IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
GALVESTON DIVISION

United State *ex rel* Ryan Griffin and The State of Texas *ex rel* Ryan Griffin Plaintiffs, v. Mediscope Global Services Pvt Ltd, Kamala Vinodh, Texas Medical Summit, Inc., Doctor's Hospital 1997, L.P., Ravishanker Mallapuram, Syed Mohiuddin, Farida Moeen, United Memorial Medical Center LLC, and Tidwell/Parkway Ventures, LLC Defendants.	§ § § § § § § § § § § § § § § § §	Civil Action No. 3:21-cv-00183

FIRST AMENDED COMPLAINT FOR VIOLATIONS OF THE FALSE CLAIMS ACT AND THE TEXAS MEDICAID FRAUD ACT

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unearned Medicare payments and unearned payments under the CARES Act. Mallapuram, Mohiuddin and others furthered the scheme by at least, preventing UMMC from correcting its false 2018 cost report, by preventing UMMC from submitting subsequent year cost reports, and by failing and refusing to correct Vinodh and Mediscope's misconduct.

4. The Defendants also induced unearned payments for UMMC under the State of Texas's medicaid programs using inflated pricing and by submitting false medical claims. Relator specifically informed the hospital, two of its vendors and their controlling persons of the fraudulent conduct and provided specific guidance for the Defendants to cure their fraud. Defendants refused and failed to do so, resulting in Relator's resignation as an employee of UMMC. Defendants continue to engage in the same fraudulent conduct, using false representations to receive money from the United States and the State of Texas.

5. Defendants have also defrauded the United States through fraud by silence[1] as well as by knowingly retaining overpayments made to UMMC by Medicare. Defendants submitted claims for payment under Medicare and under the CARES Act without notifying the United States that the claims submitted made UMMC's cost to charge ratio inaccurate. Under the circumstances, Defendants had a duty to inform the United States of this fact and knowingly failed to do so. Further, Defendants defrauded the United States by failing to notify it and its contractors that UMMC's cost-to-charge ratio was inaccurate. By failing to provide such notice, Defendants retained money owed to the United States because of overpayment of outlier claims in violation of the Federal False Claims Act.

6. Defendants' conduct constitutes a conspiracy under the 31 U.S.C. §3729. The fraudulent conduct was performed under one or more agreements between Defendants to submit false

[1] See, *Universal Health Servs., Inc. v. United States*, 136 S. Ct. 1989 (2016)

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1. Relator brings this action on behalf of the United States and on behalf of the State of Texas complaining of Mediscope Global Service Pvt. Ltd. ("Mediscope"), Kamala Vinodh ("Vinodh"), Doctor's Hospital 1997, L.P. d/b/a United Memorial Medical Center ("UMMC"), Ravishanker Mallapuram ("Mallapuram"), Syed Mohiuddin ("Mohiuddin"), Ayraa Med RCM, LLC ("Ayraa Med"), Texas Medical Summit, Inc. ("Medsum"), Farida Moeen ("Moeen"), and entities through which others have exercised control of UMMC. Mediscope and Vinodh developed a systemic method of defrauding the United States, the State of Texas and other payors through turbocharging, manipulating provider cost-to-charge ratios, inhibiting the United States' and the State of Texas's ability to audit its records, by submitting claims that included charges for services not performed and by billing the United States for services for which UMMC received payment from others. These fraudulent claims caused the United States and the State of Texas to make outlier payments and duplicate payments to UMMC to which the hospital was not entitled.
2. Medsum and subsequently Ayraa Med acted as intermediaries for submission of medical claims prepared by Mediscope on behalf of UMMC. Mediscope insulates itself from action by or on behalf of the United States by not having a place of business in the United States, by not registering to do business in any U.S. jurisdiction and by using U.S. intermediaries such as Medsum and Ayraa Med as a cover or front. Defendants Mohiuddin and Mallapuram are controlling persons with respect to both UMMC and Ayraa Med and caused UMMC and Ayraa Med to participate in the Mediscope scheme. Mohiuddin and Mallapuram personally profited from the scheme through their ownership interests in Ayraa Med and in UMMC.
3. Defendants agreed for Mediscope and its intermediaries to defraud the United States through turbocharging and through submission of false medical claims to so that UMMC would receive

claims such that UMMC could receive overpayments from the United States to which UMMC was not entitled pursuant to the Medicare statutes and regulations and pursuant to the CARES Act, as further described below. Defendants also entered one or more agreements to retain the overpayments made to UMMC, protecting each of their own unlawful gains.

PARTIES

7. Relator, Ryan Griffin, is, and was at all times material to this complaint a resident and citizen of Montgomery County, Texas. Mr. Griffin may be served via the undersigned counsel. Mr. Griffin has standing to bring this claim because he has non-public information in the form of emails and verbal communications showing the several defendants' knowledge regarding false claims being made including (i) UMMC was receiving overpayments from the United States and the State of Texas, (ii) the extent to which such overpayments were being made and (iii) the specific mechanisms by which Defendants made claims to receive such overpayments.

8. Defendant Mediscope Global Services is an entity that advertises itself as having facilities at "#6 TNHB Main Road, Chenai, [India] 600 054". Mediscope performs billing services for medical providers in the United States, including through intermediate entities authorized to do business in the United States. Mediscope has specifically targeted commercial activity to the United States and the State of Texas through contracts with at least Defendants Texas Medical Summit, Inc. and Ayraa Med RCM, LLC. Mediscope has not registered to do business in the State of Texas and therefore Mediscope may be served by service on the Texas Secretary of State.

9. Defendant Kamala "Kathy" Vinodh is a founder and principal of Mediscope Global Services and the "Managing Director". Vinodh may also be known as Kamala Kannan, Kannan Kamala and by other names. Based on information provided to Relator by Ms. Vinodh, she is a resident

of Chenai, India. Ms. Vinodh may be reached by phone at (972) 502-9160 or (832) 267-3480. Ms. Vinodh travels to and within the United States from time to time and may be served with process at any place within the United States that she may be found.

10. Defendant Doctors Hospital 1997, L.P, is a limited partnership organized and existing under the laws of the State of Texas, with principal offices at 510 W Tidwell Road, Houston, Texas and being engaged in the business of, *inter alia*, supplying medical services to enrollees of the United States Medicare System and to uninsured persons pursuant to the United States CARES Act as a result of which Doctors Hospital 1997, LP has received and continues to receive over $30,000,000 each year from the United States. Doctors Hospital 1997, L.P. also provides medical services to enrollees of the Texas Medicaid system. Doctors Hospital 1997, L.P. may be served through its registered agent, Ravishanker Mallapuram at 510 W Tidwell Road, Houston, Texas or wherever he may be found. Doctors Hospital 1997, L.P. does business under the assumed name United Memorial Medical Center and may be referred to in this Complaint as "UMMC".

11. Defendant Texas Medical Summit, Inc. is a Texas Corporation with an address at 270 Southwyck Lane, Allen, Collin County, TX 75013. Texas Medical Summit was a billing vendor for UMMC from approximately September 1, 2018 until about December 28, 2018. Texas Medical Summit may be served through Adnan Shaikh, its agent for service of process, at 270 Southwyck Lane, Allen, TX 75013 or wherever he may be found.

12. Defendant Ayraa Med RCM LLC is a limited liability company organized and existing under the laws of the State of Texas, with its principal offices at 13605 Summer Cloud Lane, Pearland, Texas and is engaged in the business of medical billing, including preparation and submission of invoices on behalf of UMMC to request payment under the United States

Medicare System, pursuant to the CARES Act, and under the Texas Medicaid System. Ayraa Med RCM LLC may be served through its registered agent, Ravishanker Mallapuram, at 13605 Summer Cloud Lane, Pearland, Texas or wherever he may be found.

13. Defendant United Memorial Medical Center, LLC ("United Memorial LLC") became the general partner of UMMC in January of 2020. United Memorial LLC may be served through its agent for service, Ravishanker Mallapuram, at 7501 Fannin Street, Houston, Texas or wherever he may be found.

14. Defendant Tidwell/Parkway Ventures, LLC was the general partner of UMMC from 2006 until an unknown date in 2019 or 2020. Tidwell/Parkway Ventures LLC was terminated on February 12, 2020 and is still subject to suit under Tex. Bus. Org. Code § 11.356. Tidwell/Parkway Ventures, LLC may be served through is agent for service, Syed Mohiuddin, at 510 West Tidwell Road, Houston, Texas or wherever he may be found.

