20

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

v.

VIJIL RAHULAN, M.D.

Defendant.

Case:2:23-cr-20467
Judge: Lawson, David M.
MJ: Patti, Anthony P.
Filed: 08-15-2023 At 04:18 PM
USA V SEALED MATTER (LG)

VIO: 18 U.S.C. § 1349
18 U.S.C. § 1347
18 U.S.C. § 2

INDICTMENT

THE GRAND JURY CHARGES:

GENERAL ALLEGATIONS

At all times relevant to this Indictment:

The Medicare Program

1. The Medicare Program ("Medicare") was a federal health care program providing benefits to persons who were 65 years of age or older or disabled. Medicare was administered by the Centers for Medicare and Medicaid Services ("CMS"), a federal agency under the United States Department of Health and Human Services. The benefits available under Medicare were governed by federal

statutes and regulations. Individuals who received benefits under Medicare were referred to as Medicare "beneficiaries."

2. Medicare was a "health care benefit program," as defined by Title 18, United States Code, Section 24(b), and a "Federal health care program," as defined by Title 42, United States Code, Section 1320a-7b(f).

3. Medicare was divided into four parts which helped cover specific services: hospital insurance (Part A), medical insurance (Part B), Medicare Advantage (Part C), and prescription drug benefits (Part D).

4. Specifically, Medicare Part B covered medically necessary physician office services and outpatient care, including (a) the ordering of durable medical equipment, prosthetics, orthotics, and supplies ("DME"), and (b) the ordering of genetic testing, which included laboratory tests designed to identify specific inherited mutations in an individual's genes, that were ordered by licensed medical doctors or other qualified health care providers.

5. Physicians, clinics, laboratories, and other health care providers (collectively, "providers") that provided services to Medicare beneficiaries were able to apply for and obtain a "provider number." A provider that received a Medicare provider number was able to file claims with Medicare to obtain reimbursement for services provided to beneficiaries.

6. To receive Medicare reimbursement or refer items and services to Medicare beneficiaries that were eligible for reimbursement, providers had to complete an application and execute a written provider agreement, known as CMS Form 855. The Medicare application was required to be signed by an authorized representative of the provider. The application contained certifications that the provider agreed to abide by the Medicare laws and regulations, and that the provider "will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of heir truth or falsity." Medicare providers were given access to Medicare manuals and service bulletins describing procedures, rules, and regulations.

7. CMS contracted with various companies to receive, adjudicate, process, and pay Part B claims, including claims for DME and genetic testing. Wisconsin Physicians Service was the CMS Medicare Administrative Contractor for Medicare Part B in the State of Michigan. AdvanceMed (now known as "CoventBridge Group") was the Zone Program Integrity Contractor ("ZPIC"), and as such, it was the Medicare contractor charged with investigating fraud, waste, and abuse during the relevant time period.

Durable Medical Equipment

8. Medicare covered a beneficiary's access to DME, such as off-the-shelf ("OTS") ankle braces, knee braces, back braces, elbow braces, wrist braces, and hand braces (collectively, "Braces"). OTS Braces required minimal self-adjustment for appropriate use and did not require expertise in trimming, bending, molding, assembling, or customizing to fit the individual.

9. A claim for DME submitted to Medicare qualified for reimbursement only if it was medically necessary for the treatment or diagnosis of the beneficiary's illness or injury and prescribed by a licensed physician. In claims submitted to Medicare for the reimbursement of provided DME, providers were required to set forth, among other information, the beneficiary's name and unique Medicare identification number, the equipment provided to the beneficiary, the date the equipment was provided, the cost of the equipment, and the name and provider number of the provider who prescribed or ordered the equipment. To be reimbursed from Medicare for DME, the claim had to be reasonable, medically necessary, documented, and actually provided as represented to Medicare.

10. Medicare claims were required to be properly documented in accordance with Medicare rules and regulations.

Genetic Testing

11. Genetic tests were laboratory tests designed to identify specific inherited mutations in an individual's genes.

12. Genetic tests were performed to identify mutations that could increase an individual's risk of developing various diseases and conditions such as cancer, cardiovascular disease, dementia, Parkinson's disease, and diabetes, or that could increase susceptibility to adverse drug reactions. Certain types of genetic tests could also assist in the treatment or management of disease.

