IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
EL PASO DIVISION

UNITED STATES OF AMERICA,	§	**CRIMINAL NO. EP-21-CR-1489-DCG**
	§	
Plaintiff,	§	**S E A L E D**
	§	
v.	§	**INDICTMENT**
	§	
ZENIA CHAVEZ (2) and	§	**CT 1:** 18 U.S.C. § 1349 – Conspiracy to
RAUL ALEJANDRO FUENTES (3),	§	Commit Health Care Fraud;
	§	
Defendants.	§	**CTS 2-15:** 18 U.S.C. § 1347 – Health
	§	Care Fraud;
	§	
	§	**CT 16:** 18 U.S.C. § 371 – Conspiracy:
	§	Illegal Remunerations regarding a Federal
	§	Health Care Program
	§	
	§	**CTS 17-27:** 42 U.S.C. §1320a-7b(b)(2) –
	§	Illegal Remunerations regarding a Federal
	§	Health Care Program
	§	
	§	***Notice of Government's Demand for***
	§	***Forfeiture***

THE GRAND JURY CHARGES:

COUNT ONE
(18 U.S.C. §§ 1349 and 1347)
CONSPIRACY TO COMMIT HEALTHCARE FRAUD

INTRODUCTION

AT ALL TIMES RELEVANT TO THIS INDICTMENT:

1. Defendant **ZENIA CHAVEZ** was a resident of El Paso, Texas and the owner and operator of Nursemind Home Health, Inc. (hereinafter "Nursemind").

2. Defendant **RAUL ALEJANDRO FUENTES** was a resident of El Paso, Texas, the nephew of defendant, **ZENIA CHAVEZ** and an employee of Nursemind.

3. Nursemind was a company located in El Paso, Texas that provided hospice care services and home health care services.

4. The Medicare Program ("Medicare") was a federally funded and administered healthcare program providing benefits to individuals sixty-five (65) years of age or older, and to disabled individuals. The program was administrated through the Centers for Medicare and Medicaid Services ("CMS"), a federal agency within the United States Department of Health and Human Services. Medicare was paid for through federal income and payroll taxes. Medicare was a "healthcare benefit program" as defined by Title 18, United States Code, Section 24(b), and a "Federal health care program" as defined by 42 U.S.C. Section 1320a-7b(f).

5. Individuals who qualified for Medicare benefits were commonly referred to as Medicare "beneficiaries." Each beneficiary was given a unique Medicare identification number that was used to process claims for healthcare services and items linked to that beneficiary.
6. Medicare paid for reasonable and necessary medical services provided to individuals and families who were deemed eligible. Medical service providers were required to be approved by and registered with Medicare in order to receive reimbursements for claims submitted by the providers for healthcare services provided to beneficiaries. Service providers enrolled with Medicare received a unique provider number to identify themselves when submitting Medicare claims.

7. Medicare was subdivided into multiple Parts. Medicare Part A covered health services provided by hospitals, skilled nursing facilities, hospices, and home health agencies. Medicare Part B covered physician services and outpatient care. Parts A and B were known as the "original fee-for-service" Medicare program, in which Medicare paid health care providers fees for services rendered to beneficiaries.

8. To participate in Medicare, providers were required to submit an application in which they agreed to comply with all Medicare-related laws and regulations. Per the provider agreement with Medicare, providers had a duty to become educated about and knowledgeable of the contents and procedures of the Medicare program. Approved providers were given access to Medicare manuals and service bulletins describing billing procedures, rules, and regulations.

9. To receive reimbursement from Medicare for qualified services, providers submitted or caused the submission of claims to Medicare, either directly or through a billing company. When submitting, or causing claims to be submitted, under the provider's unique personal identification number, a provider was certifying that the services were properly rendered and were medically necessary. Medicare paid claims submitted by providers by making automatic deposits to the designated bank accounts of providers or by issuing checks to the provider.

10. A Medicare claim for reimbursement was required to set forth, among other things, the beneficiary's name and unique Medicare identification number, the service provided to the beneficiary, the date the service was provided, the cost of the service, and the name and

unique provider identification number of the physician or health service provider who prescribed or ordered the service.

