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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA, Plaintiff, v. NIRANJAN KUMAR MITTAL, M.D.; DIVANSHU BANSAL; NIRANJAN K. MITTAL, PHYSICIAN, PLLC d/b/a CARECUBE; and NEW YORK PET IMAGING CENTER LLC, Defendants.	COMPLAINT 23 Civ. 10858 JURY TRIAL DEMANDED

Plaintiff the United States of America (the "United States" or the "Government"), by its attorney Damian Williams, United States Attorney for the Southern District of New York, alleges for its complaint as follows:

PRELIMINARY STATEMENT

1. This is a civil fraud action brought under the False Claims Act, 31 U.S.C. §§ 3729 *et seq.* (the "FCA"), by the United States (the "Government") against cardiologist Dr. Niranjan Kumar Mittal, Dr. Mittal's medical practice and PET imaging center, and Divanshu Bansal (collectively, "Defendants"), who manages many aspects of Dr. Mittal's practice and supervises

his staff. The Government seeks to recover treble damages sustained by, and civil penalties owed to, the Government as a result of the submission of false and fraudulent claims for reimbursement to Medicare and Medicaid during the period from January 2012 through the present. The Government also seeks to recover damages under the common law for payment by mistake of fact and unjust enrichment.

2. Defendants knowingly submitted, or caused to be submitted, claims for payment to Medicare and Medicaid for unreasonable and medically unnecessary peripheral vascular and cardiac tests and procedures. Defendants' primary goal was to perform and bill for as many tests and procedures as possible, regardless of patients' medical needs and conditions. At the direction of Mittal and Bansal, staff prepared fabricated office visit notes falsely stating that patients suffered from symptoms and functional limitations that would justify these repeated tests and procedures. Defendants submitted the false patient medical records to seek prior authorization for coverage and to support Medicare and Medicaid claims for payment for these tests and procedures. In some instances, even with these fraudulent practices, there was still insufficient documentation to establish medical necessity and the services were ineligible for reimbursement. Furthermore, Defendants induced other physicians to refer patients to Mittal by paying them kickbacks in the form of sham office "rent" payments, and then subjected these referred patients to a battery of medically unjustified tests and procedures.

3. Mittal's patients—many of whom were elderly, low-income individuals who did not speak English as their primary language—often waited for hours at Mittal's crowded cardiology office as they were shuttled from one unnecessary test and procedure to another. Mittal exploited these vulnerable patients for his personal financial gain, betraying the trust they placed in him.

4. Specifically, starting in or around late 2014, when he began operating an in-office catheterization lab, Mittal subjected his patients to an excessive number of invasive peripheral vascular procedures, including angioplasties, atherectomies, and stent implantations that were frequently performed over and over again on the same patient. These procedures generally begin with a peripheral angiogram, in which the physician inserts a wire and catheter into the patient's leg (typically through the groin) and injects dye to see how the blood flows. In the event a blockage is identified and further action is deemed medically necessary, the physician can then perform a revascularization procedure to improve blood flow. Mittal ordered and billed for these procedures repeatedly when they were medically unnecessary.

5. These lucrative procedures quickly became the cash cow of the practice. Mittal and Bansal manufactured the medical justification for these invasive procedures by instructing staff to prepare fictional office visit notes indicating that patients complained of severe functional limitations and experienced symptoms such as leg pain while at rest, or "ischemic rest pain," when that was often not true. Most patients derived little or no medical benefit from these procedures, and instead were subjected to a risk of serious harm. In some instances, the initial medically unnecessary peripheral interventions resulted in scar build-up and the re-narrowing of the patient's artery, leading to a cascade of additional procedures. Many of Mittal's Medicare and Medicaid patients underwent more than ten of these invasive procedures during the course of their treatment, including repeated interventions on the same vascular artery over just a few months.

6. Defendants also billed Medicare and Medicaid for a range of medically unnecessary cardiac diagnostic imaging studies, including but not limited to positron emission tomography ("PET") scans, stress tests, echocardiograms, and carotid doppler studies. Mittal

and his staff repeatedly administered and billed for the same or similar cardiac diagnostic tests without any clinical basis and without taking into account the results of the prior, duplicative tests performed on the patient. Defendants urged patients to return to Mittal's cardiology office frequently so that they could undergo additional cardiac diagnostic testing. Mittal ordered cardiac diagnostic studies as often as Medicare and Medicaid would allow, so that tests were driven more by the calendar than a patient's actual medical condition. Again, using boilerplate, generic descriptions of symptoms, Mittal's staff prepared fabricated medical records to make it appear patients exhibited symptoms and complaints that would justify performing the tests that day.

7. Additionally, Defendants engaged in a widespread kickback scheme involving the payment of sham "rent" payments to dozens of physicians in exchange for the referral of patients. Mittal's practice entered into arrangements with medical offices located in Brooklyn, Queens, and the Bronx under which it purportedly "leased" office space—usually one or two exam rooms for certain days or hours each month. Mittal and Bansal sent their staff to these physicians' offices (which Defendants referred to internally as "satellite offices" or "accounts") to perform basic cardiac and peripheral vascular diagnostic tests on the patients referred by the physicians. Mittal and Bansal pressured the staff they deployed to these satellite offices to then send these patients to Mittal's cardiology office for additional testing and treatment, including invasive revascularization procedures. Defendants paid hundreds of thousands of dollars to these referring physicians, which Defendants characterized as "rent" payments because they knew that it was illegal to make payments in exchange for referrals. In reality, the payments to the referring physicians were based on the volume of patients referred to Mittal, not on the fair market value of the office space.