15. Defendant Ravishanker Mallapuram is an individual and resident of Fort Bend County, Texas. Mr. Mallapuram is and has been a controlling person of UMMC during the period of the fraud complained of herein as he is a 67% owner or beneficial owner of UMMC, he is listed as controlling person in UMMC's 2019 Public Information Report filed with the Texas Secretary of State, he was the sole Manager of United Memorial LLC when that entity became the general partner of UMMC in 2020. Mr. Mallapuram is also the controlling person and sole Managing Member, of Ayraa Med RCM, LLC. Mr. Mallapuram may be served at 13605 Summer Cloud Lane, Pearland, Texas or wherever he may be found.

16. Defendant Syed Mohiuddin is an individual and resident of Harris County, Texas. Mr. Mohiuddin was a controlling person of UMMC through his roles as Manager of

Tidwell/Parkway Ventures, LLC and of United Memorial LLC. Mr. Mohiuddin may be served at 510 W Tidwell Road, Houston, Texas or wherever he may be found.

17. Defendant Farida Moeen ("Moeen") is an individual and the CEO of UMMC. She may be served at 510 W. Tidwell, Rd, Houston, Texas or wherever she may bee found.

JURISDICTION AND VENUE

18. This Court has jurisdiction pursuant to 31 U.S.C. §§ 3730(b)(1) and 3732 inasmuch as this action seeks remedies on behalf of the United States for violations of 31 U.S.C. § 3729 by defendants acting individually and in concert and each of the Defendants can be found, resides and transacts business in this District. Venue exists in this District pursuant to 31 U.S.C. § 3730(b)(1) and 3732 as Defendants UMMC, Ayraa Med, Mohiuddin, Mallapuram, Moeen, United Memorial LLC and Tidwell/Parkway Ventures are residents of this Judicial District, all Defendants conduct or have conducted business in this Judicial District, including by submitting claims on behalf of UMMC, and a substantial portion of the wrongful conduct claimed herein occurred in this Judicial District.

OUTLIER PAYMENTS

19. Defendants knowingly caused, and intended to cause, the United States and the State of Texas to make outlier payments to which UMMC was not entitled. Relator therefore provides this brief summary of the outlier payment programs as background for discussion of Relator's interactions with Defendants and of Defendants' unlawful conduct.

20. Medicare regulations provide that hospitals such as UMMC will be compensated under the inpatient prospective payment system ("IPPS") for patients actually admitted into the hospital. "Under the IPPS, each case is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare

patients in that DRG." Exhibit 1, downloaded from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS on July 9, 2021. The DRG payment weight is then used to determine the amount that the treating hospital will receive for its services. Payment determined according to the DRG will constitute full and complete payment for the services except where the costs to treat a specific patient are uncommonly high.[2]

21. For hospital outpatient services, Medicare uses Ambulatory Payment Classification (APC) to determine payments. Similarly to DRG weights for inpatient services, APC weights, and therefore reimbursement amounts, are determined using claims and cost report data for hospital based outpatient departments. The outpatient reimbursement system for hospitals is referred to as "OPPS".

22. Medicare provides for outlier payments under both IPPS and OPPS when a specific patient's care is unusually costly. "The hospital's cost to charge ratios are applied to the covered charges for a covered case to determine whether the costs of the case exceed the fixed-loss outlier threshold." Exhibit 2, downloaded from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/outlier on July 9, 2021. "[T]he outlier payment is based on a marginal cost factor equal to 80 percent of the combined operating and capital costs in excess of the fixed-loss threshold." Id.[3] If the billed charges multiplied by the hospital's cost-to-charge ratio exceeds a certain amount, the hospital receives additional funds from Medicare for the treatment of that patient.

23. A critical component of the IPPS and OPPS systems is the annual cost report that hospitals must submit. This report provides the operational and capital cost data used by Medicare and

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[2] A detailed discussion of Outlier Payments for Inpatient Care can be found at 68 C.F.R. 34494 – 34515, *Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient and Long-Term Care Hospital Prospective Payment Systems*; Final Rule.

[3] A sample calculation may be found at 68 CFR 34494-34495.

its contractors to determine each hospital's CCR that apply to claims submitted. When a new cost report is provisionally accepted, the CCR calculated under that report becomes the basis for determining outlier payments on subsequent claims. Medicare also reconciles the outlier payments made for a period against the actual CCR that is later calculated for that period, e.g. when the 2020 cost reports are accepted for a hospital, Medicare will re-evaluate the hospital's 2020 outlier payments against its actual 2020 CCR. Medicare can then recoup any overpayments made due to charge inflation or other factors that would make the hospital's actual CCR for the period be lower than the CCR applied when outlier payments were made.

24. The United States Health and Human Services Department adopted the IPPS and OPPS systems to determine hospital reimbursements made under the CARES Act. The U.S. Department of Health and Human Services also adopted CMS's rule for determining whether to make, and the amount of, outlier payments under the CARES Act. 85 F.R. 71142-71205. UMMC began submitting claims under the CARES Act in May of 2020.

25. Texas Health and Human Services also uses a pre-calculated base amount for services provided to subscribers of the Texas Medicaid System. Outlier payments are also available under Medicaid. Like the Medicare system, outlier payments under Texas Medicaid compare a calculated cost of treatment with a designated threshold dollar amount. If the calculated cost of treatment exceeds the threshold, the hospital receives an outlier payment. Also like Medicare, the Texas Medicaid System relies on honest claims and honest cost reports in implementing its outlier payment system. 1 Tex. Admin. Code §§ 355.8052 and 8061.

SUBMISSION OF FALSE CLAIMS FOR SARS-COV-2 TESTING

26. Defendants have also defrauded the United States by submission of claims to the United States for services subject to payment by third parties. Further, UMMC accepted and retained

payments by the United States even when such third parties actually tendered payment. UMMC rovided over 14,000 COVID-19 tests to individuals pursuant to a contract with the Texas Department of Emergency Management. Relator has identified 12,707 medical claims subject to contracts with, and payments by, the Texas Department of Emergency Management that UMMC submitted for payment under HRSA. The United States paid $1,576,573.26 as compensation for these claims already paid, or subject to payment, by the State of Texas.

27. Relator has identified at least 102,252 medical claims, that on information and belief subject to contracts with, and payments by, the city Houston's Health Department. The United States paid $12,431,155.48 as compensation for these claims. UMMC received at least a portion of these payments without verifying that tested patient did not have health insurance. Further, on information and belief, UMMC received payments for these claimsunder an Agreement with the city of Houston. RELATOR

28. Relator Ryan Griffin is a highly experienced medical administrator with substantial experience in hospital operations and in medical billing. Mr. Griffin has participated in development of medical administration and medical billing programs used by numerous hospitals in the United States. He has also served as an expert witness for medical facilities seeking claims that were unpaid or underpaid by insurance companies. Mr. Griffin is experienced in evaluating both inpatient and outpatient files to determine the appropriate DRG or APC assignments and, for Medicare subscribers, the resulting payment designated under either the IPPS or the OPPS. He is also knowledgeable with respect to the costs associated with providing medical care in the Houston area. His knowledge of typical costs provide Mr. Griffin with a strong ability to estimate whether outlier payments may be justified based on a particular patients diagnoses,

treatment, and/or length of stay. A one page resume for Mr. Griffin is attached to this Complaint as Exhibit 3.

29. Griffin became an employee of UMMC in August of 2019 when UMMC purchased Providence Hospital of North Houston, LLC. Within days, Mr. Griffin's new duties led him to review an explanation of benefits (EOB) for a UMMC patient in which UMMC charged over one million dollars for a stay of less than 10 days. To Griffin, the EOB suggested that UMMC was overcharging payors, including Medicare and Medicaid, to receive outlier payments above the standard reimbursement amounts to which UMMC was actually entitled. Relator confirmed this suspicion by review of other information available to him at the time.

30. Griffin informed both Mallapuram and Mohiuddin of his concern about the outlier payments received by UMMC. For example, in an email dated October 4, 2019, Griffin explained to Mohiuddin how Medicare used APCs to determine payments for outpatient services. Exhibit 4. Mr. Griffin included an EOB to help explain appropriate reimbursement under OPPS and to show that UMMC received an outlier payment that was ten times the OPPS base rate. Exhibit 5. Mohiuddin expressed ignorance that UMMC was receiving outlier payments for outpatient services.

31. During this time frame, Griffin also discovered that many of UMMC's line-item charges were set at more than four times the Texas average. Relator informed Mohiuddin, Mallapuram, and Vinodh that these elevated charge amounts caused UMMC to receive unearned outlier payments. On or about November 26, 2019, Realtor convinced Mallapuram and Mohiuddin to purchase data from the Texas Healthcare Information Collection (THCIC) so that UMMC could compare its rates to the Texas averages. This review confirmed Relator's conclusion

that Mediscope and Ayraa Med were submitting claims with charges far above the Texas average.

