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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

THE UNITED STATES OF AMERICA, *Plaintiff,* v. VIJAY PATEL and MOBILE DIAGNOSTIC TESING OF NJ, LLC, *Defendants.*

COMPLAINT AND DEMAND FOR JULY TRIAL

Plaintiff, the United States of America ("United States"), alleges for its Complaint as follows:

NATURE OF THIS ACTION

1. This action against Vijay Patel ("Patel") and Mobile Diagnostic Testing of NJ, LLC ("Mobile Diagnostic") is based on false or fraudulent claims for payment or approval that defendants knowingly presented or caused to be presented to Medicare.

2. Defendants submitted, or caused to be submitted, claims for diagnostic testing services performed by someone else: a cardiologist (hereinafter referred to as "Doctor #1") who

was a participant in the Medicare program and under the program's pre-payment review due to his improper billing practices and suspected fraud.

3. Patel admitted to this conduct in a criminal plea. Specifically, Patel admitted that during the period from November 2009 to October 2012, he knowingly caused false claims to be submitted to Medicare for services that Doctor #1 had performed.

4. Claims submitted by a physician on pre-payment review are strictly scrutinized by Medicare before a payment is made. This process significantly delays payment and could potentially result in the Medicare contractor rejecting claims that are not supported by proper medical and other documentation.

5. To circumvent pre-payment review, Patel and Doctor #1 devised a fraudulent scheme whereby Patel agreed to submit Doctor #1's claims to Medicare through his company, Mobile Diagnostic, and his brother's company, Biosound Medical Services, Inc. ("Biosound"), in exchange for money. Patel would receive Medicare payments either directly from Medicare or from Biosound, give a portion of the money to Doctor #1, and retain a substantial portion for himself. But for this scheme — which was effectively an end-run around Medicare's pre-payment review — Doctor #1's claims would have been closely scrutinized and possibly denied.

6. This fraudulent scheme resulted in defendants' receipt of payments from federal health care programs to which they were not entitled.

7. By billing Medicare for services they did not provide and keeping the reimbursement money, Defendants defrauded Medicare, were unjustly enriched, and were paid by mistake, and they should be required to disgorge their illegal profits.

8. The United States brings this action against defendants Patel and Mobile Diagnostic 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.

JURISDICTION AND VENUE

9. 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. This Court has jurisdiction over this action under 31 U.S.C. §§ 3730(a) and 3732(a) and 28 U.S.C. §§ 1331 and 1345.

10. This Court has personal jurisdiction over defendant Patel because he resides in and transacted business in this District and engaged in wrongdoing in this District.

11. This Court has personal jurisdiction over defendant Mobile Diagnostic because its principal place of business is located in this District and it engaged in wrongdoing in this District.

12. Venue is proper in this District pursuant to 28 U.S.C. § 1391(b) and (c) and 31 U.S.C. § 3732 because each defendant resided in or transacted business in this District and engaged in wrongdoing in this District.

THE PARTIES

13. Plaintiff United States brings this action on behalf of its Department of Health and Human Services ("HHS") and the Centers for Medicare and Medicaid Services ("CMS"), a division of HHS that directly administers the Medicare and Medicaid programs.

14. During all relevant times, defendant Patel resided in Parsippany, New Jersey, and during all relevant periods owned and operated defendant Mobile Diagnostic, a diagnostic testing facility.

15. During all relevant times, defendant Mobile Diagnostic was a limited liability company with its principal place of business in Parsippany, New Jersey, and during all relevant periods, each of its members resided in Parsippany, New Jersey.

THE LEGAL FRAMEWORK

A. The Federal Health Care Program - Medicare

16. 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.

17. HHS administers and supervises the Medicare program. CMS is an agency of HHS that administers Medicare. CMS contracts with private insurance companies to receive, review and pay claims for reimbursement from health care providers for the provision of services to Medicare beneficiaries.

B. Submitting Claims to Medicare for Reimbursement

18. A health care provider must be enrolled in Medicare in order to submit claims to Medicare.

19. In order to participate in the Medicare program, health care providers must enter into agreements with CMS in which the provider agrees to comply with all applicable statutory and regulatory requirements for reimbursement from Medicare.

20. Through entering the provider agreement, the provider certifies that they understand that payment of a claim is conditioned on the claim complying with the Medicare regulations and the law.