13. Genetic tests related to an individual's hereditary predisposition to cancer were commonly referred to as cancer genetic tests or "CGx" tests. These tests used DNA sequencing to detect mutations in genes that could indicate a higher risk of developing certain types of cancers in the future. CGx tests did not diagnose whether an individual presently had cancer.

14. To conduct a genetic test, a laboratory was required to obtain a DNA sample from the individual, commonly referred to as a "specimen." Specimens were typically obtained from the individual's saliva by using a cheek (buccal) swab to collect sufficient cells to provide a genetic profile. The specimens were then submitted to the laboratory for testing.

15. DNA specimens were submitted to laboratories together with requisition forms and other documents for diagnostic testing that identified the

individual, the individual's insurance and other personally identifiable information, the diagnosis purportedly supporting the test, and the specific type of test to be performed (collectively, "doctors' orders"). For laboratories to submit claims to Medicare for genetic tests, doctors' orders had to be signed by a physician or other authorized medical professional, who attested to the medical necessity of the test.

16. Medicare did not cover diagnostic tests, including genetic tests, that were "not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Title 42, United States Code, Section 1395y(a)(1)(A). Except for certain statutory exceptions, Medicare did not cover "[e]xaminations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury." Title 42, Code of Federal Regulations, Section 411.15(a)(1). Among the statutory exceptions Medicare covered were cancer screening tests such as "screening mammography, colorectal cancer screening tests, screening pelvic exams, [and] prostate cancer screening tests." *Id.*

17. If diagnostic tests were necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member, Medicare imposed additional requirements before covering the tests. Title 42, Code of Federal Regulations, Section 410.32(a) provided, "all diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the

physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary."

Telemedicine

18. Telemedicine provided a means of connecting patients to doctors by using telecommunications technology to interact with a patient.

19. Telemedicine companies provided telemedicine services to individuals by hiring doctors and other health care providers. In order to generate revenue, telemedicine companies typically either billed insurance or received payment from patients who utilized the services of the telemedicine company.

20. Medicare Part B covered expenses for specified telemedicine services if certain requirements were met. Prior to the COVID-19 pandemic, these requirements included, but were not limited to, that: (a) the beneficiary was located in a rural or health professional shortage area; (b) services were delivered via a two-way, real-time interactive audio and video telecommunications system; and (c) the beneficiary was at a practitioner's office or a specified medical facility—not at a beneficiary's home—during the telemedicine consultation with a remote practitioner. Medicare required providers to be physically present in the United

States when rendering services to, and prescribing and ordering items for, Medicare beneficiaries.

21. In or around March 2020, in response to the COVID-19 pandemic, some of these requirements were amended temporarily to, among other things, cover telehealth services for certain office and hospital visits, even if the beneficiary was not located in a rural area or a health professional shortage area and even if the telehealth services were furnished to beneficiaries in their home. The requirement that a provider be physically present within the United States when rendering services to, and prescribing and ordering items for, Medicare beneficiaries was not changed by these modified requirements imposed as a result of the COVID-19 pandemic.

The Defendant and Related Individuals

22. The defendant, VIJIL RAHULAN, believed to be a resident of Hyderabad, India, was a medical doctor licensed to practice medicine in Michigan and other states.

23. Between approximately March 2017 and April 2021, VIJIL RAHULAN worked as an independent contractor for various purported telemedicine companies, such as Company 1 and Company 2.

24. Company 1, a company known to the Grand Jury, was an Arizona corporation that operated a purported telemedicine company that did business throughout the United States.

25. Company 2, a company known to the Grand Jury, was a Florida corporation that operated a purported telemedicine company that did business throughout the United States.

