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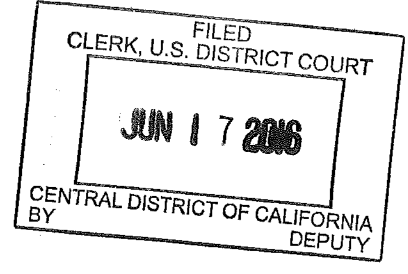

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

June 2016 Grand Jury

UNITED STATES OF AMERICA, Plaintiff, v. KNARIK VARDUMYAN, Defendant.	CR No. 16- CR 16 00433 I N D I C T M E N T [18 U.S.C. § 1347: Healthcare Fraud]

The Grand Jury charges:

COUNTS ONE TO SEVEN

[18 U.S.C. § 1347]

A. **INTRODUCTORY ALLEGATIONS**

At all times relevant to this Information:

1. From in or about 2011 to in or about August 2013, defendant KNARIK VARDUMYAN ("defendant VARDUMYAN") owned and operated a medical clinic located at 421 East Angeleno Avenue, Suite 106, Burbank, California 91501, within the Central District of California (the "Angeleno Clinic"). During that time period, defendant VARDUMYAN worked at the Angeleno Clinic as the office manager.

2. The Angeleno Clinic was in operation from in or about 2011 to in or about August 2013 and, during most or all of that time, was a Medicare provider under a physician, including Dr. R.T. and Dr. P.D. A physician's assistant ("PA"), B.C., was associated with the Angeleno Clinic from in or about September 2012 to in or about August 2013.

3. Between in or about September 2012 and in or about September 2013, the Angeleno Clinic billed Medicare approximately $387,520 for office visits and diagnostic tests such as ultrasounds, electrocardiograms ("EKGs") and spirometry tests allegedly provided to Medicare beneficiaries at the clinic, and Medicare paid the Angeleno Clinic approximately $171,487 on those claims.

4. During that same time period, Medicare providers - including durable medical equipment ("DME") supply companies, independent diagnostic testing facilities ("IDTFs"), and home health agencies - submitted to Medicare claims totaling approximately $2,064,759 for DME, diagnostic tests such as nerve conduction velocity studies ("NCVs") and sleep studies, and home health services that were allegedly prescribed or ordered by B.C. or other providers at the Angeleno Clinic, and Medicare paid those Medicare providers approximately $1,540,302 on those claims.

The Medicare Program

5. 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 ("HHS").

6. Individuals who qualified for Medicare benefits were referred to as Medicare "beneficiaries." Each Medicare beneficiary was given a Health Identification Card containing a unique identification number ("HICN").

7. DME supply companies, IDTFs, physicians, PAs, home health agencies, and other health care providers that provided medical services that were reimbursed by Medicare were referred to as Medicare "providers."

8. To obtain payments from Medicare as reimbursement for services provided to Medicare beneficiaries, a provider first had to apply for and obtain a provider number. By signing the provider application, the provider agreed to (a) abide by Medicare rules and regulations; and (b) not submit claims for payment to Medicare knowing they were false or fraudulent or with deliberate ignorance or reckless disregard of their truth or falsity.

9. If Medicare approved a provider's application, Medicare assigned the provider a Medicare provider number, which enabled the provider to submit claims to Medicare for services rendered to Medicare beneficiaries.

10. Most providers, including the Angeleno Clinic and providers associated with the Angeleno Clinic, submitted their claims electronically pursuant to an agreement with Medicare that they would submit claims that were accurate, complete, and truthful.

11. Medicare reimbursed providers only for services that were medically necessary to the treatment of a beneficiary's illness or injury, were prescribed by a beneficiary's physician, and were provided in accordance with Medicare regulations and guidelines that

governed whether a particular service would be reimbursed by Medicare.

12. Medicare required a claim for Medicare reimbursement of services to set forth, among other things, the beneficiary's name, HICN, and diagnosis; the Current Procedural Terminology ("CPT") code for the service provided to the beneficiary; the date when and location where the service was provided; and the name and physician identification number of the physician who ordered the service.