32. During the same time frame, Mallapuram, Mohiuddin, and Vinodh attempted to placate Griffin by proposing a claim processing strategy to detect claims that would generate outlier payments. Exhibit 6. Griffin was led to believe this strategy would be used to validate identified claims and ensure the outlier payments were appropriate before such claim was submitted.

33. Thus, by December 1, 2019, Griffin had clearly informed Mallapuram, Mohiuddin, and Vinodh that UMMC, through its contractor Ayraa Med, was submitting claims to Medicare, Medicaid and their contractors that resulted in payments not actually owed to UMMC. Specifically, Griffin had informed Mallpuram, Mohiuddin, and Vinodh that UMMC had received outlier payments to which UMMC was not entitled.

34. No later than December 1, 2019, Relator had informed Mallapuram, Mohiuddin, and Vinodh that UMMC's inflated line-item rates caused Medicare to make outlier payments to UMMC in circumstances when no outlier payment would be due or to make outlier payments in excess of the amount to which UMMC was actually entitled.

35. Relator continued to work toward correction of the problems caused by UMMC's excessive line-item charges and of the inaccurate 2018 cost report. By March 16, 2020, Relator had created, and Mohiuddin had approved, an updated charge file ("CDM") for use by Ayraa Med and Mediscope when preparing UMMC's claims for submission. Griffin transmitted a spreadsheet containing the new line-item charges to Vinodh at Ayraa Med on March 16, 2020 and again on April 15, 2020. Exhibits 7 and 8.

36. Relator's efforts to stop the fraud were fruitless. Mallapuram and Mohiuddin would verbally approve Griffin's proposal to prevent future submission of improper claims. Ayraa Med and

Mediscope would ignore those proposals even though Mallapuram and Mohiuddin owned and controlled both Ayraa Med and UMMC. Ayraa Med and Mediscope never implemented the outlier payment detection protocol, and Mediscope did not implement the approved CDM.

37. The improper outlier payments from Medicare could also be corrected by providing updated cost to charge data. Griffin suggested that UMMC hire a third party to review its cost data. Mallapuram and Mohiuddin approved the engagement of Dennis Nunn to perform this task. Exhibit 9. However, Mallapuram and Mohiuddin withheld and/or failed to ensure Mr. Nunn was provided with the records he needed for his analysis. As a result, the cost analysis was never completed.

38. In late July of 2020, Mallapuram and Mohiuddin asked Griffin to formally take on a compliance role at UMMC. Exhibit 10. By this time, Mallapuram and Mohiuddin had failed to follow through on the promises of correcting the CDM and stopping the improper outlier payments. Griffin was concerned that the offer was an attempt to create personal liability for him and that Defendants would use that liability to push cooperation with their scheme. He declined the offer.

39. Finally, Griffin had enough and resigned from UMMC effective on or about October 19, 2020. Exhibit 11. Griffin remains a contractor for UMMC in a limited role with respect to certain outpatient services.

40. Prior to his resignation, Griffin had discovered that UMMC's fraudulent practices either began or greatly increased during the last three months of calendar year 2018, when UMMC began using Mediscope and Texas Medical Summit as its billing vendors. During the first 9 months of 2018, UMMC billed a total of $110 million. According to the data he was provided, Mediscope, through Medsum and Ayraa Med, billed over $512 million during just the last 3

months of the 2018. During that period, Griffin estimates that Medicare paid outlier payments to UMMC on at least 49% of the inpatient claims[4] that UMMC submitted and 50% or more of the outpatient claims.

41. Relator has additional knowledge with respect to at least one other hospital for which Medsum was the U.S. billing contractor. Relator was a part owner in a billing contractor performing services for Spring Excellence Surgical Hospital. Spring Excellence replaced Relator's entity with Medsum when Relator and his co-owners refused to turbocharge claims. The THCIC data shows that, following Medsum's engagement as billing contractor, Spring Excellence had some of the highest line-item charges in Texas. Thus, Mediscope, acting through Medsum, is engaging in turbocharging or other claim inflation practices on behalf of medical providers other than UMMC.

MEDISCOPE AND ITS INTERMEDIARIES

42. Relator reasserts the allegations in paragraphs 1-41 as if fully set for the here.

43. Mediscope promotes itself as a "service delivery center" and "denial management experts" in the medical field. Mediscope is compensated by receiving a percentage of net revenue collected by the health care provider.

44. Mediscope does business through intermediates such as Ayraa Med RCM, LLC and Texas Medical Summit, Inc. rather than contracting directly with hospitals. This practice allows Mediscope to avoid registering to do business in any jurisdiction of the United States.

45. For example, Ayraa Med has a contract to provide billing services to UMMC and Ayraa Med receives a percentage of UMMC revenue for those services.

[4] Medicare payments that were at least double the 2018 cost outlier threshold were assumed to include an outlier payment.

46. Mediscope has a contract with Ayraa Med and provides the actual billing services.

47. UMMC compensates Ayraa Med when UMMC receives payment from Medicare or other payors.

48. Mediscope is compensated from the funds UMMC pays to Ayraa Med.

49. In June of 2021, Vinodh approached Griffin about using his medical software company[5], a U.S. entity, to facilitate business for Mediscope. Exhibit 12. Vinodh provided a proposal touting Mediscope's services including its pride in generating "high reimbursement". The proposal touted Mediscope as having over 200 team members and included a payment schedule showing Mediscope's compensation as a percentage of net revenue.

50. Griffin's entity is not a medical provider. Vinodh's solicitation to Griffin further shows Mediscope's strategies to use US intermediaries. The proposal also shows that it is Mediscope that would be performing the billing functions and not any entity owned by Griffin.

51. Ayraa Med has few or no employees. Instead, Mediscope employees perform the billing tasks and transmit the claim using Ayraa Med email addresses and other Ayraa Med identifiers.

52. Ayraa Med does not actually perform any billing services.

53. On information and belief, Ayraa Med does not incur overhead or employee costs to support billing on behalf of UMMC.

54. Mallapuram is the managing member of Ayraa Med.

55. Mohiuddin admitted to having an ownership interest in Ayraa Med in a conversation with Griffin on or about July 29, 2020.

56. Mallapuram and Mohiuddin receive a percentage UMMC net revenues billed by Mediscope through their ownership of Ayraa Med.

[5] Griffin is a 9.67% owner of this entity.

57. In the last three months of 2018, Medsum acted as the U.S. intermediary for Mediscope to provide UMMC's billing services.

58. As discussed above, Mallapuram admitted that Medsum was overbilling payors, including Medicare and Medicaid, in the last three months of 2018. The overbilling provided unearned windfall revenue for UMMC. Mediscope and Medsum received unearned windfall commissions arising directly from UMMC unearned revenue.

59. Mediscope used Medsum as a front and therefore Mediscope did business in Collin County, Texas when preparing and submitting bills for UMMC in 2018.

60. Ayraa Med was organized in December of 2018. The internet domain ayraamed.com was registered on December 21, 2018.

61. Ayraa Med replaced Medsum as Mediscope's intermediary immediately on Ayraa Med's formation.

62. When Ayraa med replaced Medsum, the individuals providing services to UMMC under Medsum immediately began performing the same duties for UMMC using Ayraa Med email addresses. The operation did not change, Mediscope simply switched to a different cover entity.

63. Griffin was provided the 2018 Mediscope data as a single data set from Medsum/Ayraa Med, suggesting the two entities were effectively a single actor.

64. Mediscope's practice of inflating UMMC's bills continued after Ayraa Med became the Mediscope intermediary.

65. Based on the foregoing, Mallapuram and Mohiuddin replaced Medsum with Ayraa Med so they could receive commissions on UMMC's unearned outlier payments rather than those commissions going to the owners of Medsum.

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THE SCHEME

66. Relator re-asserts the allegations in paragraphs 1-65 as if fully set forth here.

67. UMMC is a hospital that provides inpatient and outpatient medical services, including services to patients whose health care is covered by Federal Medicare, Texas Medicaid, and a program providing COVID-19 related care to uninsured persons pursuant to the CARES Act. In order to participate in these programs, UMMC executed and is subject to provider agreements covering each of these programs. UMMC agreed to abide by the reimbursement regulations of the U.S. Department of Health and Human Services for Medicare and for the CARES Act and by the reimbursement regulations of Texas Health and Human Services for services provided to subscribers of Medicaid.

Turbocharging

68. Turbocharging is the practice of generating improper outlier payments through line-item charges that are too high in comparison with the CCR applied for that hospital. For example, if a hospital's CCR is at or the near the state average CCR, each line-item charge should also be at or near the state average for that item. Such a hospital engages in turbocharging if it presents claims with line-item charges materially higher than the state average.