21. 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).

22. To obtain Medicare reimbursement under Part B, providers submit claims using a form known as a CMS Form 1500. The provider must include on the claim form certain five-digit codes, known as Current Procedural Terminology codes ("CPT" codes), that identify the services rendered and for which the provider seeks reimbursement.

23. The provider must certify on the CMS Form 1500:

- that the information contained on the form is true, accurate and complete;
- that the form was prepared in compliance with Medicare laws and regulations; and
- that the services listed in the form were personally furnished.

24. Healthcare providers are authorized to submit claims to Medicare only for services that they actually rendered.

25. In recent years, CMS has employed various measures to stop payments for fraudulent claims before they are made to providers. These efforts differ from the traditional, so-called "pay and chase" model. Under that approach, Medicare claims are paid to providers first without requiring that the provider supply medical records or other documents to support the claim. As a result, recovery for fraudulent claims or claims that should otherwise not have been paid is only sought later — after money has already been disbursed to the provider.

26. By contrast, when Medicare imposes a pre-payment review on a provider — where claims are closely reviewed before they are paid — it can prevent fraudulent claims from being paid before it is too late. Medicare places providers on pre-payment review when they are suspected of improper or fraudulent billing. The pre-payment process is applied to safeguard Medicare from fraud; unnecessary utilization of services furnished by providers; and to ensure

that no Medicare payments are made for items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.

27. Under pre-payment review, either all or a percentage of the provider's claims, depending on the of the conduct at issue that triggered the review, undergo review before a payment can be authorized.

28. In Doctor #1's case, all of his claims were placed on pre-payment review.

29. As part of the pre-payment review process, Medicare requests documentation, often including medical records, to support the claims, which the provider must provide within a specified time period. Medicare then closely scrutinizes this information to determine whether a claim should be approved or denied.

30. Providers remain on pre-payment review until Medicare approves a satisfactory rate of their claims. A provider may face exclusion from participation in Medicare and Medicaid if the provider remains on pre-payment review for a lengthy amount of time and fails to remedy the improper billing practices at issue.

C. The False Claims Act

31. 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.
>
> * * *

(b) For purposes of this section (1) the terms "knowing" and "knowingly" (A) means 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.

FACTUAL ALLEGATIONS

A. Defendants' False and Fraudulent Claims

(1) Patel and Doctor #1's Fraudulent Scheme

32. In or around November 2009, Doctor #1's Medicare contractor placed 100% of the claims Doctor #1 submitted to Medicare, for all codes and all dates of service, on pre-payment review based on information that Doctor #1 had submitted claims that were not appropriate for payment and inconsistent with Medicare policy, including a beneficiary complaint indicating that services Doctor #1 had billed were not even rendered; Doctor #1's unusually high volume of claims for diagnostic tests was not feasible; and Doctor #1's billing patterns were so aberrant from the norm that the legitimacy of his claims was called into question. Doctor #1 remained on pre-payment review through 2012.

33. Under this pre-payment review, the Medicare contractor would closely scrutinize each and every claim Doctor #1 submitted before approving the claims for payment to ensure all payments made by Medicare are appropriate and consistent with established rules and regulations and appropriate medical decision-making.

34. Documentation for all services rendered would be requested to substantiate the Medicare claims and the provider would bear the burden of producing the documentation within 45 days from the date the claim is received. This process significantly delays payment of claims

and increases the likelihood that claims will be denied because the strict review would uncover claims that are not substantiated with proper documentation.

35. To evade the Medicare program's pre-payment review, Patel and Doctor #1 devised a fraudulent scheme in which Patel would submit Doctor #1's claims to Medicare, and in exchange, Patel would keep a significant portion of the Medicare reimbursement.

36. Patel's company, Mobile Diagnostic, was not enrolled in Medicare at the time that Patel concocted this fraudulent scheme with Doctor #1. Patel therefore made arrangements with his brother to submit Doctor #1's claims for services to Medicare through his brother's company, Biosound.

