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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

UNITED STATES OF AMERICA,

v.

D-1 KASHIF RASOOL,

Defendant.
_____/

Case:2:17-cr-20744
Judge: Friedman, Bernard A.
MJ: Majzoub, Mona K.
Filed: 11-07-2017 At 10:57 AM
INFO USA v. RASOOL (SO)

VIO: 18 U.S.C. § 1349

# INFORMATION

THE UNITED STATES OF AMERICA CHARGES:

## General Allegations

At all times relevant to this Information:

### The Medicare Program

1. The Medicare program was a federal health care program providing benefits to persons who were 65 years of age or over 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. 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. Medicare has four parts: hospital insurance ("Part A"), medical insurance ("Part B"), Medicare Advantage ("Part C"), and prescription drug benefits ("Part D"). Part B of the Medicare program covered the cost of physicians' services, medical equipment and supplies, and diagnostic laboratory services.

4. Wisconsin Physicians Service ("WPS") administered the Medicare Part B program for claims arising in the state of Michigan. CMS contracted with WPS to receive, adjudicate, process, and pay claims.

5. TrustSolutions LLC was the Program Safeguard Contractor for Medicare Part A and Part B in the State of Michigan until April 24, 2012, when it was replaced by Cahaba Safeguard Administrators LLC as the Zone Program Integrity Contractor ("ZPIC"). The ZPIC is a contractor that investigates fraud, waste, and abuse. Cahaba was replaced by AdvancedMed in May 2015.

6. Payments under the Medicare program were often made directly to a provider of the goods or services, rather than to a Medicare beneficiary. This payment occurred when the provider submitted the claim to Medicare for payment, either directly or through a billing company.

7. Upon certification, the medical provider, whether a clinic, physician, or other health care provider that provided services to Medicare beneficiaries, was able to apply for a Medicare Provider Identification Number ("PIN") for billing purposes. A health care provider who was assigned a Medicare PIN and provided services to

beneficiaries was able to submit claims for reimbursement to the Medicare contractor/carrier that included the PIN assigned to that medical provider.

8. By becoming a participating provider in Medicare, enrolled providers agreed to abide by the policies and procedures, rules, and regulations governing reimbursement. To receive Medicare funds, enrolled providers, together with their authorized agents, employees, and contractors, were required to abide by all provisions of the Social Security Act, the regulations promulgated under the Act, and applicable policies, procedures, rules, and regulations issued by CMS and its authorized agents and contractors. Health care providers were given and provided with online access to Medicare manuals and services bulletins describing proper billing procedures and billing rules and regulations.

9. Health care providers could only submit claims to Medicare for reasonable and medically necessary services that they rendered. Medicare regulations required health care providers enrolled with Medicare to maintain complete and accurate patient 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 payment were submitted by the physician. Medicare requires complete and accurate patient medical records so that Medicare may verify that the services were provided as described on the claim form. These records were required to be sufficient to permit

Medicare, through WPS and other contractors, to review the appropriateness of Medicare payments made to the health care provider.

10. Under Medicare Part B, physician office visit services and nerve block injections, including facet joint injections, were required to be reasonable and medically necessary for the treatment or diagnosis of the patient's illness or injury. Individuals providing these services were required to have the appropriate training, qualifications, and licenses to provide such services. Providers were required to: (1) document the medical necessity of these services; (2) document the date the service was performed; (3) identify the provider who performed the service; and (4) identify the clinic, physician office, or group practice where the provider provided the service. Providers conveyed this information to Medicare by submitting claims using billing codes and modifiers. To be reimbursed from Medicare for physician office visit services, and nerve block injections, including facet joint injections, the services had to be reasonable, medically necessary, documented, and actually provided as represented to Medicare. Providers were required to maintain patient records to verify that the services were provided as represented on the claim form to Medicare.

11. Under Medicare Part B, for a laboratory to properly bill and be paid by Medicare for laboratory testing, including urine drug testing, the patient must, among other things, qualify for the testing, including urine drug testing, under

Medicare's established rules and regulations. The testing also must be rendered according to Medicare's rules and regulations, and certain documents must be completed before a claim is submitted for reimbursement to Medicare.

12. For a laboratory to properly bill and be paid by Medicare for urine drug testing, the urine drug testing must be both reasonable and medically necessary. For example, urine drug testing is medically necessary if the patient presents to a physician with a suspected drug overdose. Regular, routine, or recreational drug screenings, however, are not reasonable or medically necessary. Further, the patient's medical record must include documentation that fully supports the reasonableness of and medical necessity for the urine drug testing.