69. Turbocharging benefits a hospital, or other medical provider, only when turbocharged claims generate outlier payments. As discussed above, outlier payments arise when a provider's calculated cost (claim charges multiplied by the CCR) exceed the Medicare established outlier threshold. Increasing claim charges without adjusting the CCR leads to an artificially high calculated cost. This increases the likelihood of a claim exceeding the outlier threshold and generating an outlier payment.

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70. The only benefit to turbocharging is the receipt of unearned outlier payments under the IPPS, the OPPS, and under Medicaid programs.

71. Mediscope, doing business as and through Medsum and as Ayraa Med, engaged in turbocharging on behalf of UMMC. Turbocharging is readily seen from the example claims in Exhibits 13 to 18. For example, the claim in Exhibit 13 has the below highlighted room and board charge at $28,500.00 per day.

38 MEDICARE PO BOX 890108 CAMP HILL, TX 17089-0108		39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
	a	80	22				
	b						
	c						
	d						

	42 REV. CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0164	Other Room & Board-Steri	28500.00	033120	22	62700000		1
2	0251	Pharmacy-Generic Drugs		033120	64	1601088		2
3	0250	Pharmacy-General		033120	12	210720		3
4	0402	Other Imaging Services-U		040320	1	58020		4
5	0360	Operating Room Services-		040320	1	1093600		5
6	0801	Inpatient Renal Dialysis		033120	13	4550000		6

At the time this charge was submitted, Medicare was applying the state average CCR of approximately 0.2 to UMMC's invoices. Thus, to match UMMC's CCR, Mediscope should have used a state average room charge which was between $6,000 and $7,000 per day. This turbocharged room charge—a charge rate far above a rate representative of the CCR—increases the outlier payment by over $75,000 without consideration of any other inflated items. The CDM created by Griffin, as discussed above, can be compared with the line items of each UMMC claim to identify which items have been turbocharged. The excessive outlier payments resulting from such turbocharging can then be calculated for each claim.

UMMC and Ayraa Med Use Template Billing to Generate Outlier Payments

72. Ayraa Med also used template billing—billing services on a daily multiple rather than based on the patient chart—in order to create claims that would generate outlier payments. UMMC also used template building, in addition to excessive line items, to solicit outlier payments for

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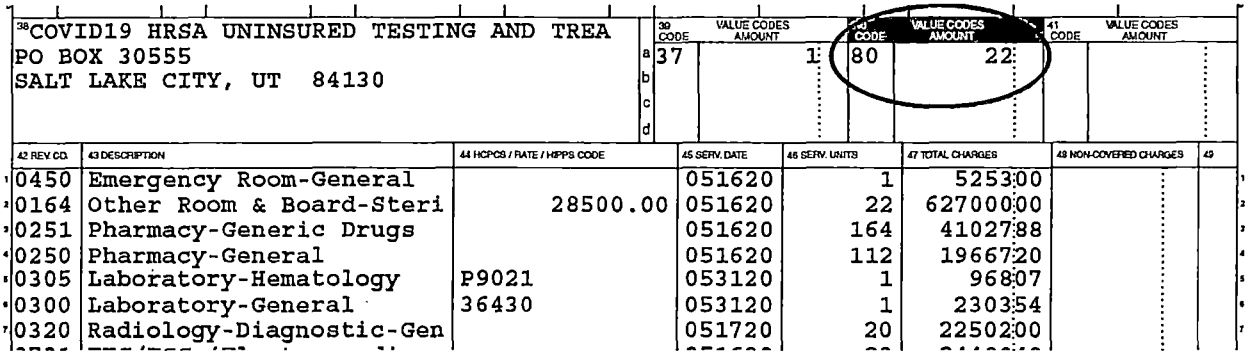
services subject to payment under the CARES Act. Exhibits 14 through 18 contain examples of these billing practices.

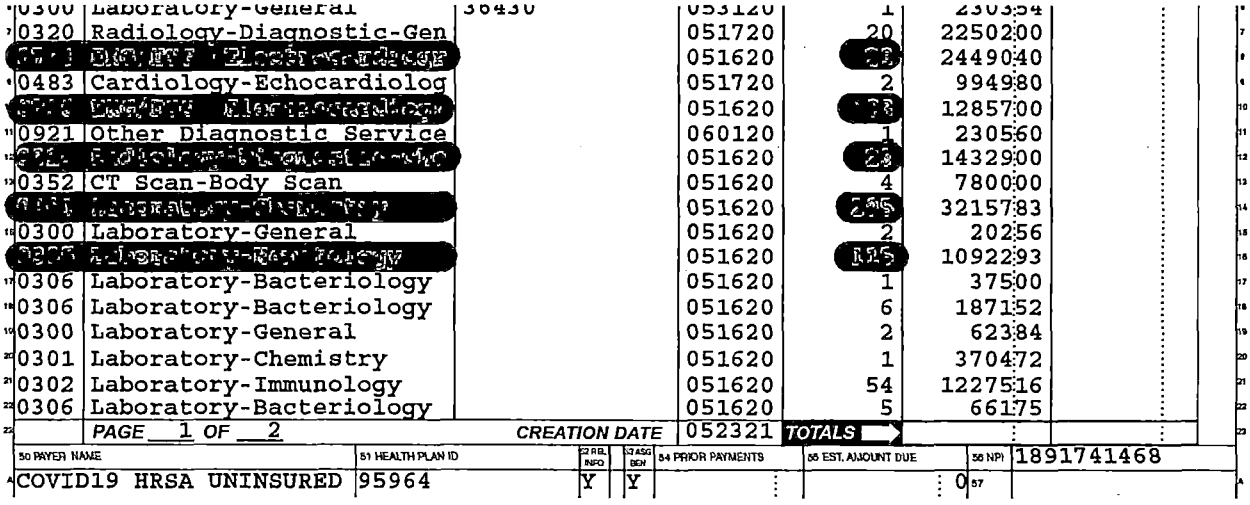
73. Exhibit 14 is a printout of a claim from the Waystar Clearinghouse, a data service that is used in processing UMMC's claims. The claim in Exhibit 14 was prepared by Mediscope/Ayraa Med on behalf of UMMC as a request for payment under the CARES Act. The claim reflects an admission period of 22 nights/23 days as can be determined from the Code and Code Amount as circled below:



38 COVID19 HRSA UNINSURED TESTING AND TREA PO BOX 30555 SALT LAKE CITY, UT 84130	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	37	1	80	22		
b						
c						
d						

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0450	Emergency Room-General		051620	1	525300		
0164	Other Room & Board-Steri	28500.00	051620	22	627000 00		
0251	Pharmacy-Generic Drugs		051620	164	41027 88		
0250	Pharmacy-General		051620	112	196672 0		
0305	Laboratory-Hematology	P9021	053120	1	9680 7		
0300	Laboratory-General	36430	053120	1	230354		
0320	Radiology-Diagnostic-Gen		051720	20	225020 00		

74. The line-item charges in Exhibit 14 discloses the templating used by UMMC and Ayraa Med so that UMMC would receive outlier payments. Particular line items from page 1 of Exhibit 14 are highlighted below:



0300	Laboratory-General	36430	053120	1	230354		
0320	Radiology-Diagnostic-Gen		051720	20	225020 00		
[redacted]			051620	[redacted]	244904 0		
0483	Cardiology-Echocardiolog		051720	2	99498 0		
[redacted]			051620	[redacted]	128570 0		
0921	Other Diagnostic Service		060120	1	23056 0		
[redacted]			051620	[redacted]	143290 0		
0352	CT Scan-Body Scan		051620	4	78000 0		
[redacted]			051620	[redacted]	321578 3		
0300	Laboratory-General		051620	2	20256		
[redacted]			051620	[redacted]	109229 3		
0306	Laboratory-Bacteriology		051620	1	3750 0		
0306	Laboratory-Bacteriology		051620	6	18715 2		
0300	Laboratory-General		051620	2	6238 4		
0301	Laboratory-Chemistry		051620	1	3704 72		
0302	Laboratory-Immunology		051620	54	122751 6		
0306	Laboratory-Bacteriology		051620	5	6617 5		
	PAGE 1 OF 2	CREATION DATE	052321	TOTALS			

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1891741468
COVID19 HRSA UNINSURED	95964	Y	Y		0	57	

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Line items such a as EKG's (2x), chest radiology (1x), chemistry (12.83x) and hematology (5x) appear in multiples of 23, the number of days for which the patient was admitted. This practice is reflected further on page 2 with Respiratory Services (2x) and DME (1x).

