UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

January 2020 Grand Jury

UNITED STATES OF AMERICA, Plaintiff, v. MINAS KOCHUMIAN, M.D., Defendant.	CR 2:20-cr-00423-RGK I N D I C T M E N T [18 U.S.C. § 1347: Health Care Fraud; 18 U.S.C. §§ 982(a)(7) and 981(a)(1)(C) and 28 U.S.C. § 2461(c): Criminal Forfeiture]

The Grand Jury charges:

COUNTS ONE THROUGH FOUR

[18 U.S.C. §§ 1347, 2(b)]

A. INTRODUCTORY ALLEGATIONS

At times relevant to this Indictment:

1. Defendant MINAS KOCHUMIAN, M.D., was a resident of Tarzana, California, within the Central District of California. Defendant KOCHUMIAN was a physician who owned, operated, and oversaw Minas Kochumian MD, a medical corporation, d/b/a California Medical and Rehabilitation Group, that operated a medical clinic located at 18251 Roscoe Boulevard, Suite 202,

Northridge, California, within the Central District of California. The majority of defendant KOCHUMIAN's patient population received health care benefits through Medicare.

The Medicare Program

2. Medicare was a federal health care benefit program, affecting commerce, that provided benefits to individuals who were 65 years and older or disabled. The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS") administered the Medicare program, which was a "health care benefit program" as defined by Title 18, United States Code, Section 24(b).

3. Individuals who qualified for Medicare benefits were referred to as Medicare "beneficiaries." Each beneficiary was given a unique health insurance claim number.

4. Health care providers who provided medical services that were reimbursed by Medicare were referred to as "providers."

5. Providers were required to maintain a medical record for each Medicare beneficiary who was their patient, and Medicare required that the medical records be accurately written, promptly complete, and accessible, and that they used a system of author identification.

6. To participate in the Medicare program, providers, including physicians, were required to submit an application in which the provider agreed: (a) to comply with all Medicare-related laws and regulations; and (b) not submit claims to Medicare knowing they were false or fraudulent or with deliberate ignorance or reckless disregard of their truth or

falsity. If Medicare approved the provider's application, Medicare assigned the provider a Medicare "provider number" which was used for submitting, processing, and paying claims to Medicare for services rendered to beneficiaries.

7. CMS contracted with regional contractors to process and pay Medicare claims. Noridian Administrative Services, LLC ("Noridian") was the Medicare contractor that processed and paid claims involving physician services in the Central District of California from approximately September 2013 to at least approximately December 2019. Prior to Noridian, from at least approximately January 2010 to approximately September 2013, the contractor for claims involving physician services in the Central District of California was Palmetto GBA.

8. The Medicare program required that claims for services reported the type of service using the American Medical Association's Current Procedural Terminology ("CPT") codes. CPT codes were intended to accurately identify, simplify, and standardize billing for medical services. The amount of reimbursement to a provider for a service based on CPT code varied depending on the work involved in the procedure, the complexity of the procedure, practice expenses, and malpractice insurance expenses.

9. For injections, when the provider purchased the drug injected, providers often submitted claims using two CPT codes: one for the administration of the injection and one for the drug injected.

10. A provider could submit a claim to Medicare through the mail or electronically. When submitting a claim, the

providers were required to certify: (a) that they were responsible for all claims submitted to Medicare by themselves, their employees, and their agents; and (b) that they would submit claims that were accurate, complete, and truthful.

11. Medicare generally reimbursed providers for physician services and procedures only if the services and procedures were medically necessary to the health of the beneficiary and were actually provided to the beneficiary by the physician or the physician's employee under the physician's direction.

12. On or before July 1, 2003, defendant KOCHUMIAN enrolled as a medical provider in the Medicare program. On or about June 17, 2013, defendant KOCHUMIAN revalidated his Medicare enrollment. In each enrollment document, defendant KOCHUMIAN certified that he would abide by the Medicare Program's rules and regulations, including an agreement that he would not submit false or fraudulent claims for reimbursement.

B. THE SCHEME TO DEFRAUD

13. Beginning no later than in or around March 2013, and continuing through at least in or around December 2019, in Los Angeles County, within the Central District of California, and elsewhere, defendant KOCHUMIAN, together with others known and unknown to the Grand Jury, knowingly, willfully, and with intent to defraud, executed, attempted to execute, and caused to be executed a continuing 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 materially 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. MANNER AND MEANS TO ACCOMPLISH THE SCHEME TO DEFRAUD

14. The fraudulent scheme operated, in substance, as follows:

a. Defendant KOCHUMIAN used itemized forms, known as "charge tickets" or "superbills," to mark the CPT codes for the procedures and services he purportedly rendered to Medicare beneficiaries.

