UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

June 2012 Grand Jury

UNITED STATES OF AMERICA, Plaintiff, v. TIGRAN AKLYAN, aka "Tony," Defendant.	CR No. CR 12 00904 I N D I C T M E N T [18 U.S.C. § 1349: Conspiracy to Commit Health Care Fraud; 18 U.S.C. § 1347: Health Care Fraud; 18 U.S.C. § 2(b): Causing an Act to be Done; 18 U.S.C. § 982(a)(7), 21 U.S.C. § 853, and 28 U.S.C. § 2461(c): Forfeiture]

The Grand Jury charges:

COUNT ONE

[18 U.S.C. § 1349]

A. INTRODUCTORY ALLEGATIONS

At all times relevant to this Indictment:

The Conspirators

1. Defendant TIGRAN AKLYAN ("AKLYAN"), also known as ("aka") "Tony," was the President of Las Tunas Medical Equipment, Inc. ("Las Tunas"), a supplier of durable medical equipment ("DME") located in San Gabriel, California. Prior to his ownership and operation of Las Tunas, defendant AKLYAN worked

for, among other places, Multiple Trading, Inc., d/b/a Advanced Medical Clinic ("AMC"), which operated a group of medical clinics in the Los Angeles area that generated false and fraudulent prescriptions and other documents for various DME, including power wheelchairs ("PWCs"), and diagnostic tests.

2. A co-conspirator known to the Grand Jury ("CC1") supervised activities at AMC. CC1 and others provided false and fraudulent prescriptions and documents generated at AMC to the owners and operators of DME supply companies in and around Los Angeles, including Las Tunas.

3. A second co-conspirator known to the Grand Jury ("CC2") was employed by AMC as a physician's assistant ("PA"). CC2 generated false and fraudulent prescriptions and documents at AMC, including medically unnecessary PWC prescriptions, that were provided to Las Tunas.

4. A third co-conspirator known to the Grand Jury ("CC3") was employed as a PA by medical clinics located on Rampart Boulevard and Vermont Avenue in Los Angeles (collectively "the Clinics"). CC3 generated false and fraudulent prescriptions and documents at the Clinics, including medically unnecessary PWC prescriptions. These false and fraudulent prescriptions and documents were later provided to Las Tunas.

5. Between on or about December 17, 2007, and on or about February 20, 2009, Las Tunas submitted to Medicare claims totaling approximately $910,377 for PWCs and related services, and Medicare paid Las Tunas approximately $653,461 on those claims.

The Medicare Program

6. 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").

7. CMS contracted with private insurance companies to (a) certify DME providers for participation in the Medicare program 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.

8. 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").

9. DME companies, physicians, and other health care providers that provided medical services that were reimbursed by Medicare were referred to as Medicare "providers."

10. 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, prohibits 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.

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

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

13. From in or about October 2006 onward, Noridian Administrative Services ("Noridian") processed and paid Medicare DME claims in Southern California.

14. Most DME providers, including Las Tunas, submitted their claims electronically pursuant to an agreement with Medicare that they would submit claims that were accurate, complete, and truthful.

15. 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.

16. To bill Medicare for DME it provided to a beneficiary, a DME provider was required to submit a claim (Form 1500) to Noridian. Medicare required claims to be truthful, complete, and not misleading. In addition, when a claim was submitted, the provider was required to certify that the services or supplies covered by the claim were medically necessary.

17. 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.

18. 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%.

B. THE OBJECT OF THE CONSPIRACY

19. Beginning on or about October 30, 2007, and continuing through on or about May 22, 2009, in Los Angeles County, within the Central District of California, and elsewhere, defendant AKLYAN, CC1, CC2, and CC3, together with others known and unknown to the Grand Jury, 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

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

a. On or about October 30, 2007, defendant AKLYAN purchased Las Tunas.

b. On or about October 30, 2007, defendant AKLYAN executed and submitted an application to Medicare to obtain and maintain a Medicare provider number for Las Tunas.

c. On or about October 30, 2007, defendant AKLYAN opened a corporate bank account for Las Tunas at Bank of America, account number xxxxxx3104 (the "Las Tunas BoA Account").