13. Under Medicare Part A and Part B, home health care services were required to be reasonable and medically necessary to the treatment of the patient's illness or injury. Reimbursement for home health care services required that a physician certified the need for services and established a Plan of Care. Home health care services that were not certified by a physician or were not provided as represented were not reasonable and necessary. Medicare Part B covered the costs of physicians' services, including physician home visits, physician certification and recertification of home health care services, and physician supervision of home health care services. Generally, Medicare Part B covered these costs only if, among

other requirements, they were medically necessary, ordered by a physician, and not induced by the payment of remuneration.

14. Medicare coverage for home health care services required that the following qualifying conditions, among others, be met: (a) the Medicare beneficiary is confined to the home; (b) the beneficiary needs skilled nursing services, physical therapy, or occupational therapy; (c) the beneficiary is under the care of a qualified physician who established a written Plan of Care for the beneficiary, signed by the physician and by a Registered Nurse ("RN"), or by a qualified physical therapist if only therapy services are required from the home health agency; (d) skilled nursing services or physical therapy services are provided by, or under the supervision of, a licensed RN or physical therapist in accordance with the Plan of Care; and (e) the services provided are medically necessary.

15. To receive reimbursement for a covered service from Medicare, a provider must submit a claim, either electronically or using a form (*e.g.*, a CMS-1500 form or UB-92), containing the required information appropriately identifying the provider, patient, and services rendered, among other things.

**The Physician Businesses**

16. Global Quality Inc. ("Global Quality") was a Michigan corporation doing business at 3800 Woodward Ave., Ste. 1100, Detroit, Michigan. Global

Quality was enrolled as a participating provider with Medicare and submitted claims to Medicare.

17. Aqua Therapy and Pain Management, Inc. ("Aqua Therapy") was a Michigan corporation doing business at 3011 West Grand Blvd., Ste. 305, Detroit, Michigan. Aqua Therapy was enrolled as a participating provider with Medicare and submitted claims to Medicare.

18. Tri-County Physician Group, P.C. ("Tri-County Physicians") was a Michigan corporation doing business at 3800 Woodward Ave., Ste. 1100, Detroit, Michigan, 3011 West Grand Blvd., Ste. 305 & 307, Detroit, Michigan, and 24001 Orchard Lake Rd., Ste. 140A, Farmington, Michigan. Tri-County Physicians was enrolled as a participating provider with Medicare and submitted claims to Medicare.

19. Tri-State Physician Group, P.C. ("Tri-State Physicians") was a Michigan corporation doing business at 3011 West Grand Blvd., Ste. 306, Detroit, Michigan, 24001 Orchard Lake Rd., Ste. 140A, Farmington, Michigan, and 2100 W. Alexis Rd., Ste. B3, Toledo, Ohio. Tri-State Physicians was enrolled as a participating provider with Medicare and submitted claims to Medicare.

20. New Center Medical, P.C. ("New Center Medical") was a Michigan corporation doing business at 3011 West Grand Blvd., Ste. 308, Detroit, Michigan. New Center Medical was enrolled as a participating provider with Medicare and submitted claims to Medicare.

**The Laboratory**

21. National Laboratories, Inc. ("National Laboratories") was a Michigan corporation doing business at 3011 West Grand Blvd., Ste. 310, Detroit, Michigan and 2100 West Alexis Rd., Ste. B-1, Toledo, Ohio. National Laboratories was enrolled as a participating provider with Medicare and submitted claims to Medicare.

**The Massage Therapy and Healthcare Management Company**

22. Tri-County Wellness, Inc. ("Tri-County Wellness") was a Michigan corporation doing business at 3031 W. Grand Blvd., Ste. 506, Detroit, Michigan and 900 Wilshire Dr., Ste. 202, Troy, Michigan.

**Defendant and Other Individuals**

23. Defendant **KASHIF RASOOL**, a resident of Oakland County, was a physician licensed in the State of Michigan who was enrolled as a participating provider with Medicare for Tri-County Physicians and New Center Medical.

24. Mashiyat Rashid, a resident of Oakland County, controlled, owned, or operated Global Quality, Aqua Therapy, Tri-County Physicians, Tri-State Physicians, New Center Medical, National Laboratories, and Tri-County Wellness, collectively referred to as the Tri-County Network.

**COUNT 1**
**18 U.S.C. § 1349**
**(Health Care Fraud Conspiracy)**
**D-1 KASHIF RASOOL**

25. Paragraphs 1 through 24 of the General Allegations section of this Information are re-alleged and incorporated by reference as though fully set forth herein.

26. Beginning in or around 2014 and continuing through in or around the present, in the Eastern District of Michigan, and elsewhere, **KASHIF RASOOL**, did willfully and knowingly combine, conspire, confederate, and agree with others known and unknown to the Grand Jury, to commit certain offenses against the United States, that is: to knowingly and willfully 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 programs, in connection with the delivery of and payment for health care benefits, items, and services, in violation of Title 18, United States Code, 1347.

