ORIGINAL

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

UNITED STATES OF AMERICA,

v.

No. 17-cr-20465
Hon. Denise Page Hood

D-9 YOUSEF ALMATRAHI,

VIO: 18 U.S.C. § 1349

Defendant.
_____/

SUPERSEDING INFORMATION

THE UNITED STATES OF AMERICA CHARGES:

General Allegations

At all times relevant to this Superseding 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. National Government Services ("NGS") was the CMS intermediary for Medicare Part A in the state of Michigan. Wisconsin Physicians Service ("WPS") administered the Medicare Part B program for claims arising in the state of Michigan. CMS contracted with NGS and 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. In its enrollment application, a provider was required to disclose to Medicare any person or company who held an ownership interest of 5% or more or who had managing control of the provider. 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. Medicare would not pay claims procured through kickbacks and bribes.

10. 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.

11. 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.

12. 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.

13. 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 Medical Providers

14. 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.

15. 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.

16. Vitality Home Care, Inc. ("Vitality") was a Michigan Corporation doing business at 161 Merriman Road, Garden City, Michigan 48135. Vitality was enrolled as a participating provider with Medicare and submitted claims to Medicare.

Defendant

17. Defendant **YOUSEF ALMATRAHI**, a resident of Wayne County, was a co-owner of Vitality.

18. **YOUSEF ALMATRAHI**, on behalf of Vitality, certified to Medicare that he would comply with all of Medicare's rules and regulations, including that he would not knowingly present or cause to be presented a false and fraudulent claim to Medicare or violate the Anti-Kickback Statute.

COUNT 1
18 U.S.C. § 1349
(Health Care Fraud Conspiracy)
D-1 YOUSEF ALMATRAHI

19. Paragraphs 1 through 18 of the General Allegations section of this Information are re-alleged and incorporated by reference as though fully set forth herein.

20. Beginning in or around 2012 and continuing through in or around July 2017, in the Eastern District of Michigan, and elsewhere, **YOUSEF ALMATRAHI**,

did willfully and knowingly combine, conspire, confederate, and agree with others known and unknown to the United States Attorney, 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

21. It was a purpose of the conspiracy for **YOUSEF ALMATRAHI** 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 of 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 (d) diverting proceeds of the fraud for the personal use and benefit of the defendant and his co-conspirators in the form of compensation and other remuneration.

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:

22. From in or around 2012 to in or around July 2017, **YOUSEF ALMATRAHI** submitted or caused the submission of false and fraudulent claims to Medicare on behalf of Vitality.

23. **YOUSEF ALMATRAHI** paid kickbacks to Mashiyat Rashid and other co-conspirators in exchange for the referral of Medicare beneficiary information, and conspired to use Vitality's Medicare billing number to bill for home health services that Vitality did not provide. Vitality billed Medicare for home health services that it purportedly provided, but in fact were provided by other companies or not provided at all. In many instances, these Medicare beneficiaries were not homebound.

24. **YOUSEF ALMATRAHI** and his co-conspirators disguised the nature and source of these kickbacks and bribes by entering into sham contracts or employment relationships, including with Tri-County Wellness, a company owned or controlled by Mashiyat Rashid. **YOUSEF ALMATRAHI** would pay a portion of the funds received from Medicare to Mashiyat Rashid in the form of payments made to Tri-County Wellness, and retain a portion of the funds paid by Medicare.

25. During the course of the conspiracy charged in the Information,

YOUSEF ALMATRAHI would submit or cause the submission of false and fraudulent claims to Medicare in the approximate amount of $1,359,512.69, as a result of false and fraudulent claims for beneficiaries who were procured through illegal kickbacks and bribes, did not receive home health services, and/or did not need home health services.

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))

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

27. Pursuant to Title 18, United States Code, Section 981(a)(1)(C) together with Title 28, United States Code, Section 2461, as a result of the foregoing violation, as charged in Count 1 of this Information, the defendant, **YOUSEF ALMATRAHI**, shall forfeit to the United States any property, real or personal, which constitutes or is derived from proceeds traceable to the commission of the offense.

28. Pursuant to Title 18, United States Code, Section 982(a)(7), as a result of the foregoing violations, as charged in Count 1 of this Information, the defendant,

YOUSEF ALMATRAHI, shall forfeit to the United States any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.

29. 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.

30. Pursuant to Title 21, United States Code, Section 853(p), as incorporated by Title 18, United States Code, Section 982(b), the defendant, **YOUSEF ALMATRAHI**, 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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