26. Individual 1 and Individual 2 were owners of Company 1.

27. Individual 3 was a co-owner of Company 2.

COUNT 1
(18 U.S.C. § 1349 – Conspiracy to Commit Health Care Fraud)

28. Paragraphs 1 through 27 of the General Allegations section of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

29. From in or around March 2017, and continuing through in or around April 2021, in the Eastern District of Michigan, and elsewhere, the defendant,

VIJIL RAHULAN,

did knowingly and intentionally combine, conspire, confederate, and agree with Individual 1, Individual 2, Individual 3, and others known and unknown to the Grand Jury, to knowingly and willfully execute a scheme and artifice to defraud a health care benefit program affecting commerce, as defined in Title 18, United States Code, Section 24(b), that is, Medicare, and to obtain, by means of false and fraudulent

pretenses, representations, and promises, money and property owned by, and under the custody and control of, said health care benefit program, in connection with the delivery of and payment for health care benefits, items, and services, in violation of Title 18, United States Code, Section 1347.

Purpose of the Conspiracy

30. It was a purpose of the conspiracy for VIJIL RAHULAN, Individual 1, Individual 2, Individual 3, and their co-conspirators to unlawfully enrich themselves and others by, among other things: (a) ordering and arranging for the ordering of items and services for Medicare beneficiaries that were medically unnecessary, ineligible for reimbursement, and/or were not provided as represented; (b) submitting and causing the submission of false and fraudulent claims to Medicare for items and services that were medically unnecessary, ineligible for reimbursement, and/or not provided as represented; (c) concealing the submission of false and fraudulent claims to Medicare and the receipt and transfer of the proceeds of the fraud; and (d) diverting proceeds of the fraud for their personal use and benefit, for the use and benefit of others, and to further the fraud.

Manner and Means

The manner and means by which VIJIL RAHULAN and his co-conspirators sought to accomplish the goal of the conspiracy included, among others, the following:

31. VIJIL RAHULAN submitted and caused the submission of false and fraudulent enrollment documents to Medicare, in which he falsely certified that he would comply with all Medicare rules and regulations and program instructions, and would not knowingly present or cause to be presented a false and fraudulent claim for payment by Medicare.

32. VIJIL RAHULAN gained access to personally identifiable information for thousands of Medicare beneficiaries, including those in the Eastern District of Michigan, from Company 1, Company 2, and others, in order for VIJIL RAHULAN to sign brace and genetic testing orders for those beneficiaries.

33. VIJIL RAHULAN solicited and received payments from Company 1, Company 2, and others to sign brace and genetic testing orders and cause the submission of claims regardless of medical necessity, in order to increase revenue for himself, Company 1, Company 2, and their co-conspirators.

34. Between June 2017 and August 2017, Individual 1 and Individual 2 elicited and transmitted pre-filled doctors' orders that VIJIL RAHULAN signed electronically, for the purpose of submitting and causing the submission of false and fraudulent claims to Medicare for DME. Between January 2019 and September 2019, Individual 3 elicited and transmitted pre-filled doctors' orders that VIJIL RAHULAN signed electronically, for the purpose of submitting and causing the submission of false and fraudulent claims to Medicare for DME and genetic testing.

35. VIJIL RAHULAN signed doctors' orders for braces and genetic testing while being located outside the United States, in violation of Medicare's rules and regulations that prohibit providers from providing services outside of the United States in connection with a claim to Medicare.

36. VIJIL RAHULAN ordered braces and genetic testing regardless of medical necessity, in the absence of a pre-existing doctor-patient relationship, without a physical examination, and frequently without any conversation with the beneficiary.

37. VIJIL RAHULAN also ordered genetic tests that were medically unnecessary as he was not treating the beneficiaries for cancer, symptoms of cancer, or any other medical condition; did not use the test results in the treatment of the beneficiaries or the management of their care; and the results of the genetic tests were often not provided to the beneficiaries.

38. VIJIL RAHULAN and others falsified, fabricated, altered, and caused the falsification, fabrication, and alteration of patient files, doctors' orders, and other records, all to support claims to Medicare for braces and genetic tests that were medically unnecessary, ineligible for Medicare reimbursement, and/or not provided as represented.