11. Nursemind was an enrolled Medicare provider.

12. Medicare hospice reimbursement: Title 42 of the Code of Federal Regulations (CFR) Section 418, prescribes the provisions, related definitions, eligibility, election, duration, patient care, organizational environment, covered services, payment, and coinsurance related to Medicare hospice.

13. Medicare for hospice care reimbursement. Pursuant to Title 42, CFR Section, 418, terminally ill "means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course." Medicare beneficiaries entitled to hospital insurance (Medicare Part A) who have terminal illnesses and a life expectancy of six months or less have the option of electing hospice benefits in lieu of standard Medicare coverage for treatment and management of their terminal condition.

14. Hospice care is available to terminally ill beneficiaries for two 90-day benefit periods followed by an unlimited number of 60-day benefit periods during the remainder of the hospice patient's lifetime. For the initial 90-day benefit period, both the hospice medical director and the patient's attending physician (if they have one) must certify the patient qualifies for hospice care. For all subsequent benefit periods, certification is only required from the hospice medical director.

15. Among other criteria, hospice certification must include: (1) that the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course; (2) clinical information and other documentation that support the medical prognosis; (3) a brief narrative explanation by the physician of the clinical findings that supports a life expectancy of six months or less; (4) an attestation statement, which is located directly above the physician's signature and confirms he/she composed the narrative based on his/her review of the patient's medical record or examination of the patient. The certification/recertification must be signed and dated by the physician and list the benefit period dates the certification/recertification covers before the services can be billed to Medicare. All certifications and recertifications must be signed and dated by the physician(s) and must include the benefit period dates to which the certification or recertification applies.

16. A hospice physician or nurse practitioner must have a face-to-face encounter with each hospice patient whose total stay is anticipated to reach the third benefit period. Such encounter must occur at least thirty days prior to the third benefit period recertification and every benefit period recertification thereafter.

17. For each 60-day benefit period recertification, a hospice physician or nurse practitioner must have a face-to-face encounter with each hospice patient prior to but no more than 30 days before the 60-day benefit period begins. Failure to meet the face-to-face encounter requirement results in failure to establish terminal illness eligibility, thus the patient would cease to be eligible for hospice benefits.

18. The hospice company providing service to the individual eligible for hospice care must file a Notice of Election with Medicare within five calendar days of the effective date of the election statement. Among other things, the election statement must contain: (1) the identification of the particular hospice and attending physician that will provide care to the individual, which must be acknowledged by the individual or representative as being the attending physician of his or her choice; (2) the individual or representative's acknowledgement that he or she has been given a full understanding of the palliative rather than curative nature of hospice care as it relates to the individual's terminal illness; (3) acknowledgement that certain Medicare services are waived, and; (4) the signature of the individual or representative.

19. Title 42, United States Code, Section 1320a through 7(b), the Federal Anti-Kickback Statute, is a law prohibiting service providers from paying or receiving money in return for inducing the referral of a patient or service being paid for by Federal funds, including the Medicare program. To receive Medicare funds, enrolled providers agree to, and are required to abide by, the Anti-Kickback Statute and other laws and regulations.

Title 18, United States Code § 24(b) defines a "health care benefit program:" the term "health care benefit program" means any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract.

Beginning on or about January 1, 2015 and continuing to and including on or about June 30, 2018, in the Western District of Texas, and elsewhere, the Defendants,

ZENIA CHAVEZ (2), and
RAUL ALEJANDRO FUENTES (3),

knowingly, intentionally, and unlawfully combined, conspired, confederated and agreed together and with others known and unknown to the Grand Jury, to execute a scheme and artifice to defraud the Medicare program, a health care benefit program as defined in Title 18, United States Code, Section 24(b), and to obtain by means of materially false and fraudulent pretenses, representations, promises, and omissions, money and property owned by and under the control of said health care

benefit program in connection with the delivery of and payment for health care benefits, items, and services;

The Scheme and Artifice to Defraud

It was part of the scheme and artifice to defraud that:

1. Defendants engaged in a conspiracy to locate elderly individuals in the El Paso, Texas area and enroll such individuals, some of whom did not qualify for hospice care, in hospice care with Nursemind.

