GARAUFIS, J.

GOLD, M.J.

WK/ABS:DJ
F. #2018R00675

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
- - - - - - - - - - - - - - - - - - X

UNITED STATES OF AMERICA

- against -

YEKATERINA KLEYDMAN,

Defendant.

- - - - - - - - - - - - - - - - - - X

INDICTMENT

CR 18 310

Cr. No.

(T. 18, U.S.C., §§ 287, 982(a)(7), 982(b)(1), 1347, 2 and 3551 et seq.; T. 21, U.S.C., § 853(p))

THE GRAND JURY CHARGES:

INTRODUCTION

At all times relevant to this Indictment, unless otherwise indicated:

I. Background

A. The Medicare and Medicaid Programs

1. The Medicare program ("Medicare") was a federal health care program providing benefits to persons who were at least 65 years old 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 ("HHS"). Individuals who received benefits under Medicare were referred to as Medicare "beneficiaries."

2. The New York State Medicaid program ("Medicaid") was a federal and state health care program providing benefits to individuals and families who met specified financial and other eligibility requirements, and certain other individuals who lacked adequate resources to pay for medical care. CMS was responsible for overseeing the Medicaid program in participating states, including New York. Individuals who received benefits under Medicaid

were similarly referred to as Medicaid "beneficiaries." Medicaid managed care plans contracted with Medicaid for a set payment per member per month for providing Medicaid health benefits to Medicaid beneficiaries.

3. Medicare and Medicaid were each a "health care benefit program," as defined by Title 18, United States Code, Section 24(b).

4. Medicare was divided into multiple parts. Medicare Part B covered the costs of physicians' services and outpatient care. Generally, Medicare Part B covered these costs only when, among other requirements, the services were medically necessary.

5. Similarly, Medicaid covered the costs of physicians' services and outpatient care. Generally, Medicaid covered these costs only when, among other requirements, the services were medically necessary.

6. In order to bill Medicare and Medicaid for the cost of treating Medicare and Medicaid beneficiaries and providing related benefits, items and services, medical providers and suppliers were required to apply for and receive a provider identification number ("PIN") or provider transaction access number ("PTAN") from each program. The PIN/PTAN allowed medical providers and suppliers to submit bills, known as claims, to Medicare and Medicaid to obtain reimbursement for the cost of treatment and related health care benefits, items and services that they had supplied and provided to beneficiaries.

7. A medical provider was required to be enrolled in Medicare and Medicaid in order to submit claims. In order to enroll in the Medicare program, a medical provider was required to enter into an agreement with CMS in which the provider agreed to comply with all applicable statutory, regulatory and program requirements for reimbursement from Medicare. By signing the Medicare enrollment application, the provider certified that the provider

understood that payment of a claim was conditioned on the claim and the underlying transaction complying with Medicare regulations, Medicare program instructions, and the law, and on the provider's compliance with all applicable conditions of participation in Medicare. A similar agreement was required of medical providers enrolled in the Medicaid program and Medicaid managed care plans.

8. Medical providers and suppliers were authorized to submit claims to Medicare and Medicaid only for services that were medically necessary.

9. To receive reimbursement from Medicare for covered services and items, medical providers were required to submit claims, either electronically or in writing, through Forms CMS-1500 or Forms UB-92. To receive reimbursement from Medicaid for covered services, medical providers were required to submit claims, either electronically or in writing, through New York State eMedNY-150003 Claim Forms. Each claim form required the medical provider to identify, among other information, the medical provider submitting the claim, the medical provider rendering the service, the referring physician, the patient and the services rendered. Each claim form required the provider to certify, among other things, that the services were medically necessary.

10. Providers submitted claims to Medicare, Medicaid and Medicaid managed care plans using billing codes, also called current procedural terminology or "CPT" codes, which specifically identified the medical services provided to beneficiaries.

11. Medicare and Medicaid covered the costs related to the removal of seborrheic keratosis and skin tags if the skin growths were inflamed and irritated.[1] Medicare and

[1] Seborrheic keratosis is one of the most common noncancerous skin growths in older adults. A seborrheic keratosis usually appears as a brown, black or light tan growth on the face, chest, shoulders or back. A skin tag is a small, soft, benign skin growth.

Medicaid considered the removal of non-inflamed and non-irritated seborrheic keratosis and skin tags to be a cosmetic procedure and did not cover the costs related to such procedures.

12. Specifically, Medicare and Medicaid covered the costs of the removal of inflamed and irritated seborrheic keratosis and skin tags associated with the CPT codes listed in the chart below, among others:

CPT Code	Description of Procedure
17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions
17111	15 or more lesions
11200	Removal of skin tags, multiple fibrocutaneous tags, any area, first 15 tags
11201	Per 10 additional tags

B. The Defendant

13. The defendant YEKATERINA KLEYDMAN was a medical doctor whose principal area of practice was dermatology. KLEYDMAN controlled Kleydman Dermatology PLLC, a medical practice located at 2960 Ocean Avenue, Brooklyn, New York. KLEYDMAN was enrolled as an individual practitioner with Medicare and Medicaid beginning in at least 2013.

