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UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA, *ex rel.* JANE DOE, *Plaintiffs*, v. HEART SOLUTION PC, BIOSOUND MEDICAL SERVICES, KIRTISH N. PATEL, NITA K. PATEL, *Defendants.*	Hon. Stanley R. Chesler *Civil Action No.* 14-3644 **UNITED STATES' COMPLAINT IN INTERVENTION**

The United States of America ("United States"), by Paul J. Fishman, United States Attorney for the District of New Jersey, for its Complaint in Intervention states:

OVERVIEW

1. The United States brings this action to recover treble damages and civil penalties under the False Claims Act, 31 U.S.C. §§ 3729-33, and to recover damages and other monetary relief under the common law or equitable theories of fraud, payment under mistake of fact, unjust enrichment, and disgorgement of illegal profits.

2. Defendants Kirtish N. Patel and Nita K. Patel have admitted in criminal pleas that they created fraudulent diagnostic test reports, forged physician signatures on these reports, and then billed Medicare for the fraudulent reports and the underlying tests that were used solely to create these reports. They also admitted in their criminal pleas that they billed Medicare for neurological testing that they conducted without the required physician supervision after falsely representing to Medicare that the tests would be supervised by a physician. The United States' civil action is based on this conduct.

3. Specifically, the United States' civil action against Kirtish N. Patel, Nita K. Patel, Biosound Medical Services, and Heart Solution PC (collectively, "Defendants") is based on false or fraudulent claims for payment or approval that Defendants knowingly presented or caused to be presented to the Medicare program for fraudulent diagnostic test reports and the diagnostic tests that were used to generate those fraudulent reports, and on false records or statements that Defendants knowingly made, used, or caused to be made or used that were material to these false or fraudulent claims. Defendants' conduct violated 31 U.S.C. §§ 3729(a)(1)(A) and 3729(a)(1)(B), because Defendants were not entitled to Medicare reimbursement for fraudulent diagnostic test reports that were not prepared by an appropriate specialist physician and for diagnostic tests that were used solely to generate these fraudulent test reports.

4. The United States' civil action against Defendants is also based on false or fraudulent claims for payment or approval that Defendants knowingly presented or caused to be presented to the Medicare program for neurological diagnostic tests that were not supervised by a licensed neurologist as required, and on false records or statements that Defendants knowingly made, used, or caused to be made or used that were material to these false or fraudulent claims. Defendants' conduct violated 31 U.S.C. §§ 3729(a)(1)(A) and 3729(a)(1)(B), because

Defendants were not entitled to Medicare reimbursement for neurological testing that lacked the requisite physician supervision.

5. The United States also brings this action against Defendants under common law or equitable theories of fraud, payment under mistake of fact, unjust enrichment, and disgorgement of illegal profits. By billing Medicare for fraudulent diagnostic test reports and diagnostic tests that were used solely to generate these fraudulent reports, and by billing Medicare for neurological diagnostic testing that lacked the requisite physician supervision, Defendants defrauded Medicare, were unjustly enriched, and were paid by mistake, and they should be required to disgorge their illegal profits.

JURISDICTION AND VENUE

6. This action arises under the False Claims Act, as amended, 31 U.S.C. §§ 3729-33, and under common law or equitable theories of fraud, payment under mistake of fact, unjust enrichment, and disgorgement of illegal profits. The Court has jurisdiction over this action under 31 U.S.C. §§ 3730(a) and 3732(a) and 28 U.S.C. §§ 1331 and 1345.

7. The Court may exercise personal jurisdiction over Defendants pursuant to 31 U.S.C. § 3732(a) because Defendants resided in and/or transacted business in the District of New Jersey and because acts proscribed by 31 U.S.C. § 3729 occurred in the District of New Jersey.

8. Venue is proper in the District of New Jersey pursuant to 28 U.S.C. §§ 1391(b) and (c) and 31 U.S.C. § 3732 because Defendants resided in and/or transacted business in the District of New Jersey and because acts proscribed by 31 U.S.C. § 3729 occurred in the District of New Jersey.

PARTIES

9. The United States brings this lawsuit on behalf of its Department of Health and Human Services.

10. The Relator resides in the State of New Jersey. In June 2014, the Relator filed an action on behalf of the Relator and the United States under the qui tam provisions of the False Claims Act.

11. During all relevant times, Defendants Biosound Medical Services and Heart Solution PC were mobile medical diagnostic companies and registered Medicare providers that were located in Parsippany, New Jersey.