37. From at least August 2011 to December 2012, Patel billed or caused Biosound or Mobile Diagnostic to bill Medicare for professional services purportedly provided by Doctor #1. Specifically, the following tests and procedures were billed to Medicare by Biosound or Mobile Diagnostic:

CPT Code	**Description**
92540	Observation, testing, and recording of abnormal eye movement
92543	Assessment and recording of balance system during irrigation of both ears
92546	Assessment and recording of abnormal eye movement with patient in a rotating chair
92547	Use of vertical electrodes during eye or balance evaluation
92588	Placement of ear probe for computerized cochlear assessment of repeated sounds with interpretation and report
95861	Needle measurement and recording of electrical activity of muscles of arms or legs
95864	Needle measurement and recording of electrical activity of muscles in arms or legs
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

95934	H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle

(2) Submission of Doctor #1's Claims to Medicare Through Biosound

38. From August 10, 2011 through August 11, 2012, Patel caused Biosound to bill Medicare, under its name and tax identification number, for services purportedly rendered by Doctor #1 during the period from December 1, 2010 to October 31, 2011.

39. Biosound did not conduct any of the services involving Doctor #1 which it had billed Medicare for.

40. Relying on the false representations, Medicare issued payments to Biosound.

41. As part and parcel of the scheme, Biosound would turn over almost all of the Medicare reimbursement money to Patel.

42. Patel would, in turn, give a portion of the Medicare reimbursement money received to Doctor #1 and keep a significant portion for himself.

43. Patel knew if Biosound submitted Doctor #1's claims under its name, it would create the false appearance that Biosound had provided the services billed for.

44. Patel also knew that Medicare would rely on Biosound's representations in makings its coverage determinations.

45. Patel knew that Medicare would not have paid for the services had it known that Biosound did not provide the services billed for.

(3) Submission of Doctor #1's Claims to Medicare Through Mobile Diagnostic

46. Mobile Diagnostic was formed October 30, 2009, but it did not apply to be a participant in the Medicare program until July 22, 2011. Although Mobile Diagnostic was formed in October 2009, Mobile Diagnostic requested an effective date of December 10, 2010,

which would allow Mobile Diagnostic to bill Medicare for services provided on or after the effective date.

47. The claims which Patel agreed to submit to Medicare on behalf of Doctor #1 were for services purportedly provided as early as December 2010. December 2010 is also the effective date Patel sought in Mobile Diagnostic's Medicare application.

48. In Mobile Diagnostic's Medicare application, Patel requested that Doctor #1 be added as the interpreting and supervising physician with an effective date of December 10, 2010. Doctor #1 signed the supervising physician certification, included in Mobile Diagnostic Medicare application, on May 18, 2011.

49. Defendants knew that they must follow all applicable Medicare laws, regulations and program instructions in order to get reimbursed by Medicare. Patel certified on the Medicare provider application for Mobile Diagnostic that he dated July 22, 2011 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.

50. After Mobile Diagnostic received a Medicare provider number, Patel knowingly caused Mobile Diagnostic to submit claims to Medicare for services purportedly provided by Doctor #1 as if Mobile Diagnostic had provided the services billed for.

51. From August 27, 2012 to December 17, 2012, Mobile Diagnostic knowingly submitted claims to Medicare under its name and tax identification number for services purportedly rendered by Doctor #1 during the period from December 5, 2011 to September 14, 2012.

52. By submitting the bills under Mobile Diagnostic's name, Defendants falsely represented that they provided the services billed for.

53. Defendants certified that they had personally provided the services billed for.

54. Defendants also certified that the claims they submitted to Medicare contained true and accurate information.

55. Defendants did not conduct any of the services involving Doctor #1which they had billed Medicare for.

56. Relying on the false representations, Medicare issued payments to Mobile Diagnostic.

57. Defendants would then transfer a portion of the money Mobile Diagnostic received from Medicare to Doctor #1 and keep a substantial portion of the money for themselves.

58. Defendants knew that submitting bills to Medicare under Mobile Diagnostic's name would create the false appearance that Mobile Diagnostic had provided the services billed for.

59. Defendants also knew that Medicare would rely on their representations in makings its coverage determinations.

60. Defendants knew that Medicare would not have paid for the services had it known that Mobile Diagnostic did not provide the services billed for.

61. During the period from August 2011 through December 2012, Patel submitted or caused to be submitted false or fraudulent claims to Medicare for nearly 3,000 services purportedly provided by Doctor #1.

62. Over the course of a sixteen-month period from August 2011 to December 2012, Patel submitted or caused Mobile Diagnostic or Biosound to submit false or fraudulent claims to

Medicare seeking more than $2,800,000 in reimbursement money for services they did not provide.

