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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

UNITED STATES OF AMERICA,

v.

D-1 KENNETH CHUN,

Defendant.
_____/

Case:2:17-cr-20451
Judge: Roberts, Victoria A.
MJ: Majzoub, Mona K.
Filed: 06-29-2017 At 03:34 PM
INDI USA V KENNETH CHUN (LG)

VIO: 18 U.S.C. § 1347
21 U.S.C. § 841(a)(1)

INDICTMENT

THE GRAND JURY CHARGES:

General Allegations

At all times relevant to this Indictment:

The Medicare Program

1. The Medicare program was a federal health care program providing benefits to persons 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. 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).

4. Part B of the Medicare program covered the cost of physicians' services, medical equipment and supplies, and diagnostic laboratory services. Specifically, Part B covered physician office services, including office visits.

5. 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 certain Part B claims, including medical services related to physician office visits.

6. 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.

7. 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.

8. 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.

9. 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.

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 B, physician office visits were required to be reasonable and medically necessary for the treatment or diagnosis of the patient's illness or injury. 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, 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.

12. Part D of the Medicare program subsidized the costs of prescription drugs for Medicare beneficiaries. In order to receive Part D benefits, a beneficiary

enrolled in a Medicare drug plan. Medicare drug plans were operated by private companies approved by Medicare. Those companies often were referred to as drug plan "sponsors."

13. A pharmacy could participate in Part D by entering a retail network agreement directly with a plan or with one or more Pharmacy Benefit Managers ("PBMs"). A PBM acted on behalf of one or more Medicare drug plans. Through a plan's PBM, a pharmacy could join the plan's network. When a Part D beneficiary presented a prescription to a pharmacy, the pharmacy submitted a claim either directly to the plan or to a PBM that represented the beneficiary's Medicare drug plan. The plan or PBM determined whether the pharmacy was entitled to payment for each claim and periodically paid the pharmacy for outstanding claims. The drug plan's sponsor reimbursed the PBM for its payments to the pharmacy.

14. A pharmacy could also submit claims to a Medicare drug plan to whose network the pharmacy did not belong. Submission of such out of network claims was not common and often resulted in smaller payments to the pharmacy by the drug plan sponsor.

15. Medicare, through CMS, compensated the Medicare drug plan sponsors. Medicare paid the sponsors a monthly fee for each Medicare beneficiary of the sponsors' plans. Such payments were called capitation fees. The capitation fee was adjusted periodically based on various factors, including the beneficiary's

medical conditions. In addition, in some cases where a sponsor's expenses for a beneficiary's prescription drugs exceeded that beneficiary's capitation fee, Medicare reimbursed the sponsor for a portion of those additional expenses.

16. 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 Medicaid Program

17. The Michigan Medicaid program ("Medicaid") was a federal and state funded 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 Michigan. Individuals who received benefits under the Medicaid program were similarly referred to as "beneficiaries."

18. Medicaid was a "health care benefit program," as defined by Title 18, United States Code, Section 24(b).

19. Medicaid covered the costs of medical services and products ranging from routine preventative medical care for children to institutional care for the elderly and disabled. Among the specific medical services and products provided

by Medicaid were reimbursements to physicians for medical services. Generally, Medicaid covered these costs if, among other requirements, they were medically necessary and actually rendered.

20. To receive reimbursement from Medicaid, medical service providers submitted or caused the submission of claims, either electronically or in writing, to Medicaid for payment of services, either directly or through a billing company.

Blue Cross and Blue Shield

21. Blue Cross and Blue Shield of Michigan ("BCBS") was a nonprofit, privately operated insurance company authorized and licensed to do business in the State of Michigan.

22. BCBS was a "health care benefit program," as defined by Title 18, United States Code, Section 24(b).

23. BCBS had agreements with participating providers to furnish medical services to patients insured by BCBS. The agreements allowed the participating providers to bill BCBS directly, and to be paid directly, for services provided to insured patients. BCBS also paid pharmacies for the cost of prescription drugs that were prescribed to its subscribers and filled by the pharmacies. BCBS routinely issued notices to all participating providers advising them that services not reasonably necessary for patient treatment would not be paid by BCBS.