12. Defendants Kirtish N. Patel and Nita K. Patel resided in Rockaway, New Jersey and during all relevant periods owned and operated Defendants Heart Solution PC and Biosound Medical Services. Neither Kirtish N. Patel nor Nita K. Patel is or ever was a licensed physician.

THE FALSE CLAIMS ACT

13. The False Claims Act provides in pertinent part that:

> (a) (1) any person who (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; . .
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> * * *
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000 (as adjusted by statute), plus 3 times the amount of damages which the Government sustains because of the act of that person.
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> * * *
>
> (b) For purposes of this section (1) the terms "knowing" and "knowingly" (A) mean that a person, with respect to information (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information; and (B) require no proof of specific intent to defraud.

31 U.S.C. § 3729.[1]

THE MEDICARE PROGRAM

14. In 1965, Congress enacted Title XVIII of the Social Security Act, known as the Medicare program, to pay for the costs of certain healthcare services. Entitlement to Medicare is based on age, disability, or affliction with end-stage renal disease. See 42 U.S.C. §§ 426, 426A.

15. The U.S. Department of Health and Human Services is responsible for the administration and supervision of the Medicare program. The Centers for Medicare and Medicaid Services ("CMS") is an agency of the U.S. Department of Health and Human Services and is directly responsible for the administration of the Medicare program.

A. Submitting Claims for Reimbursement

16. Participating health care providers must enter into agreements with CMS in which the provider agrees to conform to all applicable statutory and regulatory requirements for reimbursement from Medicare.

17. For outpatient treatment, all Medicare reimbursement is subject to Part B of Medicare. See 42 U.S.C. §§ 1395j-1395w-4. Diagnostic tests are included in the definition of "medical and other health services" for purposes of Medicare Part B coverage. See 42 C.F.R. § 410.10(e).

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[1] The False Claims Act was amended pursuant to Public Law 111-21, the Fraud Enforcement and Recovery Act of 2009 ("FERA"), enacted May 20, 2009. Given the nature of the claims at issue, § 3279(a)(1) of the statute prior to FERA, and as amended in 1986, and § 3729(a)(1)(A), are both applicable here. Section 3729(a)(1) applies to conduct before FERA was enacted, and § 3729(a)(1)(A) applies to conduct after FERA was enacted. Section 3729(a)(1)(B) was formerly § 3729(a)(2) and is applicable to all claims in this case by virtue of § 4(f) of FERA.

18. To obtain Medicare reimbursement under Part B, providers submit claims using a form known as a CMS Form 1500. Among the information the provider includes on a CMS Form 1500 is certain five-digit codes, known as Current Procedural Terminology codes, or CPT codes, that identify the services rendered and for which the provider seeks reimbursement.

19. By statute, "no payment may be made" under Medicare Part B for services that are "not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member[.]" 42 U.S.C. § 1395y(a)(1)(A); see also, 42 C.F.R. § 411.15 ("The following services are excluded from coverage: *** (k) Any services that are not reasonable and necessary for one of the following purposes: (1) For the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.")

20. Accordingly, any provider seeking Medicare reimbursement through Part B must certify on a CMS Form 1500 that "the services on this form were medically necessary[.]"

21. According to CMS regulations, diagnostic tests must be supervised by a physician:

> Except as indicated in paragraph (b)(2) of this section [dealing with tests not relevant here], all diagnostic x-ray and other diagnostic tests covered under section 1861(s)(3) of the Act and payable under the physician fee schedule must be furnished under the appropriate level of supervision by a physician as defined in section 1861(r) of the Act.

42 C.F.R. § 410.32(b)(1).

22. Diagnostic tests that are furnished without the required level of supervision are not reasonable and necessary for Medicare Part B purposes and therefore are not covered. C.F.R. §§ 410.32(b)(1), 411.15(k)(1).

23. CMS regulations establish that all diagnostic tests must be provided under at least a general level of supervision, with some also requiring either direct or personal supervision:

> Except where otherwise indicated, all diagnostic xray and other diagnostic tests subject to this provision and payable under the physician fee schedule must be furnished under at least a general level of physician supervision as defined in paragraph (b)(3)(i) of this section. In addition, some of these tests also require either direct or personal supervision as defined in paragraphs (b)(3)(ii) or (b)(3)(iii) of this section, respectively . . .