II. The Fraudulent Scheme

14. Between approximately January 2015 and March 2018, the defendant YEKATERINA KLEYDMAN, together with others, agreed to execute and executed a scheme to enrich herself and others by submitting and causing the submission of false and fraudulent claims to Medicare, Medicaid managed care plans and other health care benefit programs. Specifically, the defendant, together with others, submitted claims for the removal and destruction of inflamed

and irritated seborrheic keratosis and skin tags when, in fact, the seborrheic keratosis and skin tags were not inflamed and were not irritated.

15. In connection with the submission of false and fraudulent claims to Medicare, Medicaid managed care plans and other health care benefit programs described in paragraph 14, the defendant YEKATERINA KLEYDMAN prepared false medical documents including, but not limited to, medical records that described specific beneficiaries' seborrheic keratosis and skin tags as inflamed and irritated when, in fact, such beneficiaries' seborrheic keratosis and skin tags were not inflamed and were not irritated.

16. Between approximately January 2015 and March 2018, the defendant YEKATERINA KLEYDMAN submitted and caused to be submitted approximately $1.8 million in claims to Medicare, Medicaid and other health care benefit programs for the destruction of inflamed and irritated seborrheic keratosis and skin tags, and was paid approximately $469,000 on those claims.

COUNT ONE
(Health Care Fraud)

17. The allegations contained in paragraphs one through 16 are realleged and incorporated as if fully set forth in this paragraph.

18. In or about and between January 2015 and March 2018, both dates being approximate and inclusive, within the Eastern District of New York and elsewhere, the defendant YEKATERINA KLEYDMAN, together with others, did knowingly and willfully execute and attempt to execute a scheme and artifice to defraud one or more health care benefit programs, as defined in Title 18, United States Code, Section 24(b), to wit: Medicare and Medicaid, 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, Medicare and Medicaid, in connection with the delivery of and payment for health care benefits, items and services.

(Title 18, United States Code, Sections 1347, 2 and 3551 et seq.)

COUNTS TWO THROUGH FOUR
(False Claims)

19. The allegations contained in paragraphs one through 16 are realleged and incorporated as if fully set forth in this paragraph.

20. On or about the dates identified below, within the Eastern District of New York and elsewhere, the defendant YEKATERINA KLEYDMAN, together with others, did knowingly and intentionally make and present the claims set forth below upon and against a department and agency of the United States, to wit: the United States Department of Health and Human Services, knowing such claims to be false, fictitious and fraudulent:

Count	Date of Service	Beneficiary	Insurance	Claim Number	CPT Code Billed	Amount Billed	Amount Paid
TWO	September 2, 2015	Individual-1, whose identity is known to the Grand Jury	Healthfirst PHSP Inc.	****4850	17110	$357	$84
THREE	March 5, 2018	Individual-2, whose identity is known to the Grand Jury	NYS Catholic Health Plan Inc. dba Fidelis Care New York	****6350	17111	$404.50	$121.35

Count	Date of Service	Beneficiary	Insurance	Claim Number	CPT Code Billed	Amount Billed	Amount Paid
FOUR	March 26, 2018	Individual-3, whose identity is known to the Grand Jury	NYS Catholic Health Plan Inc. dba Fidelis Care New York	****8250	17111	$404.50	$121.35

(Title 18, United States Code, Sections 287, 2 and 3551 et seq.)

CRIMINAL FORFEITURE ALLEGATION
AS TO COUNTS ONE THROUGH FOUR

21. The United States hereby gives notice to the defendant that, upon her conviction of any of the offenses charged herein, that the government will seek forfeiture in accordance with Title 18, United States Code, Section 982(a)(7), which requires any person convicted of a federal health care offense to forfeit property, real or personal, that constitutes, or is derived directly or indirectly from, gross proceeds traceable to the commission of such offenses.

22. If any of the above-described forfeitable property, as a result of any act of 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 comingled with other property which cannot be divided without difficulty;

it is the intent of the United States, pursuant to Title 21, United States Code, Section 853(p), as incorporated by Title 18, United States Code, Section 982(b)(1), to seek forfeiture of any other property of the defendant up to the value of the forfeitable property described in this forfeiture allegation.

(Title 18, United States Code, Sections 982(a)(7) and 982(b)(1); Title 21, United States Code, Section 853(p))

A TRUE BILL

FOREPERSON

RICHARD P. DONOGHUE
UNITED STATES ATTORNEY
EASTERN DISTRICT OF NEW YORK

BY: Robert J. Robilotta
ACTING UNITED STATES ATTORNEY
PURSUANT TO 28 C.F.R. O.136

SANDRA MOSER
ACTING CHIEF, FRAUD SECTION
CRIMINAL DIVISION
U.S. DEPARTMENT OF JUSTICE