24. BCBS required participating providers to provide a diagnostic code and a procedure code on claims in order to be paid for professional services rendered to BCBS subscribers. Payment for services depended upon the truthful submission of specific diagnostic and procedure codes indicated on the claim. BCBS distributed payments to participating providers electronically, by depositing money into the providers' bank account of record, or by mailing a check to the provider's address of record.

The Physician Business

25. Bloomfield Internal Medicine Associates, P.C. ("BIMA") was a Michigan Corporation doing business at 43494 Woodward Avenue, Suite 105, Bloomfield Hills, Michigan 48302. BIMA was enrolled as a participating provider with Medicare, Medicaid, BCBS and submitted claims to Medicare, Medicaid, and BCBS.

Defendant

26. Defendant **KENNETH CHUN**, a resident of Oakland County, owned and controlled BIMA.

27. **CHUN** 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.

COUNTS 1-4
(18 U.S.C. §§ 1347 and 2 – Health Care Fraud)
D-1 KENNETH CHUN

28. Paragraphs 1 through 27 of the General Allegations section of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

29. On or about the dates enumerated below, in the Eastern District of Michigan, and elsewhere, **KENNETH CHUN**, in connection with the delivery of and payment for health care benefits, items, and services, did knowingly and willfully execute, and attempt to 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, Medicaid, and BCBS, 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, Medicaid, and BCBS, in connection with the delivery of and payment for health care benefits, items, and services.

Purpose of the Scheme and Artifice

30. It was the purpose of the scheme and artifice for **KENNETH CHUN** to unlawfully enrich himself through the submission of false and fraudulent claims for services that were not reasonable, medically necessary, documented, and/or actually provided as represented to Medicare, Medicaid, and BCBS.

The Scheme and Artifice

31. It was a scheme and artifice to defraud for defendant **KENNETH CHUN** to unlawfully enrich himself by, among other things: (a) prescribing medically unnecessary controlled substances; (b) submitting or causing the submission of false and fraudulent claims for services that were (i) medically unnecessary; (ii) not provided; and/or (iii) not eligible for reimbursement; and (c) diverting proceeds of the fraud for the personal use and benefit of the defendant.

32. **KENNETH CHUN** submitted and caused the submission of false and fraudulent claims in an approximate amount of over $7 million to Medicare for services that were not medically unnecessary, not provided, and/or not eligible for reimbursement. Medicare also paid over $4 million for controlled substances that CHUN prescribed.

Acts in Execution of the Scheme and Artifice

33. On or about the dates specified below, in the Eastern District of Michigan, and elsewhere, **KENNETH CHUN**, in connection with the delivery of and payment for health care benefits, items, and services, did knowingly and willfully execute, and attempt to execute, the above-described scheme and artifice to defraud a health care benefit program affecting commerce, that is, Medicare, Medicaid, and BCBS, 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 program:

Count Defendant	Patient	Approximate Date of Service	Description of Items Billed	Approximate Amount Billed
1 CHUN	J.H.	2/27/2015	Office Visit	$210.00
2 CHUN	J.H.	5/6/15	Office Visit	$90.00
3 CHUN	J.H.	7/8/15	Office Visit	$90.00
4 CHUN	A.B.	7/13/15	Office Visit	$90.00

In violation of Title 18, United States Code, Sections 1347 and 2.