42 C.F.R. § 410.32(b)(3).

24. Accordingly, the diagnostic tests for which Defendants billed Medicare require at least a general level of physician supervision, which means that:

> the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

42 C.F.R. § 410.32(b)(3)(i).

B. <u>Independent Diagnostic Testing Facilities</u>

25. At all relevant times, Defendants Biosound Medical Services and Heart Solution PC were considered to be Independent Diagnostic Testing Facilities ("IDTF") for Medicare Part B purposes.

26. An IDTF may be a fixed location, a mobile entity, or an individual non-physician practitioner; it is independent of a physician's office or hospital. 42 C.F.R. § 410.33(a).

27. An IDTF must have a supervising physician. CMS regulations establish the requisite qualifications for supervising physicians:

> The supervising physician must evidence proficiency in the performance and interpretation of each type of diagnostic procedure performed by the IDTF. The proficiency may be documented by certification in specific medical specialties or subspecialties or by criteria established by the carrier for the service area in which the IDTF is located.

42 C.F.R. § 410.33(b).

DEFENDANTS' FALSE AND FRAUDULENT CLAIMS

28. Defendants knew that they must follow all applicable Medicare laws, regulations, and program instructions in order to get reimbursed by Medicare. For example, Defendant Kirtish N. Patel certified on a Medicare provider application for Biosound Medical Services that he dated August 1, 2005, that:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier . . . I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the supplier's compliance with all applicable conditions of participation in Medicare.

29. From at least January 2008 to May 2014, Defendant Biosound Medical Services billed Medicare for the performance and interpretation of diagnostic tests that had been ordered by a patient's primary care physician. From at least January 2011 to May 2014, Defendant Heart Solution PC billed Medicare for the performance and interpretation of diagnostic tests that had been ordered by a patient's primary care physician. Specifically, the following tests were billed to Medicare by Biosound Medical Services and/or Heart Solution PC:

CPT Code	Description
76770	Ultrasound behind abdominal cavity
93306	Ultrasound examination of heart including color depicted blood flow
76700	Ultrasound of abdomen
76856	Ultrasound of pelvis
93975	Ultrasound scan of abdominal, pelvic, and/or scrotal arterial
93970	Ultrasound scan of veins of both arms or legs
93978	Ultrasound scan of vena cava or groin graft or vessel blood flow
93880	Ultrasound scanning of blood flow (outside the brain)
93886	Ultrasound scanning of head and neck vessel blood flow
93930	Ultrasound study of arteries and arterial grafts of both arms
93925	Ultrasound study of arteries and arterial grafts of both legs
93931	Ultrasound study of arteries and arterial grafts of one arm
93922	Ultrasound study of arteries of both arms and legs
93923	Ultrasound study of arteries of both arms and legs
93924	Ultrasound study of arteries of both legs at rest and exercise

93965	Ultrasound study of veins of both arms or legs
93351	Ultrasound examination and continuous monitoring of the heart
93888	Ultrasound limited scanning of head and neck blood flow
76882	Ultrasound of arm or leg
76536	Ultrasound of head and neck
76881	Ultrasound of leg or arm
76870	Ultrasound of scrotum
93268	Heart rhythm symptom related tracing and interpretation
93228	Heart rhythm tracing, computer analysis, and interpretation
93229	Heart rhythm tracing, computer analysis, physician prescribed
95903	Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with f-wave study
95904	Nerve conduction, amplitude and latency/velocity study, each nerve; sensory
92546	Assessment and recording of abnormal eye movement with patient in a rotating chair
95913	Nerve transmission studies, 13 or more studies
92543	Assessment and recording of balance system during irrigation of both ears
92540	Observation, testing, and recording of abnormal eye movement
95934	H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle
92588	Placement of ear probe for computerized cochlear assessment of repeated sounds with interpretation and report
92547	Use of vertical electrodes during eye or balance evaluation
92542	Observation and recording from multiple positions of abnormal eye movements
92541	Observation and recording of abnormal eye movement
92544	Complex eye movement test while viewing objects in visual field
92545	Assessment and recording of abnormal eye movement while tracking moving object
95912	Nerve transmission studies, 11-12 studies
95922	Testing of autonomic (sympathetic) nervous system function at least 5 minutes of tilt
95921	Testing of autonomic (sympathetic) nervous system function
95910	Nerve transmission studies, 7-8 studies

30. Defendants purported to offer diagnostic testing administration and interpretation services, with the testing done in the convenience of a primary care physician's office. In response to a referring doctor's request for a diagnostic test for a patient, Defendant Kirtish N. Patel or one of his employees travelled to the referring doctor's office to administer the diagnostic test. Defendants purported to send the test results to a cardiologist or other appropriate specialist physician to interpret the test. Defendants then transmitted back to the referring doctor a diagnostic report that had been purportedly authored and signed by a cardiologist or other specialist who interpreted the diagnostic results. Defendants then billed Medicare for the professional component of the tests, representing the purported diagnostic test report, and the technical component of the tests, representing non-physician work such as personnel costs.