63. Patel knew that Mobile Diagnostic and Biosound did not conduct any of services which he caused Mobile Diagnostic and Biosound to bill Medicare for.

64. Patel knowingly engaged in a fraudulent scheme and knew that the claims it caused Mobile Diagnostic and Biosound to submit were false and should not have been submitted to Medicare.

65. This Civil Action is based, in part, on conduct which Patel has already admitted to in the criminal action entitled, *U.S. v. Patel*, Crim. No. 14-709 (ES), U.S. District Court, District of New Jersey.

66. On December 15, 2014, defendant Patel pled guilty in the criminal action to one-count criminal Information that charged him with health care fraud in violation of 18 U.S.C. § 1347. As part of his guilty plea, Patel admitted that:

- he owned Mobile Diagnostic from November 2009 through at least December 15, 2014;
- he caused his company, Mobile Diagnostic, to submit claims to Medicare for diagnostic testing services performed by someone else, namely a cardiologist;
- he submitted claims to Medicare as if Mobile Diagnostic had performed services instead of Doctor #1;
- he knew Medicare would not have paid for the services had Medicare been aware that somebody else provided the services; and
- he caused the false or fraudulent claims to be submitted to Medicare during the period from November 2009 through at least December 15, 2014.

A. Representative False Claims Submitted to Medicare

67. Paragraphs 68 and 69 set forth below include a representative sample of the thousands of false or fraudulent claims Patel submitted, or caused to be submitted, to Medicare for services purportedly provided by Doctor #1.

68. The following are representative examples, identified through the government's investigation, of patients[1] and dates of service for which Patel knowingly caused Biosound to submit false claims to Medicare for services Biosound did not provide:

a. On October 19, 2011, Biosound submitted or caused to be submitted claims to Medicare, identifying itself as the "provider" and Doctor #1 as the "referring physician", for services purportedly provided on September 14, 2011 to patient R.W. under CPT codes 95903, 95904, 95934, 92540, 92543, 92546, 92547, 92588, and 92546. Biosound billed a total amount of $7,400 for these tests and services. On October 25, 2011, Medicare paid Biosound $442.48, and on November 2, 2011, Medicare paid Biosound $607.77. Medicare paid a total of $1,050.25 for these tests and services.

b. On October 19, 2011, Biosound submitted or caused to be submitted claims to Medicare, identifying itself as the "provider" and Doctor #1 as the "referring physician", for services purportedly provided on September 2, 2011 to patient P.J. under CPT codes 92540, 92543, 92546, 92547, 92588, 92546, 95903, 95904, and 95934. Biosound billed a total amount of $7,400 for these tests and services. On October 24, 2011, Medicare paid Biosound $442.48, and on November 2, 2011, Medicare paid Biosound $607.70. Medicare paid a total of $1,050.25 for these tests and services.

c. On November 16, 2011, Biosound submitted or caused to be submitted claims to Medicare, identifying itself as the "provider" and Doctor #1 as the "referring physician", for services purportedly provided on October 4, 2011 to patient A.G. under CPT codes 92540, 92543, 92546, 92547, 92588, 92546, 95903, 95904, and 95934. Biosound billed a total amount of $8,400 for these tests and services. On November 19, 2011, Medicare paid Biosound $442.48, and on December 1, 2011, Medicare paid Biosound $858.17. Medicare paid a total of $1,300.65 for these tests and services.

d. On November 16, 2011, Biosound submitted or caused to be submitted claims to Medicare, identifying itself as the "provider" and Doctor #1 as the "referring

[1] In order to protect the privacy of the patients referred to herein, the United States will provide a list of the patient names and the partial health insurance claim numbers to counsel for the defendants, subject to a protective order.

physician", for services purportedly provided on October 12, 2011 to patient H.P. under CPT codes 92540, 92543, 92546, 92547, 92588, 92546, 95903, 95904, and 95934. Biosound billed a total amount of $9,200 for these tests and services. On November 19, 2011, Medicare paid Biosound $413.20, and on December 1, 2011, Medicare paid Biosound $659.64. Medicare paid a total of $1,072.84 for these tests and services.

e. On November 16, 2011, Biosound submitted or caused to be submitted claims to Medicare, identifying itself as the "provider" and Doctor #1 as the "referring physician", for services purportedly provided on October 19, 2011 to patient B.H. under CPT codes 95903, 95904, 95934, 92540, 92543, 9546, 92547, 92588, and 92546. Biosound billed a total amount of $7,400 for these tests and services. On December 1, 2011, Medicare paid Biosound $1,012.61 for these tests and services provided on October 19, 2011.

