UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, v. JASON C. LING, Defendant.	CR No. CR14-0231 I N F O R M A T I O N [18 U.S.C. § 1349: Conspiracy to Commit Health Care Fraud]

The United States Attorney charges:

[18 U.S.C. § 1349]

A. INTRODUCTORY ALLEGATIONS

At all times relevant to this Information:

The Conspirators

1. Defendant JASON C. LING ("LING") was a physician licensed to practice medicine in the State of California, who operated a medical clinic located at 9430 Crest Drive, Spring Valley, California.

2. Co-conspirator E.O. was the owner and operator of a durable medical equipment ("DME") company in Los Angeles, California.

///

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 ("HHS").

4. CMS contracted with private insurance companies to (a) certify DME providers for participation in Medicare and monitor their compliance with Medicare standards; (b) process and pay claims; and (c) perform program safeguard functions, such as identifying and reviewing suspect claims.

5. 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").

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 payment from Medicare, a DME company first had to apply for and obtain a provider number. By signing the provider application, the DME company agreed to abide by Medicare rules and regulations, including the Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b)), which, among other things, prohibited the payment of kickbacks or bribes for the referral of Medicare beneficiaries for any item or service for which payment may be made by the Medicare program.

8. If Medicare approved a provider's application, Medicare assigned the provider a Medicare provider number, enabling the provider (such as a DME company or physician) to submit claims to Medicare for services and supplies provided to Medicare beneficiaries.

9. To obtain and maintain their Medicare provider numbers and billing privileges, DME suppliers had to meet Medicare standards for participation. The Medicare contractor responsible for evaluating and certifying DME suppliers' compliance with these standards was Palmetto GBA ("Palmetto").

10. From in or about October 2006 through the date of this Information, Noridian Administrative Services ("Noridian") processed and paid Medicare DME claims in Southern California.

11. Most Medicare providers, including the company owned and operated by co-conspirator E.O., submitted their claims electronically pursuant to an agreement with Medicare that they would submit claims that were accurate, complete, and truthful.

12. Medicare paid 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 a particular item or service would be paid by Medicare.

13. To bill Medicare for DME provided to a beneficiary, a DME supplier was required to submit a claim (Form 1500). Medicare required claims to be truthful, complete, and not misleading. In addition, when a claim was submitted, the DME

provider was required to certify that the DME or services covered by the claim were medically necessary.

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

15. Medicare had a co-payment requirement for DME. Medicare reimbursed providers 80% of the allowed amount of a DME claim and the beneficiary was ordinarily obligated to pay the remaining 20%.

16. Defendant LING wrote medically unnecessary prescriptions for power wheelchairs ("PWCs") and related accessories that co-conspirator E.O. used as the basis to submit false and fraudulent claims to Medicare.

17. Between in or around March 2010 and in or around November 2010, co-conspirator E.O. submitted, or caused to be submitted, to Medicare claims totaling approximately $496,794 for purported PWCs and other DME based on medically unnecessary prescriptions and other documents written by defendant LING, and Medicare paid approximately $311,145 on those claims.

B. THE OBJECT OF THE CONSPIRACY

18. Beginning in or around March 2010, and continuing through in or around November 2010, in Los Angeles County, within the Central District of California, and elsewhere, defendant LING, together with co-conspirator E.O. and others known and unknown to the United States Attorney, knowingly combined,

conspired, and agreed to commit health care fraud, in violation of Title 18, United States Code, Section 1347.

C. THE MANNER AND MEANS OF THE CONSPIRACY

19. The object of the conspiracy was carried out, and to be carried out, in substance, as follows:

a. Defendant LING would use street-level marketers to unlawfully recruit Medicare beneficiaries to obtain PWCs and other DME that the beneficiaries did not need.

b. The marketers would take the Medicare beneficiaries to visit defendant LING, and defendant LING would write prescriptions for PWCs and other DME that he knew the beneficiaries did not need.

c. Defendant LING would provide the prescriptions and other supporting documents to marketers and others knowing that the prescriptions and documents would be provided to a DME company in Los Angeles, California, owned by co-conspirator E.O., and knowing that the prescriptions and documents would be used to submit false and fraudulent claims to Medicare.

///

///

///

///

///

///

///

///

///

///

d. After acquiring the false and fraudulent prescriptions and supporting documents written by defendant LING, co-conspirator E.O. would submit, or cause the submission of, false and fraudulent claims to Medicare for medically unnecessary PWCs and other DME.

ANDRÉ BIROTTE JR.
United States Attorney

ROBERT E. DUGDALE
Assistant United States Attorney
Chief, Criminal Division

RICHARD E. ROBINSON
Assistant United States Attorney
Chief, Major Frauds Section

CONSUELO WOODHEAD
Assistant United States Attorney
Deputy Chief, Major Frauds Section

BEN CURTIS
Assistant Chief, Fraud Section
United States Department of Justice

ALEXANDER F. PORTER
Trial Attorney, Fraud Section
United States Department of Justice