31. On November 17, 2015, Defendants Kirtish N. Patel and Nita K. Patel both pled guilty before The Hon. William H. Walls in the United States District Court for the District of New Jersey to separate one-count criminal Informations that charged them with health care fraud in violation of 18 U.S.C. § 1347. As part of their guilty pleas, Kirtish N. Patel and Nita K. Patel separately admitted that:

- they owned and operated mobile diagnostic companies Biosound Medical Services and Heart Solution PC;
- Biosound Medical Services and Heart Solution PC billed Medicare for diagnostic testing services that they claimed to have provided;
- part of the diagnostic work that they purported to provide included having licensed specialist physicians review and interpret the diagnostic values recorded by diagnostic technicians;
- they knew that the doctors who ordered the diagnostic services relied upon the diagnostic reports that they believed were prepared by licensed specialist physicians in order to make important treatment decisions for their patients;
- from October 2008 to June 2014, despite not having a medical license, Kirtish N. Patel wrote many of the diagnostic reports that were supposed to be written by a specialist physician; and

- when Kirtish N. Patel fraudulently interpreted and wrote a diagnostic report, he or Nita K. Patel then attached a forged specialist physician signature to the report to make it look like an actual physician had authored the report.

Kirtish N. Patel and Nita K. Patel both further admitted that at the time that they submitted claims to Medicare for diagnostic reports that were never interpreted by a licensed physician, they knew that doing so was illegal.

32. Accordingly, Defendants knowingly billed Medicare for fraudulent diagnostic test reports that were not prepared by a physician and contained no reliable information upon which a doctor could make a patient treatment decision. Defendants also knowingly billed Medicare for the diagnostic tests themselves even though, because of Defendants' fraud, these tests were used solely to generate the fraudulent test reports and were never used for a legitimate purpose. Kirtish N. Patel and Nita K. Patel committed this fraud even though they knew that the doctors who ordered the diagnostic services relied upon the diagnostic reports to make treatment decisions.

33. The following are examples, identified through a Government record review, of some (but not all) patients and dates of service for which Defendants knowingly submitted or caused to be submitted false claims to federal health care programs on behalf of Biosound Medical Services for diagnostic test reports that they fraudulently created but made to look real by forging a physician's signature on the reports, and for the tests themselves even though Defendants' fraud ensured that the tests would never be used for their intended purpose of being reviewed by a specialist physician in order to prepare legitimate test reports:

a. Biosound purportedly performed diagnostic tests on patient W.B. on March 1, 2012. Biosound billed Medicare for these tests under CPT Codes 93922, 93925, 93965, and 93970 on May 9, 2012, and was paid $918.99 by Medicare for these tests on May 11, 2012.

b. Biosound purportedly performed diagnostic tests on patient G.B. on August 30, 2012. Biosound billed Medicare for these tests under CPT Codes 93880, 93931, and 93886 on September 12, 2012, and was paid $842.19 by Medicare for these tests on September 14, 2012.

c. Biosound purportedly performed diagnostic tests on patient G.G. on February 7, 2013. Biosound billed Medicare for these tests under CPT Codes 93922, 93925, 93965, and 93970 on May 17, 2013, and was paid $553.02 by Medicare for these tests on May 22, 2013.

d. Biosound purportedly performed diagnostic tests on patient W.S. on March 14, 2013. Biosound billed Medicare for these tests under CPT Codes 93306, 93380, 93931, 93922, 93930, 93965, and 93970 on May 17, 2013, and was paid $712.20 by Medicare for these tests on May 22, 2013.

e. Biosound purportedly performed diagnostic tests on patient R.P. on May 16, 2013. Biosound billed Medicare for these tests under CPT Codes 93922, 93925, 93965, and 93970 on May 29, 2013, and was paid $541.95 by Medicare for these tests on June 1, 2013.