2. Defendants conspired to place elderly individuals in hospice care that Defendants knew did not have a valid diagnosis of a terminal illness with a medical prognosis of life expectancy of six months or less if the illness runs its normal course. Defendants sought elderly individuals in various facilities, including boarding homes, otherwise known as "foster homes" and senior living facilities in order to enroll them in Nursemind's hospice care even though they were not eligible for hospice care.

3. Defendants engaged in a conspiracy to obtain reimbursement from Medicare for the services provided to the elderly individuals enrolled in hospice care with Nursemind, regardless of whether the beneficiary was eligible for hospice services.

4. Defendants offered payments and made payments for referrals of elderly individuals to Nursemind for hospice care. The offers of payment and payments were made by Nursemind with defendants' knowledge and at defendants' direction.

5. Defendants conspired to create or cause the creation of false and fraudulent medical records for those patients for whom Nursemind claimed to be proving hospice care. Such records included certifications and recertifications of qualification for hospice care which contained false diagnoses of terminal disease with a prognosis of six months or less to live if the illness runs its normal course. Other false records created or caused to be created by defendants included fictitious patient visit notes and records of patient visits that were copied verbatim from prior visits and for which defendants sought reimbursement from Medicare for such care.

6. In several instances, Defendants conspired to falsify the beneficiaries' hospice election statements required by regulation and did not inform the beneficiaries that they were enrolled in hospice care with Nursemind.

7. Defendants managed the nurses and other medical service providers who provided care to those individuals that were not eligible for hospice care. Such care did not rise to the level of that necessary for a person that was terminally ill requiring hospice care, but instead, frequently consisted of minor home health services such as measuring vital signs, organizing weekly pill boxes, assisting with bathing and dressing, and providing medical advice.

8. Defendants conspired to forge the signatures of medical directors on physical documents and electronic medical records in order to, among other things, certify and recertify patients that were not eligible for hospice care.

All in violation of Title 18, United States Code, Sections 1349 and 1347.

COUNTS TWO through FIFTEEN
(18 U.S.C. § 1347)
HEALTHCARE FRAUD

The Grand Jury re-alleges and incorporates the Introduction and Scheme and Artifice to Defraud in Count One as if fully set out herein.

Beginning on or about September 5, 2016 and continuing to and including on or about June 30, 2018, on the dates specified below, in the Western District of Texas, and elsewhere, the Defendants,

ZENIA CHAVEZ (2), and
RAUL ALEJANDRO FUENTES (3),

knowingly and willfully executed and attempted to execute a scheme and artifice to defraud the Medicare program, a health care benefit program as defined in Title 18, United States Code, § 24(b), and to obtain, by means of false and fraudulent pretenses, representations and promises, money and property owned by or under the custody and control of said health care benefit program, in connection with the delivery of, or payment for, health care benefits, items and services, by submitting or causing others to submit, false and fraudulent claims to Medicare for hospice services on multiple occasions, including, but not limited to, those set forth below:

Count	Beneficiary	Date of Claim(s) by Nursemind	Date of Payment from Medicare	Amount Paid by Medicare
Two	A.V.	September 5, 2016	September 19, 2016	$3890.30

Three	A.V.	September 5, 2016	September 19, 2016	$2886.34
Four	S.T.	November 15, 2016	November 29, 2016	$3,166.05
Five	L.A.	November 15, 2016	November 29, 2016	$4,907.38
Six	F.A.	December 13, 2016	December 27, 2016	$4,749.07
Seven	F.A.	June 5, 2018	June 19, 2018	$3,889.13
Eight	M.C.	April 17, 2017	May 1, 2017	$4,907.38
Nine	F.M.	September 18, 2017	October 2, 2017	$3,858.47
Ten	F.M.	July 10, 2018	July 24, 2018	$3,638.21
Eleven	R.O.	March 13, 2017	March 27, 2017	$4,432.37
Twelve	R.O.	April 17, 2017	May 1, 2017	$4,738.19
Thirteen	G.E.	August 29, 2017	September 12, 2017	$3,858.47
Fourteen	G.E.	June 18, 2018	June 22, 2018	$3,638.21
Fifteen	M.G.	September 13, 2016	September 27, 2016	$3,388,32

All in violation of Title 18, United States Code, § 1347.

