Miami, Florida.

19. On or about September 30, 2004, defendant **RODOLFO NIETO, JR.** took ownership and control of RONAT, listing himself as the president and registered agent. On the 2007 Articles of Amendment to the Articles of Incorporation for RONAT, filed August 24, 2007, RONAT moved to 12855 SW 136th Avenue, Suite 102, Miami, Florida. On this 2007 Articles of Amendment to the Articles of Incorporation for RONAT, **RODOLFO NIETO, JR.** certified that he was the president.

The Defendant

20. Defendant **RODOLFO NIETO, JR.,** a resident of Miami-Dade County, Florida, was at all relevant times an owner and operator of RONAT.

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

1. Paragraphs 1 through 20 of the General Allegations section of this Indictment are realleged and incorporated by reference as though fully set forth herein.

2. From in or around January 2006, and continuing through in or around November 2009, the exact dates being unknown to the Grand Jury, at Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

RODOLFO NIETO, JR.,

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), by knowingly and willfully soliciting and receiving remuneration, specifically, kickbacks and bribes, directly and indirectly, overtly and covertly, in return for referring individuals for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole or 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 defendant and his co-conspirators to unlawfully enrich themselves by: (1) paying and accepting kickbacks 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 defendant and his co-conspirators sought to accomplish the objects and purpose of the conspiracy included, among others, the following:

4. **RODOLFO NIETO, JR.** accepted kickbacks in return for recruiting Medicare beneficiaries to be placed at NANY HH.

5. Co-conspirator owners of NANY HH would offer and pay kickbacks to

RODOLFO NIETO, JR. through the same check RONAT received for providing purported home health care visits in order to disguise the payment of the kickback.

6. **RODOLFO NIETO, JR.** caused NANY HH to submit claims to Medicare for home health services allegedly rendered to Medicare beneficiaries through his company, RONAT.

7. **RODOLFO NIETO, JR.** caused Medicare to pay NANY HH based upon the claims for home health services allegedly rendered to Medicare beneficiaries through his company, RONAT.

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 March 26, 2008, **RODOLFO NIETO, JR.** deposited check No. 30837 drawn on NANY HH's corporate account in the approximate amount of $22,700 into RONAT Home Health Care, Inc.'s corporate account at Bank of America.

2. On or about May 2, 2008, **RODOLFO NIETO, JR.** deposited check No. 31065 drawn on NANY HH's corporate account in the approximate amount of $20,730 into RONAT Home Health Care, Inc.'s corporate account at Bank of America.

3. On or about July 2, 2008, **RODOLFO NIETO, JR.** deposited check No. 32637 drawn on NANY HH's corporate account in the approximate amount of $18,860 into RONAT Home Health Care, Inc.'s corporate account at Bank of America.

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

COUNTS 2-4
Receipt of Kickbacks in Connection with a Federal Health Care Benefit Program (42 U.S.C. § 1320a-7b(b)(1)(A))

1. Paragraphs 1 through 20 of the General Allegations section of this Indictment are realleged and incorporated by reference as though fully set forth herein.

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

RODOLFO NIETO, JR.,

did knowingly and willfully solicit and receive remuneration, that is, kickbacks and bribes, directly and indirectly, in the form of cash and checks, in return for referring an individual to a person for the furnishing and arranging for the furnishing of items and services for which payment may be made in whole and in part under a Federal health care program, that is, Medicare as set for below:

Count	On or About Date	Approximate Amount of Kickback Received
2	March 26, 2008	$22,700
3	May 2, 2008	$20,730
4	July 2, 2008	$18,860

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

CRIMINAL FORFEITURE
(18 U.S.C. § 982)

1. The allegations contained in this Indictment 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, **RODOLFO NIETO, JR.** has an

interest.

2. Upon conviction of a violation of, or a conspiracy to violate, Title 42, United States Code, Section 1320a-7b, as alleged in Counts 1 through 4 of this Indictment, the defendant shall forfeit all of his right, title and interest to the United States in property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of such violations, 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)(I).

A TRUE BILL

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