f. Biosound purportedly performed diagnostic tests on patient C.S. on May 30, 2013. Biosound billed Medicare for these tests under CPT Codes 93880 and 93881 on July 3, 2013, and was paid $273.34 by Medicare for these tests on July 10, 2013.

g. Biosound purportedly performed diagnostic tests on patient R.R. on July 18, 2013. Biosound billed Medicare for these tests under CPT Codes 93922, 93925, 93965, and 93970 on August 7, 2013, and was paid $541.95 by Medicare for these tests on August 10, 2013.

h. Biosound purportedly performed diagnostic tests on patient H.K. on August 8, 2013. Biosound billed Medicare for these tests under CPT Codes 93922, 93925, 93965, and 93970 on August 28, 2013, and was paid $541.95 by Medicare for these tests on August 31, 2013.

i. Biosound purportedly performed diagnostic tests on patient C.B. on August 15, 2013. Biosound billed Medicare for these tests under CPT Codes 93922, 93925, 93965, and 93970 on August 28, 2013, and was paid $541.95 by Medicare for these tests on August 30, 2013.

j. Biosound purportedly performed diagnostic tests on patient D.M. on October 17, 2013. Biosound billed Medicare for these tests under CPT Codes 93922, 93925, 93965, and 93970 on October 30, 2013, and was paid $541.95 by Medicare for these tests on November 2, 2013.

34. Because Defendants knowingly submitted claims to Medicare for reimbursement for fraudulent diagnostic test reports and for the diagnostic tests themselves, which were used solely to generate these fraudulent reports, these claims were materially false for purposes of the False Claims Act. Defendants' conduct in knowingly presenting or causing to be presented to the Medicare program false or fraudulent claims for payment or approval, and knowingly making, using, or causing to be made or used false records or statements that were material to false or fraudulent claims, violated 31 U.S.C. § 3729(a)(1) (pre-2009 amendments) and 31 U.S.C. § 3729(a)(1)(A) (current version of False Claims Act). All of these claims fall within the False Claims Act's ten-year statute of limitations. See 31 U.S.C. § 3731(b)(2). Defendants' fraudulent scheme resulted in their receipt of payments from federal health care programs to which they were not entitled.

35. As explained above, in order to receive reimbursement for their services, IDTFs such as Defendants Biosound Medical Services and Heart Solution PC were required by Medicare to have a licensed supervising physician who is proficient in the performance and interpretation of each type of diagnostic procedure performed. For example, in order to be reimbursed by Medicare for neurological diagnostic testing, Biosound Medical Services and Heart Solution PC were required by Medicare to have a supervising physician who was proficient in the performance and interpretation of neurological diagnostic procedures.

36. As part of their guilty pleas on November 17, 2015, Kirtish N. Patel and Nita K. Patel also admitted that from 2006 to 2014, they falsely represented to Medicare that the neurological testing being performed at Biosound Medical Services was being supervised by a licensed neurologist when, in fact, it was not. Kirtish N. Patel and Nita K. Patel further admitted that they knowingly made this false representation to Medicare and that at the time that they

submitted claims to Medicare for neurological testing that was not supervised by a licensed neurologist, they knew that doing so was illegal.

37. Accordingly, Defendants knowingly billed Medicare for diagnostic tests that lacked proper physician supervision and were therefore worthless and unreliable, and for test reports that, to the extent they were even created, were based on unreliable tests and were therefore worthless.

38. The following are examples, identified through a Government record review, of some (but not all) patients and dates of service for which Defendants knowingly submitted or caused to be submitted false claims to federal health care programs on behalf of Biosound Medical Services for diagnostic tests that were not supervised by a licensed neurologist and for test reports that, to the extent they were even created, were worthless because the underlying tests were unreliable:

a. Biosound purportedly performed diagnostic tests on patient I.C. on August 7, 2009. Biosound billed Medicare for these tests under CPT Codes 95903, 95904, 95934, 92545, 92546, 92547, and 92588 on September 2, 2009, and was paid $1,077.51 for these tests by Medicare on September 8, 2009.

b. Biosound purportedly performed diagnostic tests on patient J.D. on August 20, 2009. Biosound billed Medicare for these tests under CPT Codes 92541, 92542, 92543, and 92544 on August 26, 2009, and was paid $261.12 for these tests by Medicare on August 28, 2009.