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0307	Laboratory-Urology		051620	1	19.92		
0306	Laboratory-Bacteriology		051620	2	300.00		
[redacted]			051620	[redacted]	11040.00		
[redacted]			051620	[redacted]	6900.00		
[redacted]			051620	[redacted]	12650.00		
0636	Pharmacy-Extension of 25		051620	284	5126.85		
0260	IV Therapy-General		051620	412	11525.42		

75. Exhibit 15 is a printout of another claim submitted on behalf of UMMC by Ayraa Med. This claim reflects services over 15 nights/16 days. The EKG's (2x), chest radiology (1x), laboratory chemistry (12.87x), and laboratory hematology (5x) appear in the same multiples of days—multiples of 16 for this claim, as seen for the patient above.

76. Exhibit 16 is a printout of an additional claim submitted on behalf of UMMC by Ayraa Med. This claim reflects 14 nights/15 days. This claim reflects EKGs, chest radiology, lab hematology, chemistry and other items that are multiples of the number of days on the chart.

77. Each patient had a daily average of 5 hematology lab services, 2 EKG services, 1 chest radiology and between 12.8 and 13 lab chemistry services for the entire length of stay. This is template billing—billing at least certain services at the same daily multiple for every patient. Ayraa Med was billing in his fashion without regard to whether those services were performed.

78. Additional claims may be seen in Exhibits 17 and 18, which show very similar patterns. The treatment course reflected in any one of Exhibits 14 through 18 is plausible, though unlikely, for a particular patient's stay. It is virtually impossible for the same pattern to appear in patient after patient after patient. At least one non-government payor reviewed templated invoices and UMMC could not provide back up to show the billed services were actually performed. On July 29, 2020, Griffin expressly informed Mallapuram and Mohiuddin that Vinodh was

including line-items charges and/or quantities for which no one could find support in the applicable patient's file.

79. Relator specifically confronted Mallapuram and Mohiuddin, the principals of UMMC and Ayraa Med, about the use templates when submitting claims to payors, including claims made to Medicare, to HHS under the CARES Act, and to claims made to Texas Health and Human Services for Medicaid reimbursement. These communications included emails as well as in person conversations. Exhibit 10.

80. On more than one occasion during 2020, Mallapuram acknowledged to Relator that claims were being templated, that such claims were not an accurate representation of the services actually provided to the patients, and that Ayraa Med should not submit such claims to solicit payments.

81. On more than one occasion during 2020, Mohiuddin acknowledged to Relator that claims were being templated, that such claims were not an accurate representation of the services actually provided to the patients, and that Ayraa Med should not submit such claims to solicit payments.

82. Exhibit 19 illustrates another blatant abuse that generated outlier payments. Specifically, the highlighted item coded as C1776 is an implantable joint part—e.g. a replacement joint. A doctor would not perform 6 joint replacements in a single surgery and certainly not in a routine procedure with a single day hospital stay. The 5 extra joints generated approximately $50,000 in outlier for supplies not provided to this patient.

83. The claim totals at the end of each Exhibit reflects inflated billing. The dollar amounts of the bills simply are not reflective of normal charges for the length of hospital stay. Such totals might occur in rare circumstances. UMMC billed such totals in patient after patient indicating

the UMMC and/or its contractors were inflating their claims. It is also worth noting that Mallapuram and Mohiuddin did not deny the existence of such practices.

Outpatient Claims

84. With respect to outpatient claims, Mediscope has multiplied services in circumstances which make no sense, billed for inconsistent services, and billed for devices that do not match the billed services. For example, the claim contained in Exhibit 20 contains charges for implantation of two neural stimulators when only one is ever implanted. Further, the device charged is actually an internal defibrillator, not a neural stimulator.

38 AARP MEDICARE SUPPLEMENT/FIXED INDEMNIT			39 VALUE CODES CODE / AMOUNT		40 VALUE CODES CODE / AMOUNT		41 VALUE CODES CODE / AMOUNT		
			a						
			b						
			c						
			d						
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49		
1 0360	Operating Room Services-	63650	010920	1	7689460	implant stimulator	1		
2 0360	Operating Room Services-	6365059	010920	1	7689460	implant stimulator	2		
3 0920	Other Diagnostic Service	95972	010920	1	73089		3		
4 0320	Radiology-Diagnostic-Gen	77003TC59	010920	1	14782		4		
5 0730	EKG/ECG (Electrocardiogr	9300559	010920	1	36507		5		
6 0278	Medical/Surgical Supplie	C1897	010920	4	2472000		6		
7 0278	Medical/Surgical Supplie	C1822	010920	1	17321808	defibrilator	7		
8 0636	N400143992490ML1	J0690	010920	1	3340		8		
9 0260	IV Therapy-General	96365	010920	1	35000		9		
10 0636	Pharmacy-Extension of 25	J3010	010920	1	5176		10		
11 0260	IV Therapy-General	9637576	010920	1	45188		11		

85. Also, the charges for these items and the defibrillator leads designated in line item six are at very high rates when compared to the Texas averages. Thus, this invoice, submitted by Mediscope/Ayraa Med, includes both false charges and turbocharging.

86. Exhibit 21 contains line items consistent with a partial mastectomy for treatment of breast cancer. The HPCPS codes for items on lines 4 and 5 indicate tumor removal and partial breast reconstruction. Line item 3, HPCPS code 38525 corresponds to a lymphoid biopsy. This claim has several problems. The breast repair should be bundled under, and not separately charged from, the tumor removal. Further, the biopsy would precede the partial mastectomy as the biopsy sample would be reviewed by a pathologist prior to authorization of the mastectomy.

The line items are also charged at rates well above the Texas average and are further instances of turbocharging.

87. Exhibit 22 shows further examples of outpatient claim turbocharging. The charges on at least lines 2, 4, 8 and 10 for arteriogram, a catheter, a closure device and anesthesia are well above Texas averages.

88. The turbocharging and excess line items contained in these examples demonstrate Mediscope/Ayraa Med's fraudulent activities to generate unearned outlier payments for UMMC—payments that increased both Ayraa Med's and Mediscope's payments.

UMMC's Cost to Charge Ratio Data

89. In 2019, UMMC submitted data to Medicare for its 2018 cost-to-charge ratio calculation. The data was false in that it included costs for multiple UMMC facilities but only included charges for the main campus at 510 W. Tidwell, or otherwise failed to include all charges submitted on behalf of UMMC to payors in 2018. UMMC is required to update its cost information annually but has not submitted a cost report since the submission in 2019. Mallapuram and Mohiuddin know that submission of accurate cost information will lead to the United States seeking to recoup the overpayments that have been made since at least as early as October of 2018.

90. Defendants also took steps to hide their misconduct. UMMC does not have possession of its billing records, with a complete set, if any, only in the hands of Mediscope These records are offshore and not in the United States. Further, UMMC did not report all of its charges for 2018 in its 2018 cost report. According to Relator's analysis, the 2018 cost report reflected approximately $254 million in total charges, approximately 55% of the actual total of approximately $475 million. The difference in these amounts is consistent with the cost report missing charges for facilities other than UMMC's "main campus" at 510 W. Tidwell Rd.

91. Third, UMMC billed private payers at lower ratesthan it billed Medicare. Billing private payers at lower rates artificially increased UMMC's cost-to-charge ratio. Each of these behaviors, together with billing for unperformed services, interfere with Medicare's ability to properly reconcile the outlier payments upon approval of a cost report andfurther support that the Defendants' conduct was knowing and intended to defraud the United States.

Mediscope Started the Scheme with UMMC in 2018

92. Importantly, the beginning of Mediscope's services for UMMC correlates to the period when UMMC began submitting vastly inflated line-item charges. In calendar year 2017, UMMC's gross billed charges totaled $158,709,959. For the first nine months of 2018, UMMC's gross billed charges totaled $110,331,110. For the last three months of 2018, Mediscope billed $512,932,421 on behalf of UMMC. In other words, Mediscope increased UMMC's charges by twelve to fifteen-fold. This large increase in charges, coupled with the state average CCR use for UMMC, led to windfall outlier payments received by UMMC.

93. Relator raised this issue with Mallapuram in late spring/early summer of 2020. Mallapuram admitted that UMMC had submitted inflated charges. However, he dismissed the concern, asserting that Medsum was the source of the inflated line-items and not Ayraa Med. Mallapuram made this assertion despite the fact that Relator had continued to complain of and work to stop the inflated line-item charges during his tenure at UMMC.

94. The inflated line-item charges resulted in a substantial windfall of outlier payments to UMMC. However, these payments are subject to reconciliation once UMMC submitted its cost report for 2019. UMMC avoided that reconciliation by not submitting a 2019 cost report. UMMC avoided reconciliation again when it did not file its cost report for 2020.