   On that same day, November 16, 2011, Biosound submitted or caused to be submitted additional claims to Medicare for services purportedly provided to the same patient, B.H., on a different date of service, October, 26, 2011, under CPT codes 95903 and 95904. Biosound billed a total amount of $2,500 for these tests and services. On November 18, 2011, Medicare paid Biosound $555.90 for the tests and services provided on October 26, 2011 to patient B.H.

f. On November 23, 2011, Biosound submitted or caused to be submitted claims to Medicare, identifying itself as the "provider" and Doctor #1 as the "referring physician", for services purportedly provided on December 7, 2010 to patient V.B. under CPT codes 95903, 95904, and 95934. On November 23, 2011, Biosound billed a total amount of $4,400 for these tests and services. On November 29, 2011, Medicare paid $430.41 for these tests and services.

   Biosound submitted claims at a later date for other services provided on December 7, 2010 to patient V.B. On November 30, 2011, Biosound billed a total amount of $5,000 to Medicare for additional services provided to patient V.B. on December 7, 2010 under CPT codes 92540, 92543, 92546, 92547, 92588, and 92546. On December 13, 2011, Medicare paid $1,037.85 for these tests and services.

   Biosound billed Medicare a total of $9,400 for tests and services provided to patient V.B. on December 7, 2010. Medicare paid a total of $1,468.26 for these services purportedly provided on December 7, 2010 to patient V.B.

g. On November 23, 2011, Biosound submitted or caused to be submitted claims to Medicare, identifying itself as the "provider" and Doctor #1 as the "referring physician", for services purportedly provided on December 10, 2010 to patient E.J. under CPT codes 92540, 92543, 92546, 92547, 92588 and 92546. Biosound billed a total amount of $4,400 for these tests and services. On November 29, 2011, Medicare paid Biosound $430.41 for these tests and services.

Biosound later submitted more false claims to Medicare on November 30, 2011 for other services provided to patient E.J. on December 10, 2010, under CPT codes 95903, 95904, and 95934. Biosound billed a total amount of $5,000 for these tests and services. On December 13, 2011, Medicare paid Biosound $1,037.85 for these tests and services.

Biosound billed Medicare a total of $9,400 for tests and services purportedly provided to patient E.J. on December 10, 2010 and Medicare paid a total of $1,468.26 for services provided to patient E.J. on December 10, 2010.

h. On November 30, 2011, Biosound submitted or caused to be submitted claims to Medicare, identifying itself as the "provider" and Doctor #1 as the "referring physician", for services purportedly provided on January 14, 2011 to patient A.M. under CPT codes 95904, 95934, 92540, 92543, 92546, 92547, 92588, and 92546. Biosound billed a total amount of $9,400 for these tests and services. On December 3, 2011, Medicare paid Biosound $442.48, and on December 13, 2011, Medicare paid Biosound $1,116.28. Medicare paid a total of $1,558.76 for these tests and services.

i. On November 30, 2011, Biosound submitted or caused to be submitted claims to Medicare, identifying itself as the "provider" and Doctor #1 as the "referring physician", for services purportedly provided on January 10, 2011 to patient L.J. under CPT codes 95903, 95904, and 95934. Biosound billed a total amount of $5,000 for these tests and services. On December 13, 2011, Medicare paid Biosound $1,116.28 for these tests and services.

j. On November 30, 2011, Biosound submitted or caused to be submitted claims to Medicare, identifying itself as the "provider" and Doctor #1 as the "referring physician", for services purportedly provided on January 10, 2011 to patient L.B. under CPT codes 95903, 95904, 95934, 92540, 92543, 92546, 92547, and 92588. Biosound billed a total amount of $9,400 for these tests and services. On December 3, 2011, Medicare paid Biosound $444.48, and on December 13, 2011, Medicare paid Biosound $1,116.28. Medicare paid a total of $1,558.76 for these tests and services.

