IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITED STATES OF AMERICA	:	**CRIMINAL NO. 16-_____**
v.	:	**DATE FILED: _____**
BASSEM KURAN	:	**VIOLATIONS:**
	:	**18 U.S.C. § 1035 (false statement in a health care matter – 1 count)**
	:	**18 U.S.C. § 2 (aiding and abetting)**
	:	**Notice of Forfeiture**

INFORMATION

COUNT ONE

(False Statements in a Health Care Matter)

THE UNITED STATES ATTORNEY CHARGES THAT:

At all times material to this Information:

INTRODUCTION

The Defendant and VIP Ambulance, Inc.

1. On or about July 25, 2011, VIP Ambulance, Inc. ("VIP") was incorporated in the Commonwealth of Pennsylvania, with an initial corporate address of 220 Geiger Road, Suite 201, Philadelphia PA 19115.

2. The defendant, BASSEM KURAN was President and sole owner of VIP.

3. In or around October 2011, VIP applied to participate as a provider in the Medicare Program. Defendant BASSEM KURAN signed VIP's application to enroll as a Medicare provider, was the only Delegated Official identified in that application, and was the primary signatory on VIP's checking account.

4. In signing the application on behalf of VIP, defendant BASSEM KURAN certified that he understood that "any deliberate omission, misrepresentation, or falsification of any information contained in... any communication supplying information to Medicare… may be punished by criminal… penalties…." He further certified that he understood that payment of a claim by Medicare was conditioned upon the claim and the underlying transaction complying with federal law, and he agreed not to present or cause to be presented any false or fraudulent claim for payment by Medicare.

5. Starting in or around December 2011, VIP operated ambulances in the Philadelphia area. Virtually all of VIP's transports were taking Medicare beneficiaries to and from dialysis. The majority of dialysis patients needed to attend dialysis treatments three times per week, thereby allowing VIP to bill extensively for them.

The Medicare Program

6. Medicare was a federal health insurance program administered by the Centers for Medicare and Medicaid Services ("CMS"), an agency of the U.S. Department of Health and Human Services. Medicare helped to pay for reasonable and medically necessary medical services for people aged 65 and older and some persons under 65 who were blind or disabled. Medicare was divided into several parts, including Part B, outpatient services.

7. Under Medicare Part B, payment was made to providers of outpatient services. Such providers included medical transportation providers. Medicare beneficiaries paid a monthly premium for Medicare Part B.

8. CMS contracted with private insurance companies under Part B to receive, adjudicate, and pay Medicare claims submitted by approved and participating health care

providers and suppliers. Once contracted to process Medicare Part B claims, these private insurance companies were known as Medicare Administrative Contractors ("MAC"). CMS contracted with Novitas Solutions, Inc. ("Novitas," formerly known as Highmark Medicare Services, Inc.) to be the MAC to process and pay Medicare Part B claims in the Commonwealth of Pennsylvania.

9. As the MAC, Highmark was required to process applications from medical providers seeking to enroll in the Medicare program. Once the application was reviewed and approved, a provider was enrolled and issued a unique provider number. The provider number was required on all claims submitted by the provider to the carrier for payment.

10. The MAC issued a provider number to VIP based upon VIP's initial enrollment application to Medicare, signed on or about October 12, 2011 by defendant BASSEM KURAN, acting as the authorized agent for VIP.

11. Upon enrollment, providers were issued a provider manual that generally described the requirements to participate as a provider in the Medicare program. Providers also periodically received newsletters advising them of additional requirements for participation and instructions concerning which services were covered or not covered by Medicare and the prerequisites for coverage.

Payment for Medicare Claims to Providers

12. All providers and suppliers of Medicare Part B services were required to submit, within one year from the date of service, claims to the MACs on behalf of Medicare beneficiaries. During this period, providers could file their Medicare Part B claims either electronically or in paper form.

13. Providers were required to certify that (1) the services provided were medically necessary; (2) the services were personally provided by the person signing the form, or by one of his/her employees acting under the signer's direction; and (3) the information contained in the form was true, accurate, and complete. The provider number was included as a part of each submission.

14. Medicare paid for regularly scheduled, non-emergency ambulance transports to certain locations, including dialysis centers, only if either: (a) the beneficiary was bed-confined and it was documented that the beneficiary's condition was such that other methods of transportation were contraindicated (i.e., bed confinement alone was not itself a sufficient basis for such transportation), or (b) the beneficiary's medical condition, regardless of bed confinement, was such that transportation by ambulance was medically required. For a beneficiary to be bed-confined, the following criteria were required to be met: (1) the beneficiary was unable to get up from bed without assistance, (2) the beneficiary was unable to "ambulate," and (3) the beneficiary was unable to sit in a chair or wheelchair.

15. In all cases, CMS required that the appropriate documentation be kept on file and, upon request, presented to the carrier. For example, Medicare required ambulance providers to obtain a physician's written order certifying the need for an ambulance for scheduled non-emergency transports. CMS made clear that neither the presence nor absence of a signed physician's order for an ambulance transport proved (or disproved) whether the transport was medically necessary. The ambulance service had to meet all program coverage criteria in order for payment to be made, including the medical necessity requirement.

16. VIP submitted its claims electronically, via computer, to Novitas for reimbursement by Medicare. On all but one occasion, VIP received its Medicare reimbursement by electronic funds transfer to an account at Citizen's Bank in the name of VIP, upon which defendant BASSEM KURAN was a signatory. On the remaining occasion, VIP received a check which was split-deposited into two different accounts at Citizen's Bank in VIP's name. BASSEM KURAN was a signatory on both accounts.

