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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF PUERTO RICO

UNITED STATES OF AMERICA, v. **JUAN JOSE TULL-ABREU,** Defendant.	**INDICTMENT** **CRIMINAL NO. 14-484 (JAG)** **VIOLATIONS:** 18 U.S.C. §§ 1347, 1349, 1028A. 21 U.S.C. § 843(a)(4)(A). **FORFEITURE:** 18 U.S.C. § 981(a)(1)(C); 28 U.S.C. § 2461(c).

THE GRAND JURY CHARGES:

GENERAL ALLEGATIONS

At all times relevant to this indictment:

The Medicare Program

1. The Medicare Program ("Medicare") was a federal program that provides medical insurance for covered services to any person 65 years or older, to certain disabled persons, and to individuals with chronic renal disease who elected coverage under the program. Medicare was administered by the Centers for Medicare and Medicaid Services ("CMS") an agency of the United States Department of Health and Human Services ("HHS"), formerly known as the Health Care Financing Administration ("HCFA"). Individuals who receive benefits under Medicare are commonly referred to as Medicare "beneficiaries." Medicare is a health care benefit program as defined by 18 U.S.C. § 24(b).

2. The Medicare program was divided into different "parts". "Part A" of Medicare covers health services provided by hospitals, skilled nursing facilities, hospices and home health agencies. "Part B" of the Medicare Program is a medical insurance program that covers, among other things, certain physician services, outpatient services, and other services, including face to

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face office visits. "Part C" of Medicare, commonly referred to as Medicare Advantage (MA), provides beneficiaries with all of the services provided under Parts A and B (except hospice care), in addition to mandatory supplemental benefits and optional supplemental benefits.

3. Part C beneficiaries choose to enroll in a managed care plan administered by private health insurance companies or health maintenance organizations. A number of entities are contracted by CMS to provide managed care to Part C beneficiaries through various approved plans. Medical Card System ("MCS"), Triple-S ("SSS"), American Health Medicare ("AHM"), Humana and First Medical were insurance plans that contracted with CMS to provide managed care to beneficiaries under Part C, which covered office visits and related health care benefits, items and services. Among its responsibilities as a Medicare Advantage Plan, MCS, SSS, AHM, Humana and First Medical received, adjudicated, and paid the claims of authorized suppliers seeking reimbursements for the cost of health care benefits, items, or services supplied to Medicare Part C beneficiaries.

Medicare Billing Procedures

4. Physicians who perform medical services in connection with the Medicare program applied for and were given a "number." The number allowed the physician to submit bills, commonly referred to as "claims", for payment to Medicare, through MCS, SSS, AHM, Humana and First Medical in order to seek reimbursement for medical services that they had supplied to Medicare Part C beneficiaries.

5. In order to receive payment from Medicare through MCS, SSS, AHM, Humana, and First Medical, a physician was required to submit a health insurance claim form, known as Form HCFA-1500 ("HCFA 1500") through which the physician certified that the claims were true, correct, complete and that the form was prepared in compliance with the laws and

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regulations governing the Medicare program. The physician also certified that the services being billed were medically necessary and were in fact provided as billed. MCS, SSS, AHM, Humana and First Medical permitted authorized participant physicians to submit these claims either electronically or in hard copy claim forms. Each claim form required certain important information, including:

a. the supplier's Medicare identification number;

b. the Medicare beneficiary's name, address, and date of birth;

c. the Medicare beneficiary's identification number;

d. the name and identification number of the physician who ordered the item or service;

e. the health care products, items, or services supplied to the beneficiary;

f. the applicable Medicare billing codes for these products, or services;

g. the date of service; and

h. the diagnosis.

6. Under MA regulations, Medicare Part C would pay for the cost of participant physicians provided to the beneficiary. In order for MCS, SSS, AHM, Humana and First Medical to pay for physician services, the procedure must be medically necessary and performed.

7. For Medicare billing purposes, physician services provided to beneficiaries were identified by a Current Procedural Terminology ("CPT") code. The CPT codes for Office or Other Outpatient Services for an Established Patient include the following:

a. 99213: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem

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focused examination; medical decision making of low complexity.

b. 99214: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity.

These codes are classified by the CPT code as Evaluation and Management Codes. For medical billing purposes, these codes are used for face to face office visits.