39. VIJIL RAHULAN and others concealed and disguised the scheme by preparing or causing to be prepared false and fraudulent documentation, and/or

submitting or causing the submission of false and fraudulent documentation to Medicare, including documentation falsely certifying and attesting that items and services for Medicare beneficiaries were medically necessary.

40. VIJIL RAHULAN caused the submission of approximately $82 million in false and fraudulent claims to Medicare for genetic tests and DME that were medically unnecessary, ineligible for reimbursement, and/or not provided as represented. Medicare paid suppliers and laboratories approximately $28.7 million based on these false and fraudulent claims.

All in violation of Title 18, United States Code, Section 1349.

COUNTS 2 through 8
(18 U.S.C. §§ 1347 and 2 - Health Care Fraud)

41. Paragraphs 1 through 27 of the General Allegations section of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

42. From in or around March 2017, and continuing through in or around April 2021, the exact dates being unknown to the Grand Jury, in the Eastern District of Michigan, and elsewhere, the defendant, VIJIL RAHULAN, in connection with the delivery of, and payment for, health care benefits, items, and services, did knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud Medicare, a federal health care benefit program affecting commerce, as defined in Title 18, United States Code, Section 24(b), and to obtain by means of

materially false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of, said health care benefit program, in connection with the delivery of, and payment for, health care benefits, items, and services.

Purpose of the Scheme and Artifice

43. It was a purpose of the scheme and artifice for VIJIL RAHULAN and his accomplices to unlawfully enrich themselves by: (a) ordering and arranging for the ordering of items and services for Medicare beneficiaries that were medically unnecessary, ineligible for reimbursement, and/or were not provided as represented; (b) submitting and causing the submission of false and fraudulent claims to Medicare that were medically unnecessary, ineligible for reimbursement, and/or not provided as represented; (c) concealing the submission of false and fraudulent claims and the receipt and transfer of the proceeds from the fraud; and (d) diverting proceeds of the fraud for their personal use and benefit.

The Scheme and Artifice

44. The scheme to defraud is described in Paragraphs 30 to 40 of this Indictment and is re-alleged and incorporated by reference as if fully set forth herein.

Acts in Execution of the Scheme and Artifice

45. On or about the dates specified below, in the Eastern District of Michigan, and elsewhere, VIJIL RAHULAN, aided and abetted by, and aiding and

abetting, others known and unknown to the Grand Jury, submitted and caused to be submitted the following false and fraudulent claims to Medicare for DME and genetic testing that was, among other things, medically unnecessary, ineligible for reimbursement, and not provided as represented, in furtherance of the scheme as described in paragraphs 30 to 40, with each execution set forth below forming a separate count:

Count	Bene.	Approx. Date of Claim	Claim Number	Description of Devices/Testing Billed; HCPCS Code	Approx. Amount Billed
2	C.Bo.	07/25/2019	911119206032400	Gene analysis (mutS homolog 2, colon cancer, nonpolyposis type 1) full sequence analysis	$763.40
3	C.Bo.	07/25/2019	911119206032402	Gene analysis (breast cancer 1 and 2) of full sequence and analysis for duplication or deletion variants (L81162)	$4,505.86
4	K.M.	09/11/2019	911119254036670	Gene analysis (adenomatous polyposis coli), full gene sequence (L81201)	$1,560.00
5	K.M.	09/11/2019	911119254036672	Gene analysis (breast cancer 1 and 2) of full sequence and analysis for duplication or deletion variants (L81162)	$4,505.86
6	C.Br.	09/23/2019	531119266018390	Gene analysis (postmeiotic segregation	$2,914.04

Count	Bene.	Approx. Date of Claim	Claim Number	Description of Devices/Testing Billed; HCPCS Code	Approx. Amount Billed
				increased 2 [S cerevisiae]) full sequence analysis (L81317); Gene analysis (peripheral myelin protein 22), duplication or deletion analysis (L81324)	
7	R.G.	02/19/2020	20050800196000	Back Brace (L0648)	$1,100.00
8	J.F.	02/20/2020	20051800105000	Back Brace (L0648); Ankle Brace (L1906); Foot Stabilizer (L3170); Knee Braces (L1851); Suspension Sleeves (L2397)	$4,055.00

Each in violation of Title 18, United States Code, Sections 1347 and 2.