The False Statements

17. Prior to becoming President of VIP, defendant BASSEM KURAN had been employed by another Medicare provider, Brotherly Love Ambulance ("Brotherly Love").

18. On or about October 4, 2011, the premises of Brotherly Love were searched pursuant to a federal search warrant, after which Brotherly Love immediately ceased operations. The operation of Brotherly Love resulted in felony convictions of its owner, three of its employees, and four of its beneficiaries.

19. Part of the scheme at Brotherly Love involved Medicare beneficiaries who were not actually transported to dialysis by ambulance at all but who instead drove themselves or one another to dialysis much or all of the time. Among the Medicare beneficiaries who participated in this aspect of the Brotherly Love scheme were C.B., L.B., and J.A.

20. C.B. pleaded guilty to accepting kickbacks and making false statements. During that process, C.B. admitted that he had allowed Brotherly Love to bill Medicare as though it were transporting him when in fact he was driving himself and others including L.B. and, at times, J.A. to dialysis.

21. In or around 2012, VIP billed Medicare for the transport of C.B., L.B., and J.A.

22. The defendant, BASSEM KURAN, personally signed documentation in the form of ambulance "run sheets" certifying that he had served as the driver on ambulances transporting Medicare beneficiaries C.B., L.B. and J.A. Each of these run sheets identified the date of the claimed ambulance service and specified the time at which the service occurred. Those runs were billed to Medicare and were paid by Medicare based on VIP's representation that the runs had occurred.

23. CMS retained contractors to perform audits of billing by its providers, including suspicious billings. These contractors were empowered to request documents from providers to substantiate or justify the providers' billings.

24. In or around 2013, the CMS audit contractor requested documents from VIP Ambulance to substantiate VIP's billings.

25. On or about November 8, 2013, in response to the contractor's requests, on behalf of VIP, defendant BASSEM KURAN provided run sheets to substantiate the ambulance transports for which VIP had been paid. Among the run sheets that defendant BASSEM KURAN provided were run sheets that defendant BASSEM KURAN had signed, certifying that he had been the ambulance driver for ambulance trips for C.B., L.B., and J.A. on particular dates and times that were among those for which Medicare had paid VIP.

26. These run sheets described services paid by Medicare that could not have been provided as the run sheet described them.

27. For example, defendant BASSEM KURAN signed a run sheet, which he provided to the CMS audit contractor to substantiate a bill submitted to Medicare, certifying that he had

transported Medicare beneficiary C.B. on January 30, 2012. C.B. had received a kidney transplant in January 2012 and neither required nor received dialysis on January 30, 2012.

28. Defendant BASSEM KURAN also signed a run sheet certifying that he had transported C.B. on February 3, 2012. C.B. neither required nor received dialysis on February 3, 2012.

29. Defendant BASSEM KURAN also signed a run sheet certifying that he had transported Medicare beneficiary L.B. on February 17, 2012. L.B. did not receive dialysis on February 17, 2012.

30. Defendant BASSEM KURAN also signed a run sheet certifying that he had transported Medicare beneficiary L.B. on March 2, 2012. L.B. did not receive dialysis on March 2, 2012.

31. In each of the foregoing cases, the times listed on the run sheets were consistent with what they would have been had the patient actually received dialysis that day.

32. At all times relevant to this Information, C.B. was ambulatory and, accordingly, no transport of C.B. by ambulance would have been medically necessary under the governing Medicare regulations. Nonetheless, trip sheets for the alleged transport of C.B. were written so as to suggest that such transportation was necessary.

33. Until his kidney transplant, C.B. drove himself to and from dialysis.

34. At all times relevant to this Information, L.B. was ambulatory and, accordingly, no transport of L.B. by ambulance would have been medically necessary under the governing Medicare regulations. Nonetheless, the trip sheets for the alleged transport of L.B. were written so as to suggest that such transportation was necessary.

35. L.B. took public transportation to and from dialysis during the time that defendant BASSEM KURAN certified that he was transporting L.B. as a driver at VIP.

36. Medicare paid VIP $66,901.93 for transporting C.B., L.B. and J.A. to and from dialysis.

37. Between January 30, 2012 and March 2, 2012, in the Eastern District of Pennsylvania, defendant

BASSEM KURAN

knowingly and willfully made materially false statements and representations and used a materially false writing or document knowing the same to contain a materially false statement in connection with the delivery of or payment for health benefits, items or services, that is ambulance transportation, in a matter involving a health care benefit program, that is Medicare,

All in violation of Title 18, United States Code, Sections 1035 and 2.

NOTICE OF FORFEITURE

THE UNITED STATES ATTORNEY FURTHER CHARGES THAT:

1. As a result of the violation of Title 18, United States Code, Section 1035, set forth in this indictment, defendant

BASSEM KURAN

shall forfeit to the United States of America any property that constitutes or is derived from gross proceeds traceable to the commission of such offense(s), including, but not limited to, $66,901.93 paid for false claims, and any other accounts and proceeds of these offenses.

2. If any of the property subject to forfeiture, as a result of any act or omission of the defendant:

(a) cannot be located upon the exercise of due diligence;

(b) has been transferred or sold to, or deposited with, a third party;

(c) has been placed beyond the jurisdiction of the Court; or

(d) has been substantially diminished in value,

it is the intent of the United States, pursuant to Title 18, United States Code, Section 982(b), incorporating Title 21, United States Code, Section 853(p), to seek forfeiture of any other property of the defendant up to the value of the property subject to forfeiture.

All pursuant to Title 18, United States Code, Section 982(a)(7).

ZANE DAVID MEMEGER
United States Attorney

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