COUNT SIXTEEN
(18 U.S.C. § 371)
CONSPIRACY: ILLEGAL REMUNERATIONS REGARDING A FEDERAL HEALTH CARE PROGRAM

The Grand Jury re-alleges and incorporates the Introduction and Scheme and Artifice to Defraud in Count One as if fully set out herein.

Beginning on or about January 29, 2016 and continuing to and including on or about June 15, 2018, in the Western District of Texas, and elsewhere, the Defendant,

ZENIA CHAVEZ (2),

did knowingly and willfully combine, conspire, confederate, and agree with others, known and unknown to the Grand Jury, to commit offenses against the United States, that is,

a. to defraud the United States by impairing, impeding, obstructing and defeating through deceitful and dishonest means, the lawful government functions of the United States in its administration and oversight of Medicare;

b. to violate Title 42, United States Code, Section 1320a-7b(b)(2), by knowingly and willfully paying and offering to pay any remuneration, specifically, kickbacks and bribes, directly and indirectly, overtly and covertly, to any person to induce such person to refer any individual to Nursemind 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 Medicare; and for the purchasing, leasing, ordering and arranging for and recommending the purchasing, leasing and ordering of any good, item and service for which payment may be made in whole and in part by a Federal health care program, that is, Medicare.

Overt Acts of the Conspiracy

1. On or about January 29, 2016, a check in the amount of $627.00 was issued to Y.O. that included payment for two referrals by Y.O. to Nursemind for hospice patients.

2. On or about February 12, 2016, a check in the amount of $440.10 was issued to S.J. that included payment for two referrals by S.J. to Nursemind for hospice patients.

3. On or about December 16, 2016, a check in the amount of $240.00 was issued to M.N. as payment for two referrals of hospice patients to Nursemind.

4. On or about December 30, 2016, a check in the amount of $300.00 was issued to M.N. that included payment for one referral to Nursemind for a hospice patient.

5. On or about January 27, 2017, a check in the amount of $1,170.00 was issued to D.T. that included payment for four referrals to Nursemind for hospice patients.

6. On or about February 10, 2017, a check in the amount of $1,215.00 was issued to D.T. that included payment for two referrals to Nursemind for hospice patients.

7. On or about March 10, 2017, a check in the amount of $1,485.00 was issued to D.T. that included payment for a referral to Nursemind for a hospice patient.

8. On or about April 7, 2017, a check was issued in the amount of $920.00 was issued to T.M. that included payment for a referral to Nursemind for a hospice patient.

9. On or about January 13, 2017, a check in the amount of $1,475.00 was issued to M.R. that included payment for a referral to Nursemind for two hospice patients.

10. On or about January 27, 2017, a check in the amount of $1,097.00 was issued to M.R. that included payment for a referral to Nursemind for a hospice patient.

11. On or about February 24, 2017, a check in the amount of $1,125.00 was issued to M.R. that included payment for a referral of one hospice patient to Nursemind.

12. On or about February 26, 2018, payment in the amount of $200.00 was issued to L.C. in payment for a referral of two hospice patients to Nursemind.

13. On or about February 24, 2017, a check in the amount of $808.74 was issued to P.L. that included payment for referrals for two hospice patients.

14. On or about June 15, 2018, payment was made to P.L. that included payment for a referral of a hospice patient to Nursemind.

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

COUNTS SEVENTEEN through TWENTY-SEVEN
(42 U.S.C. § 1320a-7b(b)(2) and 18 U.S.C. § 2)
ILLEGAL REMUNERATIONS REGARDING A FEDERAL HEALTH CARE PROGRAM

The Grand Jury re-alleges and incorporates the Introduction and Scheme and Artifice to Defraud in Count One and the Overt Acts of the conspiracy in Count Sixteen as if fully set out herein.