95. Claim data from UMMC for January 1 through August 18, 2019 is not available to Relator. However, UMMC almost certainly received improper outlier payments from Medicare during this time. Mediscope began submitting inflated claims to Medicare on UMMC's behalf in the latter part of 2018 and engaged in the same behavior from August, 2019 through at least April of 2020. Mediscope resisted correcting this behavior when confronted by Relator from August 2019 and much of 2020. *Materiality and Reliance*

96. Medicare's regulations and guidance makes it clear that Medicare relies on the charges stated in the claim when determining whether to pay an outlier and how much to pay. 42 C.F.R. 412.84(g); 68 F.R. at 34501 ("[W]e can only estimate actual costs based on charges for a case because **charges are the only data available** that indicate the resource usage for an individual case. Therefore, **our ability to identify true outlier case is dependent on the accuracy of the cost to charge ratios.**" Emphasis added). By submitting charges that are inflated with respect to the applied CCR, a provider makes the CCR inaccurate.

97. HHS also relies on the billed charges and cost to charge ratios to determine outlier payments under the CARES Act.

98. Texas Health and Human Services relies on billed charges and cost to charge ratios to determine outlier payments under Texas Medicaid. 1 Tex. Admin. Code §§ 355.8052 and 8061.

Payments Received by UMMC

99. Relator has attached a table showing payments from Medicare, its contractors, and Texas Medicaid Contractors as Exhibit 23. Griffin evaluated the claims based on Medicare's IPPS and OPPS system and estimated the outlier payments resulting from individual claims. A

negative number in the outlier payment column reflects that Relator believes no outlier was paid for a particular claim.

100. Exhibit 23 is derived from approximately 11,000 files for claims submitted by Mediscope/Ayraa Med on behalf of UMMC and for which UMMC received payment. These claims date from August 18, 2019 to May 20, 2021.

101. During this period, UMMC received payments from Medicare, Medicaid, and under the CARES Act totaling at least $28,486,678 for inpatient services and at least $8,042,727 for outpatient services. Of these amounts, UMMC received $19,793,006 as outlier payments for inpatient services and $6,050,430 as outlier payments for outpatient services. $11.6 million of the outlier payments, inpatient and outpatient combined, were paid to contractors of Medicaid and/or Medicare who provide managed care services. Relator does not have sufficient information specifically delineate what portion of those payments were made by the United States under Medicare and what portion was made by the State of Texas as Medicaid. The number of such claims and the dollar totals make it certain that a portion of these claims were made to and paid under each of Medicare, Texas Medicaid, in possibly both.

102. Based on this data, Defendants submitted claims for payment under each of Medicare, Medicaid, and the CARES Act and received payments under each.

Defendants Hide their Scheme

103. Defendants took affirmative steps to hide their scheme. First, the Defendants failed to include all of the charges submitted to private payers in the 2018 cost report. Exhibit 24. Further, UMMC's billing data was not kept by UMMC or anywhere in the United States. In conversations, Mallapuram and/or Mohiuddin acknowledged that only Vinodh and Mediscope had UMMC's relevant billing records. Further, Relator's review of payment information

revealed that UMMC billed private payers at lower rates than the rates billed to Medicare. Defendants even resubmitted paid claims in a manner that did not increase payment to UMMC but only decreased the charges for those services. These and other practices would have prevented a cost-to-charge reconciliation from recovering a substantial portion of the outlier overpayments.

IMPROPER BILLING FOR SARS-COV-2 TESTING

104. UMMC entered into a contract with the Texas Department of Emergency Management (TDEM) to provide individual testing for the presence of/infection with SARS CoV-2 in those patients. TDEM paid UMMC for these testing services. *See, e.g.* Exhibits 25 and 26. Despite receiving payment from the state of Texas, UMMC billed the United States, through the CARES Act programs for these same tests. UMMC's internal records recorded the locations at which the sample for an individual test was acquired. Relator used this location information to identify patients from whom samples were acquired at a TDEM contract site. Relator then cross referenced these patients with the electronic claims filed from CARES Act payments to determine which patients from TDEM sites were billed to the United States. Exhibit 27 contains a partial listing of claims that were billed to and paid by the United States and, based on location, billed to the TDEM.

105. For example, UMMC records identify 226 patients, with specific account numbers, for testing at the Pattison Fire Department for July 23 and 25, 2020. Cross referencing with electronic claims payment data show that testing for 219 of these patients was billed to, and payment received from, the United States. Exhibit 25 reflects UMMC also billed TDEM for these tests.

106. Duplicate billing is also evident in records for testing performed at the Walker County Fairgrounds. Exhibit 26. UMMC data shows testing of 786 individuals at the Walker County Fairground between July 22 and 30, 2020. UMMC billed TDEM for Walker County Fairground tests and data from the electronic claims files shows that the United States paid for these same tests.[6]

107. UMMC records show that the hospital was responsible for more than 651,000 SARS-CoV-2 tests from March 18, 2020 to February 22, 2020. Over 91% of the 651,000 plus tests were billed to the United States.[7] UMMC was required to bill private payors if a patient had health insurance at the time the test was administered. However, at least some of the forms used by UMMC did not attempt to collect health insurance information from the SARS-CoV-2 tested patients. Exhibits 28 and 29. Clearly, UMMC submitted claims to the United Stated for SARS-CoV-2 testing services without verifying that the claim was properly payable by the United States under the CARES Act. UMMC's conduct in doing so is either false certification or fraud by silence. Relator estimates, based on his experience in Houston area health care, that at least one-third of the almost 600,000 testing claims submitted to the United States were not subject to payment by the United States.[8]

108. On information and belief, UMMC also had a contract to conduct testing in partnership with the City of Houston and the City of Houston agreed to pay for that testing. See Exhibit 30, p. 26. For example, UMMC conducted testing in conjunction with the World Table Tennis Championships. Exhibit 29. The individual patient consent forms were completed on City of

[6] The Patient Control Number in Exhibits 26 and 27 contain both a patient identifier and a visit identifier. For example, if the patient identification number is 1234567, and the claim is for the patient's second visit, the Patient Control Number will be 1234567-2, the "-2" identifying the claim as being for the second patient visit.
[7] Out of the 651,000 plus tests, Relator could only identify 58,432 billed to payors other than the United States.
[8] Between 40-50% patients at UMMC are uninsured, and this ratio is at the higher end for hospitals in the Houston area.

Houston letterhead and the test results were to be reported directly to officials of the Houston area sports venue.[9] This suggests that the compensation for UMMC for these testing services was to be made by Houston area officials outside of the CARES Act. This is further supported by the phone numbers on the consent forms, providing numbers with country codes for Brazil (55), Nigeria (+234) and other countries, suggesting these were not routine tests for residents of the United States but encompassed event participants in the United States for the listed event.

109. UMMC received excess payments from the United States of at least $34,000,000 due to services contracted by TDEM and by billing for claims without ensuring that the patient tested did not have private insurance.

PARTIES ENRICHED BY THE SCHEME BUT NOT NAMED AS DEFENDANTS

110. Mallapuram owns or beneficially owns 67.43 percent of UMMC. Seven other individuals own various amounts of the remaining interests in UMMC. Such owners have been enriched by the scheme in which Defendants have engaged. Relator has not identified direct evidence that these individuals participated in the scheme and they are therefore not named herein. Relator reserves the right to add these individuals as defendants if appropriate evidence becomes available.

111. Relator is not aware of all persons or entities who own interests in Ayraa Med, Medsum, Mediscope or other entity defendants. Such owners also benefit from the scheme through distributions from the relevant entity defendants. Relator reserves the right to add owners of these entities as defendants if appropriate evidence becomes available.

[9] Houston hosted the World Table Tennis Championships. UMMC provided testing under its partnership for that event and the results were reported directly to the Harris County Sports Authority.

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CAUSES OF ACTION

Count I--Mediscope and Vinodh
Presenting False Claims to Secure Outlier Payments for its Hospital Clients

112. Plaintiff reasserts paragraphs 1-110as if fully set forth here.

113. Mediscope is liable to the United States pursuant to at least 31 U.S.C. 3729(a)(1)(A) and (B) it made, used, presented and caused to be made or used false claims to the United States.

114. Mediscope has engaged in a scheme of presenting false claims to the United States for payments under Medicare and under the CARES Act.

115. The false claims presented by Mediscope include turbocharged line items which make the relevant provider's cost to charge ratio inaccurate. The turbocharged line items falsely represent costs incurred by the provider when providing care to the applicable patients.

116. Mediscope is also liable under the theory of fraud by silence in that Mediscope took no steps to notify the United States that turbocharged line items were not billed consistently with the cost to charge ratio applied for the applicable provider.

117. The turbocharged line items increased the total charges on the affected claims such that the United States, through the Department of Health and Human Services and its contractors, made outlier payments on those claims. The Department of Health and Services made such outlier payments under the United States Medicare program and pursuant to the CARES Act.

118. False claims by Mediscope include charges for services that were not performed by Mediscope's hospital client and were not contained in the patient file provided to Mediscope.