COUNT ONE

Conspiracy to Commit Health Care Fraud
18 U.S.C. § 1349

8. Paragraphs 1 through 7 of the General Allegations of this Indictment are realleged and incorporated by reference as though fully set forth herein.

9. From on or about August 12, 2009, to in or about October, 2013, in the District of Puerto Rico, and elsewhere, the defendant,

JUAN JOSE TULL-ABREU,

did knowingly and willfully conspire and agree with others known and unknown to the Grand Jury to commit an offense against the United States, that is, to knowingly and willfully execute a scheme and artifice to defraud, 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 a health care benefit program as defined in 18 U.S.C. § 24(b), that is Medicare, in connection with the delivery of and payment for health care benefits, items, and services, in violation of 18 U.S.C. § 1347; all in violation of 18 U.S.C. § 1349.

OBJECT OF THE CONSPIRACY

10. The object of the conspiracy was that the defendant would unlawfully enrich

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himself by submitting false and fraudulent claims to Medicare through claims submissions to Medicare Advantage plans for medical services that were never performed.

MANNER AND MEANS OF THE CONSIRACY

11. The manner and means used by the members of the conspiracy to accomplish the objects of the conspiracy included, among other things, the following:

12. The defendant would cause to be submitted false and fraudulent claims for services, including face-to-face office visits, allegedly performed by the defendant at his Arecibo, Puerto Rico office on Fridays, which were never in fact performed due to the fact that the Arecibo office was closed on Friday. The defendant fraudulently billed Medicare $16,931.65, and he caused Medicare to pay $16,407.04 based on these false and fraudulent claims.

13. The defendant would cause to be submitted false and fraudulent claims for services, including face-to-face office visits, allegedly performed by the defendant at his Arecibo and Utuado, Puerto Rico, offices, which were never in fact performed due to the fact that the defendant was travelling out of the country when the services were allegedly performed. The defendant fraudulently billed Medicare $117,501.46, and he caused Medicare to pay $109,713.54 based on these false and fraudulent claims.

COUNTS TWO THROUGH NINE

Health Care Fraud
18 U.S.C. § 1347

14. Paragraphs 1 through 7 of the General Allegations of this Indictment are realleged and incorporated by reference as though fully set forth herein.

SCHEME AND ARTIFICE TO DEFRAUD

15. The scheme and artifice to defraud was that the defendant would unlawfully

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enrich himself by submitting false and fraudulent claims to Medicare through claims submissions to Medicare Advantage plans for medical services that were never performed.

MANNER AND MEANS OF THE SCHEME AND ARTIFICE TO DEFRAUD

16. The manner and means used by the defendant to accomplish the scheme and artifice to defraud included, among other things, the following:

17. The defendant would cause to be submitted false and fraudulent claims for services, including face-to-face office visits, allegedly performed by the defendant at his Arecibo, Puerto Rico office on Fridays, which were never in fact performed due to the fact that the Arecibo office was closed on Friday. The defendant fraudulently billed Medicare $16,931.65, and he caused Medicare to pay $16,407.04 based on these false and fraudulent claims.

18. The defendant would cause to be submitted false and fraudulent claims for services, including face-to-face office visits, allegedly performed by the defendant at his Arecibo and Utuado, Puerto Rico, offices, which were never in fact performed due to the fact that the defendant was travelling out of the country when the services were allegedly performed. The defendant fraudulently billed Medicare $117,501.46, and he caused Medicare to pay $109,713.54 based on these false and fraudulent claims.

19. On or about the dates listed below, in the District of Puerto Rico, and elsewhere, the defendant,

JUAN JOSE TULL-ABREU,

aiding and abetting others, knowingly and willfully executed a scheme and artifice to defraud, and obtained by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by and under the custody and control of a health care

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benefit program, as defined in 18 U.S.C. § 24(b), that is Medicare, in connection with the delivery of and payment for health care benefits, items, and services, all in violation of 18 U.S.C. § 1347.