Defendant AKLYAN maintained sole signature authority on this account.

d. On or about November 7, 2007, defendant AKLYAN executed and submitted an electronic funds transfer agreement to Medicare, requesting that all future reimbursements from Medicare be directly deposited into the Las Tunas BoA Account.

e. CC1, CC2, and CC3 generated, and caused to be generated, false and fraudulent prescriptions and documents, including medically unnecessary PWC prescriptions, at AMC and the Clinics, respectively.

f. Defendant AKLYAN and his co-conspirators thereafter acquired these false and fraudulent prescriptions and documents for the purpose of using these prescriptions and documents to submit, and cause the submission of, false and fraudulent claims to Medicare on behalf of Las Tunas.

g. After acquiring the false and fraudulent prescriptions and documents, defendant AKLYAN and his co-conspirators submitted, and caused the submission of, false and fraudulent claims to Medicare for PWCs and related accessories that were purportedly provided by Las Tunas to Medicare beneficiaries.

h. As a result of the submission of false and fraudulent claims, Medicare made payments to the Las Tunas BoA Account.

i. Defendant AKLYAN then transferred and disbursed, and caused the transfer and disbursement of, monies from the Las Tunas BoA Account to himself and others.

COUNTS TWO THROUGH FIVE

[18 U.S.C. §§ 1347, 2(b)]

A. INTRODUCTORY ALLEGATIONS

21. The Grand Jury incorporates by reference and re-alleges paragraphs 1 through 18 above of this Indictment as though set forth in their entirety here.

B. THE SCHEME TO DEFRAUD

22. Beginning at least as early as on or about October 30, 2007, and continuing through at least on or about May 22, 2009, in Los Angeles County, within the Central District of California, and elsewhere, defendant AKLYAN, CC1, CC2, and CC3, together others known and unknown to the Grand Jury, knowingly, willfully, and with intent to defraud, executed, and attempted to execute, 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. MEANS TO ACCOMPLISH THE SCHEME TO DEFRAUD

23. The fraudulent scheme operated, in substance, as described in paragraph 20 above of this Indictment, which is hereby incorporated by reference as though set forth in its entirety here.

D. THE EXECUTION OF THE FRAUDULENT SCHEME

24. On or about the dates set forth below, within the Central District of California and elsewhere, defendant AKLYAN,

together with others known and unknown to the Grand Jury, for the purpose of executing and attempting to execute the fraudulent scheme described above, knowingly and willfully caused to be submitted to Medicare for payment the following false and fraudulent claims purportedly for power wheelchairs and related accessories:

COUNT	BENEFICIARY	CLAIM NUMBER	APPROXIMATE DATE SUBMITTED	APPROXIMATE AMOUNT OF CLAIM
TWO	M.C.	108116808102000	04/25/08	$5,536
THREE	I.P.R.	108206822979000	07/24/08	$5,541
FOUR	J.L.M.	108351835559000	12/16/08	$5,541
FIVE	J.O.	109009832504000	01/09/09	$5,541

FORFEITURE ALLEGATIONS

[18 U.S.C. § 982(a)(7), 21 U.S.C. § 853,
and 28 U.S.C. § 2461(c)]

25. The Grand Jury hereby realleges and incorporates by reference counts one through five of this Indictment as though fully set forth herein, for the purpose of alleging forfeiture, pursuant to the provisions of Title 18, United States Code, Section 982(a)(7).

26. Counts one through five of this Indictment allege acts or activities constituting federal health care fraud offenses pursuant to Title 18, United States Code, Sections 1347 and 1349. Pursuant to Title 18, United States Code, Section 982(a)(7), upon conviction of a federal health care fraud offense, defendant AKLYAN shall forfeit to the United States of America:

a. All right, title, and interest in any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of such offense; and

b. A sum of money equal to the total amount of gross proceeds derived from such offense.

27. Pursuant to Title 21, United States Code, Section 853(p), as incorporated by Title 18, United States Code, Section 982(b)(1), and Title 28, United States Code, Section 2461(c), defendant AKLYAN, if so convicted, shall forfeit substitute property, up to the value of the amount described in paragraph 26, if, by any act or omission of defendant AKLYAN, the property described in paragraph 26, or any portion thereof, cannot be located upon the exercise of due diligence; has been transferred,

sold to, or deposited with a third party; has been placed beyond the jurisdiction of this court; has been substantially diminished in value; or has been commingled with other property that cannot be divided without difficulty.

A TRUE BILL

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