69. The following are representative examples, identified through the government's investigation, of patients and dates of service for which Patel and Mobile Diagnostic knowingly submitted or caused to be submitted false claims to Medicare for services they did not provide:

a. On August 27, 2012, defendant Mobile Diagnostic submitted or caused to be submitted claims to Medicare, identifying itself as the "provider" and Doctor #1 as the "referring physician", for services purportedly provided on December 9, 2011 to patient M.F. under CPT codes 95903, 95904, 92543, 92546, 92547,

92588, 95934, and 95864. Mobile Diagnostic billed a total amount of $10,850 for these tests and services. On August 30, 2012, Medicare paid Mobile Diagnostic $1,223.58, and on August 31, 2012, Medicare paid Mobile Diagnostic $350.34. Mobile Diagnostic received a total of $1,573.92 from Medicare for these tests and services.

b. On August 27, 2012, defendant Mobile Diagnostic submitted or caused to be submitted claims to Medicare, identifying itself as the "provider" and Doctor #1 as the "referring physician", for services purportedly provided on December 9, 2011 to patient C.T. under CPT codes 95903, 95904, 92543, 92546, 92547, and 92588. Mobile Diagnostic billed a total amount of $10,850 for these tests and services. On August 30, 2012, Medicare paid Mobile Diagnostic $1,223.58, and on August 31, 2012, Medicare paid Mobile Diagnostic $350.34. Mobile Diagnostic received a total of $1,573.92 for these tests and services.

c. On August 29, 2012, defendant Mobile Diagnostic submitted or caused to be submitted claims to Medicare, identifying itself as the "provider" and Doctor #1 as the "referring physician", for services purportedly provided on July 18, 2012 to patient J.F. under CPT codes 95903, 95904, 92543, 92546, 92547, 92588, and 95934. Mobile Diagnostic billed a total amount of $8,350 for these tests and services. On September 1, 2012, Medicare paid Mobile Diagnostic $1,133.02, and on September 4, 2012, Medicare paid Mobile Diagnostic $327.55. Mobile Diagnostic received a total of $1,460.57 for these tests and services.

d. On October 12, 2012, defendant Mobile Diagnostic submitted or caused to be submitted claims to Medicare, identifying itself as the "provider" and Doctor #1 as the "referring physician", for services purportedly provided on September 5, 2012 to patient L.B. under CPT codes 95903, 95904, 92543, 92546, 92547, 92588, and 95934. Mobile Diagnostic billed a total amount of $8,350.00 for these tests and services. On October 17, 2012, Medicare paid Mobile Diagnostic $1,161.23, and on October 18, 2012, Medicare paid Mobile Diagnostic $327.55. Mobile Diagnostic received a total of $1,488.78 for these tests and services.

e. On October 12, 2012, defendant Mobile Diagnostic submitted or caused to be submitted claims to Medicare, identifying itself as the "provider" and Doctor #1 as the "referring physician", for services purportedly provided on August 13, 2012 to patient S.R. under CPT codes 95903, 95904, 92543, 92546, 92547, 92588, and 95934. Mobile Diagnostic billed a total amount of $8,350.00 for these tests and services. On October 17, 2012, Medicare paid Mobile Diagnostic $1,161.23, and on October 18, 2012, Medicare paid Mobile Diagnostic $327.55. Mobile Diagnostic received a total of $1,488.78 for these tests and services.

f. On October 12, 2012, defendant Mobile Diagnostic submitted or caused to be submitted claims to Medicare, identifying itself as the "provider" and Doctor #1 as the "referring physician", for services purportedly provided on September 12, 2012 to patient L.Q. under CPT codes 95903, 95904, and 95934. Mobile

Diagnostic billed a total amount of $4,750 for these tests and services. On October 17, 2012, Medicare paid Mobile Diagnostic $1,161.23 for these tests and services.

g. On October 12, 2012, defendant Mobile Diagnostic submitted or caused to be submitted claims to Medicare, identifying itself as the "provider" and Doctor #1 as the "referring physician", for services purportedly provided on August 14, 2012 to patient T.S. under CPT codes 95903, 95904, 92543, 92546, 92547, 92588, and 95934. Mobile Diagnostic billed a total amount of $8,350.00 for these tests and services. On October 17, 2012, Medicare paid Mobile Diagnostic $1,161.23, and on October 18, 2012, Medicare paid Mobile Diagnostic $327.55. Mobile Diagnostic received a total of $1,488.78 for these tests and services.