b. Defendant KOCHUMIAN marked a variety of procedures and services on charge tickets that he never rendered to Medicare beneficiaries ("the fraudulent procedures and services"). The fraudulent procedures and services included:

i. Injections of denosumab, commercially known as "Prolia," billed by defendant KOCHUMIAN using CPT codes J0897 and 96372 for the drug and administration of the injection, respectively;

ii. Injections of ibandronate sodium, commercially known as "Boniva," billed by defendant KOCHUMIAN using CPT codes J1740 and 96374 for the drug and administration of the injection, respectively;

iii. Injections of hyaluronan or derivative, commercially known as "Euflexxa," billed by defendant KOCHUMIAN using CPT codes J7323 and 20610 for the drug and administration of the injection, respectively;

iv. Drainage of tailbone cysts, billed by defendant KOCHUMIAN using CPT code 10081 for the procedure;

v. Destruction of external female genital growths, billed by defendant KOCHUMIAN using CPT code 56501 for the procedure;

vi. Destruction of internal anal hemorrhoids, billed by defendant KOCHUMIAN using CPT code 46930 for the procedure; and

vii. Removal of malignant growth (0.5 centimeters or less) of the trunk, arms, or legs, billed by defendant KOCHUMIAN using CPT code 11600.

c. Defendant KOCHUMIAN submitted these charge tickets, with the fraudulent procedures and services marked, to third-party billing personnel, knowing and intending that those billing personnel would use the charge tickets in the submission of claims to Medicare for the fraudulent procedures and services for reimbursement to defendant KOCHUMIAN.

d. As a result of the submission of such false and fraudulent claims, Medicare made payments to defendant KOCHUMIAN's City National Bank account, defendant KOCHUMIAN's Union Bank account, and defendant KOCHUMIAN's J.P Morgan Chase account.

15. From in or around March 2013 to in or around December 2019, defendant KOCHUMIAN caused the submission of approximately $41,549,346 in claims to Medicare, and received approximately $14,724,827 in reimbursement on those claims. Of that amount, defendant KOCHUMIAN caused the submission of at least approximately $20,523,031 in claims to Medicare using the CPT codes associated with the fraudulent procedures and services,

and received approximately $7,001,479 in reimbursement on those claims.

D. EXECUTIONS OF THE FRAUDULENT SCHEME

16. On or about the dates set forth below, within the Central District of California, and elsewhere, defendant KOCHUMIAN, together with others known and unknown to the Grand Jury, knowingly and willfully executed, attempted to execute, and caused to be executed the fraudulent scheme described above by submitting and causing to be submitted to Medicare for payment the following false and fraudulent claims:

COUNT	BENEF-ICIARY	DATE SUBMITTED	CLAIM NUMBER	PROCEDURE	CPT CODE	AMOUNT BILLED
ONE	M.M.	5/11/2016	55111613 3088100	Injection into large joint or joint capsule of Hyaluronan or derivative, euflexxa	20610; J7323	$600
TWO	A.A.	8/4/2016	55111621 8066560	Drainage of tailbone cyst	10081	$600
THREE	S.C.	10/7/2016	55111628 4028210	Injection beneath the skin or into muscle of denosumab, 1 mg	96372; J0897	$1275
FOUR	L.A.	4/6/2017	55111709 7064942	Injection into a vein of ibandronate sodium, 1 mg	96374; J1740	$925

FORFEITURE ALLEGATION

[18 U.S.C. §§ 982(a)(7), 981(a)(1)(C) and 28 U.S.C. § 2461(c)]

17. Pursuant to Rule 32.2(a), Fed. R. Crim. P., notice is hereby given to defendant MINAS KOCHUMIAN, M.D., that the United States will seek forfeiture as part of any sentence in accordance with Title 18, United States Code, Sections 982(a)(7) and 981(a)(1)(C), and Title 28, United States Code, Section 2461(c), in the event of defendant's conviction under any of the Counts One through Four of this Indictment.

18. Defendant KOCHUMIAN, if so convicted, shall forfeit to the United States the following property:

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

b. A sum of money equal to the total value of the property described in subparagraph a. above.

19. Pursuant to Title 21, United States Code, Section 853(p), as incorporated by Title 28, United States Code, Section 2461(c), and Title 18, United States Code, Section 982(b), defendant shall forfeit substitute property, up to the total value of the property described in the preceding paragraph if, as a result of any act or omission of defendant, the property described in the preceding paragraph, or any portion thereof (a) cannot be located upon the exercise of due diligence; (b) has been transferred, sold to or deposited with a third party; (c) has been placed beyond the jurisdiction of the Court; (d) has been substantially diminished in value; or (e) has been

commingled with other property that cannot be divided without difficulty.

A TRUE BILL

/S/

Foreperson

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