COUNTS 5-10
21 U.S.C. § 841(a)(1)
Distribution of a Controlled Substance
D-1 KENNETH CHUN

34. Paragraphs 1 through 27 of the General Allegations section of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

35. On or about the dates enumerated below, in the Eastern District of Michigan, and elsewhere, the defendant, **KENNETH CHUN**, knowingly and

intentionally distributed and dispensed, and caused to be distributed and dispensed, controlled substances to the patients listed below, outside of the usual course of professional practice and without a legitimate medical purpose:

Count Defendant	Patient	Approximate Date	Drug(s)	Quantity
5 CHUN	J.H.	2/27/2015	Hydrocodone Xanax	60 60
6 CHUN	J.H.	3/25/15	Hydrocodone	60
7 CHUN	J.H.	5/6/15	Hydrocodone Xanax	60 60
8 CHUN	J.H.	7/8/15	Hydrocodone Xanax	90 60
9 CHUN	A.B.	7/13/15	Xanax Methadone	90 (+90 refill) 150
10 CHUN	M.M.	11/8/16	Adderall Xanax	90 60

All in violation of Title 21 United States Code, Section 841(a)(1).

FORFEITURE ALLEGATIONS
(18 U.S.C. § 982(a)(7) and/or 21 U.S.C. § 853)

36. The above allegations contained in this Indictment are hereby incorporated by reference as if fully set forth herein for the purpose of alleging forfeiture pursuant to the provisions of Title 21, United States Code, Section 853 and Title 18, United States Code, Section 982.

37. As a result of the foregoing violations, as charged in Counts 1-4 of this Indictment, the defendant, **KENNETH CHUN**, 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 such violations, pursuant to Title 18, United States Code, Section 982(a)(7).

38. As a result of the foregoing violations, as charged in Counts 5-10 of this Indictment, the defendant, **KENNETH CHUN**, shall forfeit to the United States: (a) any property constituting, or derived from, any proceeds obtained, directly or indirectly, as a result of such violations; and (b) any property used, or intended to be used, in any manner or part, to commit or to facilitate the commission of such violation, pursuant to Title 21, United States Code, Section 853(a).

39. Such property includes, but is not limited to, a forfeiture money judgment in an amount to be proved in this matter, representing the total value of all property representing the gross proceeds of the aforementioned offenses, or is

traceable to such property, and/or is involved in or was used to commit or facilitate the commission of, violations charged in Counts 1-10 of this Indictment.

40. Pursuant to Title 21, United States Code, Section 853(p), as incorporated by Title 18, United States Code, Section 982(b), the defendant, **KENNETH CHUN**, 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.

THIS IS A TRUE BILL.

s/Grand Jury Foreperson
Grand Jury Foreperson

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Date: June 29, 2017

ORIGINAL

United States District Court Eastern District of Michigan	Criminal Case Cover Sheet

NOTE: It is the responsibility of the Assistant U.S. Attorney signing this form to co

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Companion Case Information	**Companion Case Number:**
This may be a companion case based upon **LCrR 57.10 (b)(4)**[1]:	**Judge Assigned:**
☐ **Yes** ☒ **No**	**AUSA's Initials:** JMF

Case Title: USA v. Kenneth Chun

County where offense occurred : Oakland County

Check One: ☒**Felony** ☐**Misdemeanor** ☐**Petty**

✓ Indictment/____Information --- **no** prior complaint.
____Indictment/____Information --- based upon prior complaint **[Case number:**]
____Indictment/____Information --- based upon **LCrR 57.10 (d)** ***[Complete Superseding section below].***

Superseding Case Information

Superseding to Case No: _____ **Judge:** _____

☐ Corrects errors; no additional charges or defendants.
☐ Involves, for plea purposes, different charges or adds counts.
☐ Embraces same subject matter but adds the additional defendants or charges below:

Defendant name	**Charges**	**Prior Complaint (if applicable)**

Please take notice that the below listed Assistant United States Attorney is the attorney of record for the above captioned case.

June 29, 2017
Date

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[1] Companion cases are matters in which it appears that (1) substantially similar evidence will be offered at trial, or (2) the same or related parties are present, and the cases arise out of the same transaction or occurrence. Cases may be companion cases even though one of them may have already been terminated.