FORFEITURE ALLEGATIONS

(18 U.S.C. § 982 and/or 18 U.S.C. § 981 with 28 U.S.C. § 2461)

46. The allegations contained in Count 1 through 8 of this Indictment are re-alleged and incorporated by reference as though fully set forth herein for the purpose of alleging forfeiture against defendant VIJIL RAHULAN, M.D., pursuant to the provisions of Title 18, United States Code, Sections 981(a)(1)(C), 982(a)(7), and Title 28, United States Code, Section 2461(c).

47. Pursuant to Title 18, United States Code, Section 982(a)(7), upon conviction of the offense set forth in Counts 1 of this Indictment, in violation of Title 18, United States Code, Section 1349, the convicted defendant shall forfeit to the United States any property, real or personal, that constitutes or is derived, directly or indirectly, from the gross proceeds traceable to the commission of the offense.

48. Pursuant to Title 18, United States Code, Section 981(a)(1)(C) and Title 28, United States Code, Section 2461(c), upon conviction of the offense set forth in Count 2 through 8 of this Indictment, in violation of Title 18, United States Code, Sections 1347 and 2, the convicted defendant shall forfeit to the United States any property, real or personal, that constitutes or is derived, directly or indirectly, from the gross proceeds traceable to the commission of the offense.

49. Substitute Assets: If any of the property described above as being 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;

d. has been substantially diminished in value; or

e. has been commingled with other property that cannot be subdivided without difficulty;

the United States of America shall be entitled to forfeiture of substitute property pursuant to Title 21, United States Code, Section 853(p), as incorporated by Title 18, United States Code, Section 982(b)(1).

50. Money Judgment: Upon conviction of one or more violations alleged in this Indictment, VIJIL RAHULAN, M.D. shall be ordered to pay the United States a sum of money equal to the total amount of proceeds defendant obtained as a result of such violation(s).

THIS IS A TRUE BILL.

s/ Grand Jury Foreperson
Grand Jury Foreperson

DAWN N. ISON
UNITED STATES ATTORNEY

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Date: August 15, 2023

United States District Court Eastern District of Michigan	**Criminal Case Cover**

Case:2:23-cr-20467
Judge: Lawson, David M.
MJ: Patti, Anthony P.
Filed: 08-15-2023 At 04:18 PM
USA V SEALED MATTER (LG)

NOTE: It is the responsibility of the Assistant U.S. Attorney signing this form to complete

Companion Case Information	**Companion Case Number:**
This may be a companion case based upon **LCrR 57.10 (b)(4)**[1]:	**Judge Assigned:**
☐ Yes ☒ No	**AUSA's Initials:** KMW

Case Title: USA v. Vijil Rahulan

County where offense occurred : Wayne

Check One: ☒ **Felony** ☐ **Misdemeanor** ☐ **Petty**

✓ Indictment/____Information --- **no** prior complaint.
____Indictment/____Information --- based upon prior complaint [**Case number:**]
____Indictment/____Information --- based upon **LCrR 57.10 (d)** ***[Complete Superseding section below]***.

Superseding Case Information

Superseding to Case No: ____________ **Judge:** ____________

☐ Corrects errors; no additional charges or defendants.
☐ Involves, for plea purposes, different charges or adds counts.
☐ Embraces same subject matter but adds the additional defendants or charges below:

Defendant name	Charges	Prior Complaint (if applicable)
Vijil Rahulan	18 U.S.C. § 1349 18 U.S.C. § 1347 18 U.S.C. § 2	

Please take notice that the below listed Assistant United States Attorney is the attorney of record for the above captioned case.

August 15, 2023
Date

s/ Kelly M. Warner

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[1] Companion cases are matters in which it appears that (1) substantially similar evidence will be offered at trial, or (2) the same or related parties are present, and the cases arise out of the same transaction or occurrence. Cases may be companion cases even though one of them may have already been terminated.