119. The charges for services not performed increased the total claim charges such that the United States, through the Department of Health and Human Services and its contractors, made outlier payments on those claims. The Department of Health and Human Services made such outlier payments under the United States Medicare program and pursuant to the CARES Act.

120. The United States has expressly stated that it relies on the charges submitted by or on behalf of providers when determining whether to make and the amount of outlier payments.

121. Vinodh, and therefore Mediscope, knew and knows the turbocharged claims were fraudulent. Mediscope's knowledge is demonstrated by its actions with respect to UMMC: (i) Mediscope initiated the massive increase in charges for UMMC when it took over UMMC's billing in 2018, (ii) Mediscope refused to implement changes to stop the turbocharging despite being expressly told that turbocharging was improper, and (iii) Mediscope engaged in template billing, adding services to claims that were not reflected in patient files provided to Mediscope by UMMC and doing so in a format calculated to avoid routine detection by the United States and its contractors.

122. The United States overpaid on the UMMC claims submitted by Mediscope Based on the Medsum/Ayraa Med data he received, Griffin calculates that UMMC received over $27.5 million in Medicare outlier payments for services in the last three months of 2018. Based on the data in Exhibit 23, UMMC received at least $25.7 million in outlier payments from the United States and from the State of Texas from August 2019 through May of 2021. For the claims in Exhibit 23, at least $14.1 million of these outlier payments were made by the United States or its contractors. The remaining amounts were made by contractors that acted, depending on the patient, on behalf of either the United States or the State of Texas.

123. The continuation of outlier payments beginning in 2018 until the present show that Mediscope's conduct was continuous and that further outlier payments were received by or on behalf of UMMC from January 1, 2019 through August 2019, and Griffin does not have data for those specific months.

124. The United States has been harmed in the amounts of these payments made in excess of amounts to which UMMC was actually entitled.

125. Vinodh's solicitation of Griffin's medical software entity and the materials Vinodh provided to Griffin show that Mediscope represents providers other than UMMC in submitting claims to the United States and its contractors. Further, Mediscope does so through intermediaries other than Ayraa Med or Medsum.

126. Thus, Mediscope has harmed the United States by soliciting outliers on behalf of other medical providers through false billing and turbocharging. Mediscope, and Vinodh through her control and/or ownership of Mediscope, profit from this scheme by at least the increase in Mediscope's commission payments that result form the unearned outlier payments.

127. Mediscope and Vinodh have been enriched by their fraudulent conduct through increased compensation that directly results from the increased revenue of UMMC and other providers because Mediscope's compensation is calculated as a percentage of that revenue.

Count II—Mediscope, Ayraa Med and UMMC
Presenting False Claims to Secure Outlier Payments on behalf of UMMC

128. Plaintiff reasserts paragraphs 1-126 as if fully set forth here.

129. Mediscope, Ayraa Med and UMMC are liable to the United States pursuant to at least 31 U.S.C. 3729(a)(1)(A) and (B) by making, using, presenting and causing to be made or used false claims to the United States.

130. Mediscope/Ayraa Med engaged in a scheme of presenting false claims to the United States for payments under Medicare and under the CARES Act. Mediscope and Ayraa Med did so acting on behalf of UMMC.

131. The false claims presented by Mediscope/Ayraa Med include turbocharged line items which makes the relevant provider's cost to charge ratio inaccurate. The turbocharged line items falsely represent costs incurred by UMMC in providing care to the applicable patients.

132. Mediscope, Ayraa Med and UMMC are also liable under the theory of fraud by silence in that none of these parties notified the United States that turbocharged line items were not billed consistently with the cost to charge ratio applied for UMMC.

133. The turbocharged line items increased the total charges on the affected claims such that the United States, through the Department of Health and Human Services and its contractors, made outlier payments on those claims. The Department of Health and Human Services made such outlier payments under the United States Medicare program and pursuant to the CARES Act.

134. The false claims also included charges for services that were not performed by UMMC and were not contained in the patient file provided to Mediscope.

135. The charges for services not performed increased the total claim charges such that the United States, through the Department of Health and Human Services and its contractors, made outlier payments on those claims. The Department of Health and Services made such outlier payments under the United States Medicare program and pursuant to the CARES Act.

136. The United States has expressly stated that it relies on the charges submitted by or on behalf of providers when determining whether to make and the amount of outlier payments.

137. Mediscope, Ayraa Med, and UMMC knew and know that the turbocharged claims were fraudulent through the knowledge of Vinodh, Mallapuram and Mohiuddin. These individuals knowledge is demonstrated by the actions of Mediscope and Ayraa Med with respect to UMMC: (i) Mediscope initiated the massive increase in charges for UMMC when it took over UMMC's billing in 2018, (ii) Mediscope and Ayraa Med refused to implement changes

to stop turbocharging despite being expressly told that turbocharging was improper, (iii) Mediscope/Ayraa Med engaged in template billing, thereby adding services to claims that were not reflected in UMMC's patient files and doing so in a format calculated to avoid routine detection by the United States and its contractors, (iv) by UMMC has not submitted a cost report to Medicare since the summer of 2018 despite Medicare withholding payments for several months until UMMC submits a new cost report and (v) UMMC has left a false cost report on file for almost three years without providing Medicare with any correction.

138. The United States overpaid on the UMMC claims submitted by Mediscope/Aryaa Med. Based on the data in Exhibit 23, UMMC received at least $25.7 million in outlier payments from the United States and from the State of Texas from August 2019 through May of 2021. At least $14.1 million of these outlier payments were made by the United States or its contractors. The remaining amounts were made by contractors that acted, depending on the patient, on behalf of either the United States or the State of Texas.

139. The continuation of outlier payments from 2018 until the present show that Mediscope's conduct was continuous, including after it switched to Ayraa Med as a front. Thus, Mediscope, Ayraa Med and UMMC solicited outlier payments from the United States during the period of January 1, 2019 through August 2019. Griffin does not have specific data to identify the amount of outlier payments during those months.

140. Because of the turbocharging and the charges for services not performed through template billing, outlier payments were made to UMMC that were not owed or in amounts in excess of what was owed. The United States has been harmed in the amounts of these payments made in excess of amounts to which UMMC was actually entitled.

141. Mediscope, Ayraa Med and UMMC have been enriched by their fraudulent conduct through increased compensation that directly results from the increased revenue of UMMC. United Memorial, LLC and Tidwell/Parkway Ventures are jointly liable with UMMC for the period in which each of them was UMMC's general partner.

Count III—Mediscope, Medsum, and UMMC
Presentation of False Claims to Secure Outlier Payments

142. Plaintiff reasserts paragraphs 1-140 as if fully set forth here.

143. Mediscope, Medsum and UMMC are liable to the United States pursuant to at least 31 U.S.C. 3729(a)(1)(A) and (B) by making, using, presenting and causing to be made or used false claims to the United States.

144. Mediscope/Medsum engaged in a scheme of presenting false claims to the United States for payments under Medicare and under the CARES Act. Mediscope and Medsum did so acting on behalf of UMMC.

145. The false claims presented by Mediscope/Medsum include turbocharged line items which makes the relevant provider's cost to charge ratio inaccurate. The turbocharged line items falsely represent costs incurred by UMMC in providing care to the applicable patients.

146. Mediscope, Medsum and UMMC are also liable under the theory of fraud by silence in that none of these parties notified the United States that turbocharged line items were not billed consistently with the cost to charge ratio applied for UMMC.

147. The turbocharged line items increased the total charges on the affected claims such that the United States, through the Department of Health and Human Services and its contractors, made outlier payments on those claims. The Department of Health and Services made such outlier payments under the United States Medicare program and pursuant to the CARES Act.

148. The United States has expressly stated that it relies on the charges submitted by or on behalf of providers when determining whether to make and the amount of outlier payments.

149. Mediscope, and UMMC knew and know that the turbocharged claims were fraudulent through the knowledge of Vinodh, Mallapuram and Mohiuddin. These individuals knowledge is demonstrated by the actions of Mediscope and Ayraa Med with respect to UMMC: (i) Mediscope initiated the massive increase in charges for UMMC when it took over UMMC's billing in 2018, (ii) Mediscope and Ayraa Med refused to implement changes to stop turbocharging despite being expressly told that turbocharging was improper, (iii) Mediscope/Ayraa Med engaged in template billing, thereby adding services to claims that were not reflected in UMMC's patient files and doing so in a format calculated to avoid routine detection by the United States and its contractors and (iv) by UMMC has not submitted a cost report to Medicare since the summer of 2018 despite Medicare withholding payments for several months until UMMC submits a new cost report and (v) UMMC has left a false cost report on file for almost three years without providing Medicare with any correction.

