UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

June 2011 Grand Jury

UNITED STATES OF AMERICA, Plaintiff, v. ZINA TAMAMIAN, Defendant.	No. CR CR 11 00827 I N D I C T M E N T [18 U.S.C. § 1347: Health Care Fraud; 18 U.S.C. § 2(b): Causing an Act to be Done]

The Grand Jury charges:

COUNTS ONE THROUGH SEVEN

[18 U.S.C. §§ 1347, 2(b)]

A. GENERAL ALLEGATIONS

At all times relevant to this Indictment:

Defendant

1. Defendant ZINA TAMAMIAN ("TAMAMIAN") owned and operated a durable medical equipment ("DME") supply company called Gana Medical Supply ("Gana") from on or about July 14, 2006, through at least in or about January 2007.

CSW

CSW:csw

2. Gana was located at 13322 Burbank Blvd., Sherman Oaks, California, within the Central District of California. Gana was a Medicare provider.

The Medicare Program

3. Medicare was a federal health care benefit program, affecting commerce, that provided benefits to individuals who were over the age of 65 or disabled. Medicare was administered by the Centers for Medicare and Medicaid Services ("CMS"), a federal agency under the United States Department of Health and Human Services.

4. Medicare provided coverage for medically necessary DME, including orthoses, which are orthopedic appliances or devices used to support, align, prevent, or correct deformities or to improve function of movable parts of the body.

5. Individuals who qualified for Medicare benefits were referred to as Medicare "beneficiaries." Each beneficiary was given a unique health identification card number ("HICN").

6. DME companies, physicians, and other health care providers that provided medical services that were reimbursed by Medicare were referred to as Medicare "providers."

7. To obtain reimbursement from Medicare, a DME company first had to apply for and obtain a provider number. If Medicare approved a DME provider's application, Medicare assigned the provider a Medicare provider number, which enabled the DME company to submit claims to Medicare to obtain reimbursement for services rendered to Medicare beneficiaries.

8. CMS contracted with private insurance companies to process and pay DME claims. Prior to approximately October 1,

2006, the Medicare contractor responsible for the processing and payment of DME claims in Southern California was CIGNA Government Services ("CIGNA"). After approximately October 1, 2006, the Medicare contractor responsible for the processing and payment of such claims was Noridian Administrative Services ("Noridian").

9. Most DME providers, including Gana, submitted their claims electronically pursuant to an agreement with Medicare that they would submit claims that were accurate, complete, and truthful.

10. Medicare reimbursed DME providers only for DME that was medically necessary to the treatment of a beneficiary's illness or injury, was prescribed by a beneficiary's physician, and was provided in accordance with Medicare regulations and guidelines that governed whether that item or service would be reimbursed by Medicare.

11. To bill Medicare, a DME provider submitted a claim (Form 1500) to Noridian or CIGNA. Medicare required claims to be truthful, complete, and not misleading. In addition, when a claim was submitted, the provider certified that the services or supplies covered by the claim were medically necessary.

12. Medicare required a claim for Medicare reimbursement of DME to set forth, among other things, the beneficiary's name and HICN, the type of DME provided to the beneficiary, the date that the DME was provided, and the name and unique physician identification number ("UPIN") of the physician who prescribed or ordered the DME.

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B. THE SCHEME TO DEFRAUD

13. Beginning on or about July 14, 2006, and continuing through in or about January 2007, in Los Angeles County, within the Central District of California, and elsewhere, defendant TAMAMIAN, together with others known and unknown to the Grand Jury, knowingly, willfully, and with intent to defraud, executed and attempted to execute a scheme and artifice: (a) to defraud a health care benefit program, namely Medicare, as to material matters in connection with the delivery of and payment for health care benefits, items, and services; and (b) to obtain money from Medicare by means of material false and fraudulent pretenses and representations and the concealment of material facts in connection with the delivery of and payment for health care benefits, items, and services.

C. MANNER AND MEANS TO ACCOMPLISH THE SCHEME TO DEFRAUD

14. The scheme operated, in substance, in the following manner:

a. Defendant TAMAMIAN purchased Gana from an individual who had already obtained a provider number for the company. Defendant TAMAMIAN did not report the change of ownership to Medicare.

b. Defendant TAMAMIAN opened a business bank account for Gana at Bank of America.

c. Defendant TAMAMIAN obtained the names and HICNs of numerous Medicare beneficiaries and the names and UPINs of two physicians, neither of whom specialized in orthopedics.

d. Defendant TAMAMIAN then used this information to prepare and cause to be prepared false and fraudulent claims to

Medicare for orthoses and other DME products that were not medically necessary, were not ordered by the physicians whose names were listed as the ordering physicians, and were not in fact provided to the beneficiaries.

e. Defendant TAMAMIAN, through Gana, submitted and caused the submission of the false and fraudulent claims to Medicare for orthoses vastly in excess of the amount she purchased from DME suppliers. Between approximately July 2006 and January 2007, Gana submitted false and fraudulent claims to Medicare totaling approximately $2.9 million but spent less than approximately $30,000 on purchases from DME suppliers. Over 95% of Gana's claims were for orthoses.

f. Based upon the false and fraudulent claims defendant TAMAMIAN submitted and caused to be submitted, Medicare paid Gana approximately $2.1 million.

g. Defendant TAMAMIAN transferred over $1 million from the Gana business bank account at Bank of America into her personal account.

D. THE EXECUTION OF THE FRAUDULENT SCHEME

15. On or about the dates set forth below, in Los Angeles County, within the Central District of California, and elsewhere, defendant TAMAMIAN, together with others known and unknown to the Grand Jury, for the purpose of executing and attempting to execute the fraudulent scheme described above, knowingly and willfully caused to be submitted to Medicare the following false and fraudulent claims:

COUNT	CLAIM NUMBER	DATE CLAIM SUBMITTED	AMOUNT CLAIMED	BENEFICIARY - DME
ONE	10624284 5799000	8/30/06	$1,650	B.J.- Left and right elbow orthoses; lumbar-sacral orthosis; multi-prong cane; electric heat pad
TWO	10625784 2540000	9/14/06	$644	D.H. - Thoracic-lumbar-sacral orthosis; electric heat pad; left and right wrist-hand-finger orthoses
THREE	10627884 7771000	10/5/06	$1,694	B.J. - Left and right knee orthoses; left and right wrist-hand-finger orthoses; semi-rigid cervical collar
FOUR	10628484 7013000	10/11/06	$1,876	D.H.- Left and right knee orthoses; custom fabricated shoulder orthosis; left and right elbow orthoses
FIVE	10629981 6635000	10/26/06	$3,031	R.C.- Lumbar-sacral orthosis; multi-prong cane; ankle-foot orthosis, molded to patient; left and right elbow orthosis; multiple post cervical collar
SIX	10632084 4779000	11/16/06	$2,136	R.C. - Left and right knee orthoses; left and right custom fabricated hand orthoses; custom fabricated shoulder orthosis

COUNT	CLAIM NUMBER	DATE CLAIM SUBMITTED	AMOUNT CLAIMED	BENEFICIARY - DME
SEVEN	10701983 5849000	1/19/07	$2,792	H.H. - Left and right knee orthoses; left and right elbow orthoses; custom fabricated shoulder orthosis

A TRUE BILL

/S/
Foreperson

ANDRÉ BIROTTE
United States Attorney

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