B. THE SCHEME TO DEFRAUD

13. Beginning in or about September 2012, and continuing until in or about September 2013, in Los Angeles County, within the Central District of California, and elsewhere, defendant VARDUMYAN, together with others known and unknown to the Grand Jury, knowingly, willfully, and with intent to defraud, executed 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. THE FRAUDULENT SCHEME

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

a. Co-schemers known as marketers recruited and brought Medicare beneficiaries to the Angeleno Clinic, often with the promise of free, medically unnecessary DME, and free food.

b. Once at the Angeleno Clinic, the beneficiaries presented their personal information, including their Medicare identification cards and HICNs.

c. Defendant VARDUMYAN arranged for the issuance of, and sometimes directed PA B.C. to sign, prescriptions and orders for medically unnecessary: (1) diagnostic tests, including ultrasounds, spirometry tests, nerve conduction velocity studies ("NCVs"), and sleep studies; (2) DME; and (3) home health services.

d. Defendant VARDUMYAN arranged for L.T., who was neither a licensed physician nor PA, to treat beneficiaries at the Angeleno Clinic and then instructed PA B.C. to sign the medical charts, prescriptions, and other orders for the beneficiaries treated by L.T. so that the Angeleno Clinic could falsely represent that PA B.C. had treated these beneficiaries and submit claims to Medicare for these services under PA B.C.'s Medicare provider number.

e. As defendant VARDUMYAN then well knew would happen and intended to happen, the Angeleno Clinic submitted claims to Medicare for office visits and diagnostic tests, such as ultrasounds, electrocardiograms ("EKGs"), and spirometry tests under the Medicare provider number of Dr. R.T., Dr. P.D., or B.C., even though, as defendant VARDUMYAN then well knew, these services were not medically necessary or did not otherwise meet Medicare's reimbursement requirements.

f. As defendant VARDUMYAN then well knew would happen and intended to happen, the Angeleno Clinic referred the orders and prescriptions for DME, diagnostic tests such as NCVs and sleep studies, and home health services to other Medicare providers -- including DME supply companies, IDTFs, and home health agencies --

which, in turn, billed Medicare for the medically unnecessary items and services that had been ordered and prescribed, but were often never provided or performed.

15. Between in or about September 2012 and in or about September 2013, the Angeleno Clinic billed Medicare and was paid by Medicare as described in paragraph 3. During that same time period, other Medicare providers – including DME supply companies, IDTFs, and home health agencies – billed Medicare for DME, diagnostic tests such as NCVs and sleep studies, and home health services and were paid for those claims by Medicare as described in paragraph 4.

D. EXECUTIONS OF THE FRAUDULENT SCHEME

16. On or about the dates set forth below, within the Central District of California, and elsewhere, defendant VARDUMYAN, together with others known and unknown to the Grand Jury, knowingly and willfully executed and attempted to execute the fraudulent scheme

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described above, by submitting and causing to be submitted to Medicare the following false and fraudulent claims:

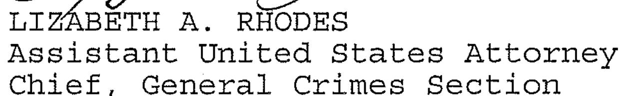
COUNT	APPROXIMATE DATE CLAIM SUBMITTED	BENEFICIARY	APPROXIMATE AMOUNT CLAIMED	CLAIM NO.
ONE	5/3/2013	C.M.	$930.00	551113123368790
TWO	5/7/2013	M.P.	$735.00	551813127302860
THREE	6/14/2013	R.R.	$945.00	551113165872450
FOUR	6/14/2013	A.A.	$910.00	551113165872350
FIVE	6/21/2013	M.F.	$915.00	551113172547130
SIX	7/16/2013	M.M	$905.00	551813197030720
SEVEN	8/1/2013	H.F.	$650.00	551113213574010

A TRUE BILL

/S/
Foreperson

EILEEN M. DECKER
United States Attorney

LAWRENCE S. MIDDLETON
Assistant United States Attorney
Chief, Criminal Division



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