**Purpose of the Conspiracy**

27. It was a purpose of the conspiracy for **KASHIF RASOOL** and his co-conspirators to unlawfully enrich themselves by, among other things: (a) submitting or causing the submission of false and fraudulent claims to Medicare for claims

based on kickbacks and bribes; (b) submitting or causing the submission false and fraudulent claims to Medicare for services that were (i) medically unnecessary; (ii) not eligible for Medicare reimbursement; and/or (iii) not provided as represented; (c) concealing the submission of false and fraudulent claims to Medicare and the receipt and transfer of the proceeds from the fraud; and (d) diverting proceeds of the fraud for the personal use and benefit of the defendants and their co-conspirators.

**Manner and Means**

The manner and means by which the defendant and his co-conspirators sought to accomplish the purpose of the conspiracy included, among others, the following:

28. Mashiyat Rashid, **KASHIF RASOOL** and others submitted and caused to be submitted false and fraudulent enrollment materials to Medicare that failed to disclose the ownership interest and/or managing control of Mashiyat Rashid.

29. Mashiyat Rashid, **KASHIF RASOOL**, and others disguised Mashiyat Rashid's ownership interest and/or control over these provider numbers by, among other things, entering into sham agreements and making misrepresentations and omissions in the enrollment applications and claims submitted to Medicare.

30. On or about September 9, 2013, **KASHIF RASOOL** falsely certified to Medicare that he was the owner of Tri-County Physicians. **KASHIF RASOOL** falsely certified to Medicare that Tri-County Physicians would comply with all

Medicare rules and regulations, and federal laws, including that Tri-County Physicians would refrain from violating the federal Anti-Kickback statute.

31. After Tri-County Physicians was suspended from Medicare on or about November 30, 2016, **KASHIF RASOOL** falsely certified to Medicare on or about December 21, 2016 that he was the owner of New Center Medical and that New Center Medical would comply with all Medicare rules and regulations, and federal laws, including that New Center Medical would refrain from violating the federal Anti-Kickback statute.

32. Mashiyat Rashid, **KASHIF RASOOL** and others would submit and/or cause the submission of false and fraudulent claims for services purportedly provided by the Tri-County Network that were medically unnecessary, not eligible for Medicare reimbursement, and/or not provided as represented.

33. **KASHIF RASOOL** and others falsified, fabricated, altered, and caused the falsification, fabrication, and alteration of Tri-County Network medical records, including home health certifications, treatment plans, diagnostic testing orders, and other records, to support claims for home health services, urine drug testing, diagnostic testing, and other services that were obtained through illegal kickbacks and bribes, medically unnecessary; not eligible for Medicare reimbursement; and/or not provided as represented.

34. Mashiyat Rashid, **KASHIF RASOOL** and others submitted and caused the submission of false and fraudulent claims to Medicare in an approximate amount of $6,613,128.66 for services that were obtained through illegal kickbacks and bribes, medically unnecessary, not eligible for Medicare reimbursement, and/or not provided as represented as represented.

In violation of Title 18, United States Code, Section 1349.

## FORFEITURE ALLEGATIONS
## (18 U.S.C. § 981(a)(1)(C) and 28 U.S.C. § 2461; 18 U.S.C. § 982(a)(7))

35. The above allegations contained in this Information are hereby incorporated by reference as if fully set forth herein for the purpose of alleging forfeiture against defendant **KASHIF RASOOL** pursuant to Title 18, United States Code, Sections 981(a)(1)(C) and 982; and Title 28, United States Code, Section 2461.

36. Pursuant to Title 18, United States Code, Sections 981(a)(1)(C) and 982(a)(7), together with Title 28, United States Code, Section 2461, as a result of the foregoing violations as charged in Count 1 of this Information, the defendant, **KASHIF RASOOL** shall forfeit to the United States: any property, real or personal (a) which constitutes or is derived from proceeds traceable to the commission of the offense, and (b) that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.

37. Such property includes, but is not limited to, a forfeiture money judgment, in an amount to be proved in this matter, representing the total amount of proceeds and/or gross proceeds obtained as a result of Defendant's violations as charged in Count 1 of this Information.

38. Pursuant to Title 21, United States Code, Section 853(p), as incorporated by Title 18, United States Code, Section 982(b), the defendant, **KASHIF RASOOL**, shall forfeit substitute property, up to the value of the properties described above or identified in any subsequent forfeiture bills of particular, if, by any act or omission of the defendant, the property cannot be located upon the exercise of due diligence; has been transferred or sold to, or deposited with, a third party; has been placed beyond the jurisdiction of the Court; has been substantially diminished in value; or has been commingled with other property that cannot be subdivided without difficulty.

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Dated: November 6, 7, 2017