c. Biosound purportedly performed diagnostic tests on patient H.R. on April 29, 2010. Biosound billed Medicare for these tests under CPT Codes 92540, 92543, 92546, and 92547 on January 5, 2011, and was paid $258.84 for these tests by Medicare on January 7, 2011.

d. Biosound purportedly performed diagnostic tests on patient I.M. on January 19, 2011. Biosound billed Medicare for these tests under CPT Codes 92540, 92543, 92546, 92547, and 92588 on April 6, 2011, and was paid $89.51 by Medicare for these tests on April 9, 2011.

e. Biosound purportedly performed diagnostic tests on patient P.E. on February 17, 2011. Biosound billed Medicare for these tests under CPT Codes 92540, 92543, 92546, 92547, and 92588 on April 6, 2011, and was paid $323.69 by Medicare for these tests on April 9, 2011.

f. Biosound purportedly performed diagnostic tests on patient C.M. on January 30, 2013. Biosound billed Medicare for these tests under CPT Codes 95913, 92540, 92543, 92546, 92547, and 92588 on May 17, 2013, and was paid $415.68 by Medicare for these tests on May 23, 2013.

g. Biosound purportedly performed diagnostic tests on patient G.H. on January 30, 2013. Biosound billed Medicare for these tests under CPT Codes 92540, 92543, 92546, and 92588 on May 17, 2013, and was paid $415.68 by Medicare for these tests on May 23, 2013.

h. Biosound purportedly performed diagnostic tests on patient A.L on January 31, 2013. Biosound billed Medicare for these tests under CPT Codes 95913, 92540, 92543, 92546, 92547, and 92588 on May 17, 2013, and was paid $688.10 by Medicare for these tests on May 23, 2013.

i. Biosound purportedly performed diagnostic tests on patient B.R. on April 19, 2013. Biosound billed Medicare for these tests under CPT Codes 95913, 92540, 92543, 92546, 92547, and 92588 on May 17, 2013, and was paid $256.58 by Medicare for these tests on May 22, 2013.

j. Biosound purportedly performed diagnostic tests on patient C.P. on July 9, 2013. Biosound billed Medicare for these tests under CPT Codes 92540, 92543, 92546, 92547, and 92588 on October 23, 2013, and was paid $407.38 by Medicare for these tests on October 29, 2013.

39. Because Defendants knowingly submitted claims to Medicare for reimbursement for diagnostic tests that were not supervised by a licensed physician and for reports based on those tests, these claims were materially false for purposes of the False Claims Act. Defendants' conduct in knowingly presenting or causing to be presented to the Medicare program false or fraudulent claims for payment or approval, and knowingly making, using, or causing to be made or used false records or statements that were material to false or fraudulent claims, violated 31 U.S.C. § 3729(a)(1) (pre-2009 amendments) and 31 U.S.C. § 3729(a)(1)(A) (current version of False Claims Act). All of these claims fall within the False Claims Act's ten-year statute of limitations. See 31 U.S.C. § 3731(b)(2). Defendants' fraudulent scheme resulted in their receipt of payments from federal health care programs to which they were not entitled.

40. As part of their November 17, 2015, pleas, Defendants Kirtish N. Patel and Nita K. Patel further admitted that Defendants Biosound Medical Services and Heart Solution PC

were paid at least $1,668,954.95 by Medicare for diagnostic testing and reports that were never interpreted by a licensed physician and for neurological diagnostic testing that was never supervised by a licensed neurologist. Kirtish N. Patel and Nita K. Patel both testified that they were pleading guilty because they were in fact guilty.

41. Defendants presented or caused these claims to be presented to Medicare with actual knowledge of their falsity, or in deliberate ignorance or reckless disregard that such claims were false and fraudulent.

COUNT I

False Claims Act, 31 U.S.C. § 3729(a)(1) and (a)(1)(A) Presentation of False Claims

42. The United States incorporates by reference the preceding paragraphs of this Complaint in Intervention as if set forth fully herein.

43. Defendants knowingly presented or caused to be presented to the United States false or fraudulent claims for payment or approval in violation of 31 U.S.C. § 3729(a)(1) (pre-2009 amendments) and 31 U.S.C. § 3729(a)(1)(A) (current version of the False Claims Act) when they submitted or caused to be submitted claims to Medicare for: (i) fraudulent diagnostic test reports and the diagnostic tests that were used to generate these fraudulent reports; and (ii) neurological diagnostic tests that were not supervised by a licensed neurologist as required.