COUNT	CLAIM NO.	PATIENT	DATE OF SERVICE	SERVICE CODE	AMOUNT BILLED
2	08122011edi0210	M.B.	8/12/2011	99214	$79.28
3	03072012edi0287	M.B.	2/10/2012	99214	$79.28
4	06202012edi0186	H.G.Z.	6/15/2012	99214	$79.28
5	05082012edi2879	H.G.Z.	5/4/2012	99214	$80.04
6	07312012edi0675	J.S.	7/28/2012	99214	$79.28
7	09042012edi0807	J.M.	7/27/2012	99214	$79.28
8	07132012edi0609	L.R.	7/5/2012	99214	$79.28
9	08212012edi0418	N.A.	7/30/2012	99214	$79.28

20. Each of the claims listed above constituting a separate and distinct violation of 18 U.S.C. § 1347.

COUNTS TEN THROUGH FIFTEEN

Aggravated Identity Theft
18 U.S.C. § 1028A(a)(1)

21. Paragraphs 1 through 7 of the General Allegations of this Indictment are realleged and incorporated by reference as though fully set forth herein.

22. On or about each of the dates listed below, in the District of Puerto Rico, and elsewhere, the defendant,

JUAN JOSE TULL-ABREU,

aiding and abetting others, did knowingly transfer, possess, and use, without lawful authority, a means of identification of another person, that is the names, dates of birth, and unique member

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identification numbers of other persons whose initials appear below, during and in relation to a felony violation enumerated in 18 U.S.C. § 1028A(c), that is a violation of 18 U.S.C. §§ 1347 (health care fraud), and 1349 (conspiracy):

COUNT	DATE	CLAIM NUMBER	VICTIM INITIALS
10	8/12/2011	08122011edi0210	M.B.
11	6/15/2012	06202012edi0186	H.G.Z.
12	7/28/2012	07312012edi0675	J.S.
13	7/27/2012	09042012edi0807	J.M.
14	7/5/2012	07132012edi0609	L.R.
15	7/30/2012	08212012edi0418	N.A.

23. Each count listed above constitutes a separate and distinct violation of 18 U.S.C. § 1028A(a)(1).

COUNTS SIXTEEN THROUGH NINETEEN
21 U.S.C. § 843(a)(4)(A)

24. On or about the dates listed below, in the District of Puerto Rico and elsewhere,

JUAN JOSE TULL-ABREU,

the defendant herein, aiding and abetting others, knowingly and intentionally furnished false and fraudulent material information in prescriptions for controlled substances, which were applications, reports, records, and documents required to be made, kept, and filed under Title 21, United States Code.

COUNT	DATE	CONTROLLED SUBSTANCE
16	12/24/2011	Percocet
17	7/22/2013	Percocet
18	12/12/2012	Percocet
19	7/23/2013	Percocet

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25. Each count listed above constitutes a separate and distinct violation of 21 U.S.C. § 843(a)(4)(A).

HEALTH CARE FRAUD FORFEITURE ALLEGATION

26. The allegations contained in Counts One through Nine of this Indictment are hereby re-alleged and incorporated by reference for the purpose of alleging forfeitures pursuant to 18 U.S.C. § 981(a)(1)(C) and 28 U.S.C. § 2461(c).

27. Upon conviction of one or more of the offenses in violation of 18 U.S.C. §§ 1347, 1349 set forth in Counts One through Nine of this Indictment, the defendant,

JUAN JOSE TULL-ABREU,

shall forfeit to the United States of America, pursuant to 18 U.S.C. § 981(a)(1)(C) and 28 U.S.C. § 2461(c), any property, real or personal, which constitutes or is derived from, proceeds traceable to the offenses.

28. If any of the property described above, as a result of any act or omission 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; has been placed beyond the jurisdiction of the court; c) has been substantially diminished in value; or d) 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 the forfeiture procedures of 21 U.S.C. § 853(p), as incorporated by 28 U.S.C. § 2461(c). All pursuant to 18 U.S.C. § 981(a)(1)(C) and 28 U.S.C. § 2461(c).

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ROSA EMILIA RODRIGUEZ-VELEZ
United States Attorney

TRUE BILL

Jose A. Ruiz-Santiago
Assistant United States Attorney
Chief, Criminal Division

Foreperson

Date: 08/12/2014

Timothy Henwood
Assistant United States Attorney
Chief, White Collar Crime Unit

Justin R. Martin
Assistant United States Attorney