150. Medsum's knowledge that the charges were fraudulent is shown by Medsum's conduct in dramatically increasing the charge rates of UMMC as well and Medsum's conduct in dramatically increasing the charge rates of Spring Excellence Surgical Hospital, replacing a prior vendor that refused to do so.

151. The United States overpaid on the UMMC claims submitted by Mediscope/Medsum. Based on the Medsum/Ayraa Med data he received, Griffin calculates that UMMC received over $27.5 million in Medicare outlier payments for services in the last three months of 2018.

152. Because of the turbocharging, outlier payments were made to UMMC that were not owed or in amounts in excess of what was owed. The United States has been harmed in the amounts of these payments made in excess of amounts to which UMMC was actually entitled.

153. Mediscope, Medsum and UMMC have been enriched by their fraudulent conduct through increased compensation that directly results from the increased revenue of UMMC. United Memorial, LLC and Tidwell/Parkway Ventures are jointly liable with UMMC for the period in which each of them was UMMC's general partner.

Count IV—UMMC, Ayraa Med, Mallapuram, Mohiuddin, Moeen, Mediscope and Vinodh Retention of Overpayments

154. Plaintiff reasserts the allegations contained in paragraphs 1-152 as if fully set forth here.

155. No later than December 1, 2019, Mallapuram, Mohiuddin and Vinodh had actual knowledge that UMMC received improper outlier payments from the United States through the Medicare program because of inflated line-item charges on UMMC's claims. Mallapuram and/or Mohiuddin's knowledge was imputed to UMMC and Ayraa Med because at all times relevant to this cause of action, they were controlling persons of UMMC and of Ayraa Med..

156. Mallapuram provided Relator with an email showing that Moeen was actually aware of overpayments made UMMC.

157. UMMC had a duty to inform the United States of these overpayments so that the United States could re-coup those funds through offset or through repayment. The email provided to Relator by Mallapuram disclosed UMMC's duty to self-report. Further, Relator had disclosed the duty to self-report to Mallapuram, Mohiuddin and Vinodh.

158. UMMC failed to make the required self-report.

159. The failure to make such a report violated at least 31 U.S.C. 3729(a)(1)(G). Each of Vinodh, Mallapuram, Mohiuddin, and Moeen—on behalf of themselves and their respective

entities—knowingly concealed and or avoided UMMC's obligation to return the overpayments to the United States. United Memorial, LLC and Tidwell/Parkway Ventures are jointly liable with UMMC for the period in which each of them was UMMC's general partner.

Count V—Mediscope, Vinodh, UMMC, Mallapuram, Mohiduddin, Ayraa Med, Moeen Conspiracy

160. Plaintiff reasserts the allegations contained in paragraphs 1-158 as if fully set forth here.

161. Each of Mediscope, Vinodh, UMMC, Mallapuram, Mohiuddin, Ayraa Med, and Moeen entered into one or more agreements to violate provisions of 31 U.S.C. 3729(a). Specifically, Mallapuram and Mohiuddin entered into one or more contracts with Mediscope on behalf of Ayraa Med and UMMC. The purpose of those agreements was for Mediscope to perform billing functions for UMMC. The proceeds of these agreements enriched Vinodh, Mallapuram, and Mohiuddin through their applicable control and ownership of Mediscope and of Ayraa Med.

162. Mallapuram and Mohiuddin intended for Mediscope to present and agreed that Mediscope would present fraudulent invoices. The agreement by Mallapuram and Mohiuddin is evidenced by (i) their failure to stop the fraud even when expressly informed of such fraud by Relator and in the face of Relator's providing actual solutions for stopping the fraud (ii) failing to have UMMC correct the CCR for 2018, (iii) failing to have UMMC submit its annual cost reports in 2019 and in 2020, (iv) the replacement of Medsum with Ayraa Med so that the unlawful payments would benefit them directly instead of the owners of Medsum. Mallapuram and Mohiuddin controlled UMMC and Ayraa Med and they were in position to agree on behalf of the entities. Mediscope's agreement to engage in the fraudulent conduct is indicated by the fact that Mediscope actually performed the fraudulent conduct and benefitted from the fraudulent conduct by increases in its revenues.

163. The United States was harmed by the unlawful conduct in which Defendant's engaged as alleged in Counts I, II and III above.

Count VI—UMMC, Ayraa Med, Mallapuram, Mohiuddin
Texas Medicaid Fraud Prevention Act

164. Plaintiff reasserts the allegations contained in paragraphs 1-162 as if fully set forth here.

165. As recited above, Mediscope and Ayraa Med submitted claims, on behalf of UMMC, that contained turbocharged line items and line items for services that UMMC did not perform.

166. UMMC submitted some of these claims for reimbursement to contractors for the Texas Medicaid System and received payment through these contractors. Thus, at least some of these claims were submitted for payment by and were paid from Texas Medicaid.

167. By submitting turbocharged claims and claims for services not performed, Ayraa Med and Mediscope violated at least Tex. Hum. Resources Code §36.002(1) and (2).

168. The State of Texas was harmed by such unlawful conduct at least in the amount by which Texas Medicaid made outlier payments which exceed outlier payments to which UMMC was entitled.

Count VII—UMMC
Fraudulent Billing for SARS-CoV-2 Testing

169. Plaintiff reasserts the allegations contained in paragraphs 1-167 as if fully set forth here.

170. UMMC billed the United States, under provisions of the CARES ACT, for SARS-CoV-2 testing for which the United States was not obligated to pay.

171. UMMC billed the United States for testing services subject to payment by other entities.

172. UMMC billed the United States for testing services for individual patients that were subject to payment under one or more contracts between UMMC and the State of Texas.

173. UMMC billed the United States for testing services for individual patients that were subject to payment under one or more contracts between UMMC and the City of Houston.

174. UMMC billed the United States for testing services under the CARES Act, certifying that such claims were for uninsured individuals, as required under the CARES Act.

175. Payments under the CARES Act are limited to testing for which the patient had no other insurance of there was no other payer with a duty to pay UMMC for those services. Claims for such services were therefore a certification that Defendants had investigated whether a private payer was obligated to pay for the particular patient's testing and/or that no other payer was obligated to pay for those testing services.

176. The United States was harmed in the amount of at least $34,000,000 as a result of UMMC receiving payment from the United States for testing services not subject to payment under the CARES Act.

177. UMMC submitted over 200,000 false claims for testing services and each claim is an individual fraud on the United States. UMMC is therefore liable to the United States for penalties in excess of two billion dollars.

REQUEST FOR RELATOR FEES

178. Having brought this action on behalf of the United States of America, Relator is entitled to an award between no less than 15% and no more than 30% of the proceeds of the action collected by the United States of America as a result of the institution of this action, plus reasonable costs and attorneys' fees associated with the prosecution of this claim.

179. Having brought this action on behalf of the State of Texas, Relator is entitled to an award between no less than 15% and no more than 30% of the proceeds of the action collected by the

State of Texas as a result of the institution of this action, plus reasonable costs and attorneys' fees associated with the prosecution of this claim.

PRAYER

Wherefore, Plaintiff United States of America, *ex rel.* through Relator, prays that:

a) each Defendant be summoned to appear and file an answer to this Complaint;

b) that judgment be entered in favor of the Plaintiff United States of America *ex rel.* Griffin, which awards the United States damages in an amount three times the amount of all sums paid by the United States and/or retained by any one or more of Defendants as a result of Defendants' violations of 31 U.S.C. § 3729, plus mandatory statutory penalties pursuant to 31 U.S.C. § 3729(a);

c) awards Relator on his own behalf 30 percent of the proceeds awarded to the United States of America as a result of this action;

d) that judgment be entered in favor of Plaintiff the State of Texas *ex rel.* Griffin, which awards the State of Texas damages in an amount two times the amount of all sums paid by the State of Texas as a result of Defendant's violations of the Texas Medicare Fraud Act, plus mandatory statutory penalties pursuant to the Texas Medicare Fraud Act;

e) awards Relator on his own behalf 30 percent of the proceeds awarded to the State of Texas as a result of this action;

f) Plaintiffs' and Relator's costs and attorney fees incurred as a result of bringing this action pursuant the False Claims Act and the Texas Medicaid Fraud Act, and

g) such other and further relief as Plaintiffs and Relator may shows themselves entitled.

FILED UNDER SEAL

Respectfully Submitted,

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FILED UNDER SEAL

CERTIFICATE OF SERVICE

I hereby certify that on March 17, 2022 a true and correct copy of the above and foregoing First Amended Complaint for Violations of the False Claims Act and the Texas Medicaid Fraud Act were forwarded to the United States Department of Justice, the U.S. Attorney for the Southern District of Texas and the Attorney General of Texas via this Court's E-file system, by electronic mail or by First Class US Mail.

Michael K. Barnhart