On or about the dates specified below, in the Western District of Texas, the Defendant,

ZENIA CHAVEZ (2),

aided and abetted by others known to the Grand Jury, knowingly and willfully, offered to pay and paid any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, to any person in return for referring patients to Nursemind for the furnishing of hospice care, payment for which would be made in whole or in part by a Federal health care program, specifically, Medicare:

Count	**Payee**	**Date on Check**	**Amount**
Seventeen	M.N.	December 16, 2016	$150
Eighteen	M.N.	December 30, 2016	$300
Nineteen	D.T.	January 27, 2017	$600
Twenty	D.T.	February 10, 2017	$300
Twenty-one	D.T.	March 10, 2017	$150
Twenty-two	T.M.	April 7, 2017	$150
Twenty-three	M.R.	January 13, 2017	$300
Twenty-four	M.R.	January 27, 2017	$150
Twenty-five	M.R.	February 24, 2017	$150
Twenty-six	P.L.	February 24, 2017	$300
Twenty-seven	P.L.	June 15, 2018	$100

All in violation of Title 42, United States Code, § 1320a-7b(b)(2).

NOTICE OF GOVERNMENT'S DEMAND FOR FORFEITURE
[*See* Fed. R. Crim. P. 32.2]

I.
Conspiracy to Commit Health Care Fraud Violation and Forfeiture Statutes
[Title 18 U.S.C. §§ 1349 and 371, subject to forfeiture pursuant to Title 18 U.S.C. §

981(a)(1)(C), as made applicable to criminal forfeiture by Title 28 U.S.C. § 2461(c)]

As a result of the foregoing criminal violations set forth in Count One and Count Nineteen, the United States gives notice to Defendants **ZENIA CHAVEZ** and **RAUL ALEJANDRO FUENTES** of its intent to seek the forfeiture of certain property upon conviction pursuant to FED. R. CRIM. P. 32.2 and Title 18 U.S.C. § 981(a)(1)(C), as made applicable to criminal forfeiture by Title 28 U.S.C. § 2461(c), which states:

> **Title 18 U.S.C. § 981. Civil Forfeiture**
>
> (a)(1) The following property is subject to forfeiture to the United States:
>
> * * *
>
> (C) Any property, real or personal, which constitutes or is derived from proceeds traceable to a violation . . . of this title or any offense constituting "specified unlawful activity" (as defined in section 1956(c)(7) of this title), or a conspiracy to commit such offense.

II.

Health Care Fraud Violation and Forfeiture Statutes

[Title 18 U.S.C. §§ 1347(a)(2) & Title 42 U.S.C. § 1320a-7b(b)(2), subject to forfeiture pursuant to Title 18 U.S.C. § 982(a)(7)]

As a result of the foregoing criminal violations set forth in Counts Eleven through Fifteen, the United States gives notice to Defendants **ZENIA CHAVEZ** and **RAUL ALEJANDRO FUENTES** of its intent to seek the forfeiture of the below described property upon conviction pursuant to FED. R. CRIM. P. 32.2 and Title 18 U.S.C. § 982(a)(7), which states:

> **Title 18 U.S.C. § 982. Criminal Forfeitures**
>
> * * *
>
> **(a)(7)** The court, in imposing sentence on a person convicted of a Federal health care offense, shall order the person to forfeit property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.

Health Care Fraud is an offense constituting "specified unlawful activity" as defined in Title 18 U.S.C. § 1956(c)(7).

This Notice of Demand for Forfeiture includes but is not limited to the property described

in Paragraph II.

II.
Money Judgment

A sum of money that represents the amount of proceeds obtained, directly or indirectly, property involved in such offense, or traceable to such property as a result of the violations set forth in Indictment for which Defendants **ZENIA CHAVEZ** and **RAUL ALEJANDRO FUENTES** are individually liable.

Substitute Assets

If any of the above described forfeitable property, 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 person;

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 subdivided without difficulty;

it is the intent of the United States to seek forfeiture, pursuant to Title 21 U.S.C. § 853(p), as incorporated by Title 28 U.S.C. § 2461(c), of any other property of said Defendants up to the value of the forfeitable property.

A TRUE BILL.

ORIGINAL SIGNATURE
REDACTED PURSUANT TO
E-GOVERNMENT ACT OF 2002

FOREPERSON OF THE GRAND JURY

ASHLEY C. HOFF
UNITED STATES ATTORNEY

BY: _____
Assistant U.S. Attorney