

## **FIVE ARRESTED IN HEALTH CARE FRAUD SCHEME THAT COLLECTED AT LEAST \$20 MILLION FROM MEDICARE PROGRAM**

**Los Angeles, CA** - An Altadena couple, two of their relatives and a fifth associate were arrested this morning on federal charges related to a long-running Medicare fraud scheme that netted at least \$20 million when the federal health care program paid for tests that either were unnecessary or were never performed.

A criminal complaint unsealed this afternoon details a scheme to pay kickbacks to recruit patients and to submit fraudulent billings to Medicare on behalf of medical service providers, such as medical clinics and diagnostic testing centers. The scheme is commonly called a beneficiary-sharing or patient-rotating scheme in which "marketers" obtain data about Medicare beneficiaries and sell the information to Medicare providers who engage in fraudulent billings. Some marketers known as "cappers" recruit patients with Medicare coverage to travel to clinics and receive services that are medically unnecessary, and sometimes they receive no medical services at all.

In a scheme that allegedly began in 1997, the defendants, led by Konstantin Mikhaylovich Grigoryan, conducted fraudulent activity through 12 Los Angeles-area medical providers. The providers were controlled by the defendants and purportedly conducted diagnostic tests, such as ultrasound examinations and blood tests. The medical providers allegedly generated revenue by utilizing cappers who brought in Medicare beneficiaries by car, van and bus from across California in exchange for kickbacks. Once the patients came into a physician's office, the medical providers allegedly billed the patients' Medicare numbers on the dates of their visits and on many other dates – whether or not any services were in fact provided to the beneficiaries. In many cases where diagnostic testing services were billed to Medicare, according to the complaint, there was no test actually performed on the patient on the purported date of service. The conspirators would fabricate the tests so that the patients' files could withstand an audit by Medicare.

The five defendants arrested this morning are scheduled to make their initial court appearances this afternoon in United States District Court in Los Angeles. They are:

- Konstantin Grigoryan, 56, of Altadena;
- Mayya Leonidovna Grigoryan, 54, who is Konstantin's wife;
- Eduard Gershelis, 34, of Los Angeles, who is the Grigoryans' son-in-law;
- Aleksandr Treyner, 48, of Canoga Park, who is Mayya Grigoryan's brother-in-law; and
- Haroutyun Gulderyan, 36, of Tujunga.

The defendants are charged in a criminal complaint with conspiracy, health care fraud, medicare kickbacks, false statements as to a Medicare Part B provider and money laundering.

The complaint alleges that the scheme caused Medicare to pay out at least \$20 million in fraudulent claims from 2000 until 2005. Much of the money was deposited into a maze of bank accounts of "management" and "consulting" companies, including a Panamanian shell corporation with a Swiss account.

This case is the result of an ongoing investigation by the Federal Bureau of Investigation; the United States Department of Health and Human Services, Office of the Inspector General; and IRS-Criminal Investigation Division. The Centers for Medicare & Medicaid Services provided assistance in the investigation.

## **Burbank Man Sentenced to Eight Years in Federal Prison for Laundering Proceeds Related to Health Care Fraud**

A publisher of Russian-language newspapers and magazines was sentenced today to eight years in federal prison for running a sophisticated “cash-back” scheme that helped numerous perpetrators of health care fraud to avoid the payment of taxes and to obtain cash to be used for kickbacks to associates.

Andranik Petrosian, 43, of Burbank, was sentenced to 96 months in prison by United States District Judge Stephen V. Wilson. In addition to the prison term, Judge Wilson ordered Petrosian to pay \$521,845 in restitution to the Internal Revenue Service.

Following a trial in April 2008, a federal jury convicted Petrosian of conspiracy to defraud the Internal Revenue Service and making false statement to special agents with the IRS.

At today’s sentencing hearing, Judge Wilson said the evidence at trial showed that Petrosian was at the “fulcrum” of a money-laundering scheme that helped perpetrators of health care fraud avoid paying federal taxes.

A joint investigation by IRS-Criminal Investigation, the Federal Bureau of Investigation, and the Office of Inspector General for the U.S. Department of Health and Human Services found that Petrosian used his publications as fronts to launder more than \$10 million for fraudulent medical companies. The medical companies wrote checks to Petrosian's companies—which included the newspaper Contact Weekly and the magazines Kakadu and Tet-a-Tet—for advertising or graphic design services that were never provided. Petrosian returned approximately 90 percent of the money to the medical company administrators in cash. The cash was handed over in white envelopes during back-office meetings at Petrosian’s office on Glenoaks Boulevard in Burbank. Petrosian obtained large quantities of cash, either by smuggling cash into the United States derived from wire transfers to Armenia, or via an elaborate Hawalla-type money-changing system.

Petrosian provided invoices for the advertising, which allowed the medical companies to falsely deduct the payments on their tax returns. While Petrosian did place advertisements in his

publications, these advertisements were worth only a small fraction of the price paid by medical companies across the Southwest. The medical company administrators used the cash Petrosian returned to finance payments made to patients and cappers as part of their health care fraud schemes.

Petrosian's operation fueled medical insurance fraud schemes by providing a steady stream of untraceable cash. In one such scheme, a clinical laboratory used the cash Petrosian provided to make illegal kickback payments to clinics in exchange for the clinics referring blood samples to the laboratory for analysis. The payments motivated the clinics to refer patients for medically unnecessary tests that were paid for by Medicare. The organization involved in this scheme defrauded Medicare out of more than \$20 million