h. On October 12, 2012, defendant Mobile Diagnostic submitted or caused to be submitted claims to Medicare, identifying itself as the "provider" and Doctor #1 as the "referring physician", for services purportedly provided on September 14, 2012 to patient T.C. under CPT codes 95903, 95904, 92543, 92546, 92547, 92588, and 95934. Mobile Diagnostic billed a total amount of $8,350.00 for these tests and services. On October 17, 2012, Medicare paid Mobile Diagnostic $1,161.23, and on October 18, 2012, Medicare paid Mobile Diagnostic $327.55. Mobile Diagnostic received a total of $1,488.78 for these tests and services.

i. On October 18, 2012, defendant Mobile Diagnostic submitted or caused to be submitted claims to Medicare, identifying itself as the "provider" and Doctor #1 as the "referring physician", for services purportedly provided on August 30, 2012 to patient F.K. under CPT codes 95903, 95904, and 95934. Mobile Diagnostic billed a total amount of $4,750 for these tests and services. On November 9, 2012, Medicare paid Mobile Diagnostic $1,161.23 for these tests and services.

j. On October 18, 2012, defendant Mobile Diagnostic submitted or caused to be submitted claims to Medicare, identifying itself as the "provider" and Doctor #1 as the "referring physician", for services purportedly provided on September 12, 2012 to patient O.S. under CPT codes 95903, 95904, 92543, 92546, 92547, 92588, and 95934. Mobile Diagnostic billed a total amount of $8,350.00 for these tests and services. On November 9, 2012, Medicare paid Mobile Diagnostic $1,161.23, and on November 10, 2012, Medicare paid Mobile Diagnostic $327.55. Mobile Diagnostic received a total of $1,488.78 for these tests and services.

70. Mobile Diagnostic represented that it personally provided the services in each claim set forth in paragraph 69. Biosound represented that it personally provided the services in each claim set forth in paragraph 68.

71. Patel caused Mobile Diagnostic and Biosound to bill Medicare for every claim listed in paragraphs 68 and 69 above.

72. None of the patients listed in paragraphs 68 and 69 above received services from Mobile Diagnostic or Biosound.

73. The patients listed in paragraphs 68 and 69 were patients of Doctor #1, and were not patients of Mobile Diagnostic or Biosound.

74. For each claim listed in paragraph 68 above, Biosound turned over a substantial portion of the Medicare reimbursement it received to Patel.

75. For every claim listed in paragraphs 68 and 69 above, Patel gave a portion of the Medicare reimbursement received to Doctor #1 and kept a significant portion for himself.

76. 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.

77. Medicare would not have paid for the services if it knew that Mobile Diagnostic and Biosound did not provide the services they billed for.

78. Defendants knowingly submitted claims to Medicare for reimbursement for services they did not provide, 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)(A) (the False Claims Act). All of these claims fall within the False Claims Act's ten-year statute of limitations. See 31 U.S.C. § 373(b)(2).

COUNT I

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

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

80. 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)(A) (the False Claims Act) when they submitted or caused to be submitted claims to Medicare for services they did not provide.

81. As a result of the false and/or fraudulent claims that Defendants presented or caused to be presented to Medicare, 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 II

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

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

83. 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)(1)(B) (the False Claims Act) when they used false records and made false statements in connection with seeking reimbursement from Medicare for services they did not provide.

84. As a result 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

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

86. 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.

87. The United States acted in justifiable reliance upon the truthfulness of these claims.

88. The United States would not have reimbursed Defendants for these claims if it had known the true facts.

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

COUNT IV

Unjust Enrichment

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

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

92. 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 proceeds therefrom, which are to be determined at trial, to the United States.

COUNT V

Disgorgement

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

94. This is a claim for disgorgement of the profits Defendants received by knowingly submitting, or causing to be submitted, false claims.

95. 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.

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

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

COUNT VI

Payment Under Mistake of Fact

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

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

100. 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 understanding of material fact.

101. 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:

A. 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 prejudgment interest and all such further relief as may be just and proper.

B. 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.

C. 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.

D. 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: December 6, 2016
Newark, New Jersey

Respectfully submitted,

PAUL J. FISHMAN
United States Attorney

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