44. By virtue of the false or fraudulent claims that Defendants presented or caused to be presented, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,500 to $11,000 for each violation.

45.

COUNT II

False Claims Act, 31 U.S.C. § 3729(a)(1)(B) Making or Using False Records or Statements

46. The United States incorporates by reference the preceding paragraphs of this Complaint in Intervention as if set forth fully herein.

47. Defendants knowingly made, used, or caused to be made or used false records or statements material to false or fraudulent claims in violation of 31 U.S.C. § 3729(a)(2) (pre-2009 amendments) and 31 U.S.C. § 3729(a)(1)(B) (current version of the False Claims Act) when they used false records and made false statements in connection with seeking reimbursement from Medicare for: (i) fraudulent diagnostic test reports and the diagnostic tests that were used to generate these fraudulent reports; and (ii) neurological diagnostic tests that were not supervised by a licensed neurologist as required.

48. By virtue of Defendants' making, using, or causing to be made or used false records or statements material to false or fraudulent claims, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,500 to $11,000 for each violation.

COUNT III

Common Law Fraud

49. The United States incorporates by reference the preceding paragraphs of this Complaint in Intervention as if set forth fully herein.

50. Defendants submitted or caused to be submitted material and false claims to Medicare with knowledge of their falsity or reckless disregard for their truth, and with the

intention that the United States would act upon the false claims to its detriment. The United States acted in justifiable reliance upon the truthfulness of these claims.

51. Had the true facts been known to the United States, the United States would not have reimbursed Defendants for these claims.

52. By reason of its reimbursement of these claims, the United States has been damaged in an amount to be determined at trial.

COUNT IV

Unjust Enrichment

53. The United States incorporates by reference the preceding paragraphs of this Complaint in Intervention as if set forth fully herein.

54. The United States claims the recovery of all monies by which Defendants have been unjustly enriched.

55. By directly or indirectly obtaining Government funds to which they were not entitled, Defendants were unjustly enriched at the expense of the United States and are liable to account and pay such amounts, or the proceeds therefrom, which are to be determined at trial, to the United States.

COUNT V

Disgorgement

56. The United States incorporates by reference the preceding paragraphs of this Complaint in Intervention as if set forth fully herein.

57. This is a claim for disgorgement of profits earned by Defendants by knowingly submitting or causing to be submitted false claims.

58. Defendants concealed their prohibited activity through false records, statements, and claims and failed to abide by their duty to disclose such information to the United States.

59. The United States did not detect Defendants' prohibited conduct.

60. This Court has the equitable power to, among other things, order Defendants to disgorge the payments Defendants received as a result of their violations of the False Claims Act.

COUNT VI

Payment Under Mistake of Fact

61. The United States incorporates by reference the preceding paragraphs of this Complaint in Intervention as if set forth fully herein.

62. The United States claims the recovery of all monies by which Defendants have been paid by mistake.

63. The false claims that Defendants submitted or caused to be submitted to the United States were paid by the United States based upon mistaken or erroneous understandings of material fact.

64. The United States, acting in reasonable reliance on the truthfulness of the claims that Defendants submitted or caused to be submitted to the United States and the truthfulness of the records or statements that Defendants made, used, or caused to be made or used, paid certain sums of money, to which Defendants were not entitled, and Defendants are thus liable to account and pay such amounts, which are determined at trial, to the United States.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff United States requests that judgment be entered in its favor and against Defendants jointly and severally as follows:

1. On the First and Second Counts under the False Claims Act for the amount of the United States' damages, trebled as required by law, and such civil penalties as are required by law, together with all such further relief as may be just and proper.

2. On the Third Count, for common law fraud, for compensatory and punitive damages in an amount to be determined, together with costs and interest, and for all such further relief as may be just and proper.

3. On the Fourth and Sixth Counts for unjust enrichment and payment by mistake, for the damages sustained and/or amounts by which Defendants were unjustly enriched or by which Defendants retained illegally obtained monies, plus interest, costs, and expenses, and all such further relief as may be just and proper.

4. On the Fifth Count, for disgorgement of illegal payments obtained by Defendants and such further equitable relief as may be just and proper.

DEMAND FOR JURY TRIAL

The United States demands a jury trial in this case.

Dated: November 18, 2015
Newark, New Jersey

Respectfully submitted,

PAUL J. FISHMAN
United States Attorney

By: 
CHARLES GRAYBOW
Assistant United States Attorney

Attorneys for the United States