JURISDICTION AND VENUE

8. This Court has jurisdiction over the claims brought under the FCA pursuant to 31 U.S.C. § 3730(a) and 28 U.S.C. §§ 1331 and 1345, and over the common law claims pursuant to 28 U.S.C. § 1345.

9. The Court may exercise personal jurisdiction over Defendants pursuant to 31 U.S.C. § 3732(a), which provides for nationwide service or process.

10. Venue is proper in this District under 31 U.S.C. § 3732(a) and 28 U.S.C. § 1391(b) because Defendants transact business in this District and a substantial part of the acts complained of took place in this District. Defendants submitted or caused to be submitted claims for reimbursement for medical services provided to individuals who resided in this District.

11. No official of the United States charged with responsibility to act in the circumstances knew or should have known of the facts material to the FCA claims related to the fraudulent billing practices alleged herein prior to August 1, 2018. The Government and Mittal, Niranjan K. Mittal, Physician, PLLC, and New York PET Imaging Center LLC (collectively, the "Mittal Defendants") have entered into a tolling agreement, pursuant to which the parties agreed that any statute of limitations applicable to the claims at issue here would be tolled from July 27, 2021, through January 27, 2024.

PARTIES

12. Plaintiff is the United States of America and is suing on its own behalf and on behalf of the United States Department of Health and Human Services ("HHS"), and its component agency, the Centers for Medicare and Medicaid Services ("CMS"), which administers the Medicare and Medicaid programs.

13. Defendant Niranjan Kuman Mittal, M.D. ("Mittal") is a cardiologist who, during the relevant period, owned and operated a medical practice (the "Practice") with numerous locations in New York City. Mittal primarily worked at the office located at 7404 5th Avenue, Brooklyn, NY 11209 (the "Cardiology Office"), which focused on the provision of cardiology and vascular care. Mittal oversaw all aspects of the Cardiology Office's operations, and ordered and/or approved tests, studies, and procedures performed on Medicare and Medicaid patients at that office. Mittal also owns New York PET Imaging Center LLC, which is located in the basement of the Cardiology Office. Mittal resides in Brooklyn, New York.

14. Defendant Divanshu Bansal ("Bansal") owns Vini Consulting LLC, d/b/a Eazy Doc ("Vini"). Starting in 2017, Bansal, personally and through Vini, provided a wide range management services to the Practice, including overseeing patient scheduling, managing the Practice's staff, handling the insurance claim process, obtaining prior authorization from insurers for tests and procedures, marketing the Practice's services, and managing the Practice's accounts payable and receivable. Bansal is not a licensed health care provider. Bansal resides in Brooklyn, New York.

15. Defendant Niranjan K. Mittal, Physician, PLLC d/b/a CareCube is the entity that owns the Practice. In addition to the Cardiology Office, the Practice has other locations that operated during the relevant period and offered primary care and other medical services, including offices located at 1718 Pitkin Avenue, Brooklyn, NY 11212; 7322 Fifth Avenue, Brooklyn, NY 11209; 1369 Nostrand Avenue, Brooklyn, NY, 11226; 1381 Linden Boulevard, Brooklyn, NY 11212; and 256 East 138th Street, Bronx, NY 10451. There were also several CareCube offices throughout New York City that only offered Covid-19 testing.

16. Defendant New York PET Imaging Center LLC (the "PET Imaging Center") is the limited liability corporation that owned the diagnostic testing facility located in the basement of the Cardiology Office. During the relevant period, the PET Imaging Center administered PET scans, including cardiac PET scans and other imaging.

BACKGROUND

I. Relevant Federal Health Care Programs

A. The Medicare Program

17. In 1965, Congress enacted Title XVIII of the Social Security Act, known as the Medicare program, to pay for the costs of certain health care services. Entitlement to Medicare is based on age, disability, or affliction with end-stage renal disease. *See* 42 U.S.C. §§ 426, 426A. HHS is responsible for the administration and supervision of the Medicare program. CMS is an agency of HHS and is directly responsible for the administration of the Medicare program.

18. Medicare has several parts, including Part B, which primarily provides reimbursement for reasonable and necessary outpatient medical services, including physicians' services, supplies incident to physicians' services, and diagnostic tests.

19. To assist in the administration of Part B, CMS contracts with Medicare Administrative Contractors ("MACs") to administer and pay Part B claims from the Medicare Trust Fund. *See* 42 U.S.C. § 1395u. Physicians submit claims for payment to MACs, and, in turn, MACs process medical claims for Medicare beneficiaries. MACs may issue Local Coverage Determinations regarding whether or not a particular item or service is covered. 42 U.S.C. § 1395ff(f)(2).

20. Medicare enters into agreements with physicians to establish the physician's eligibility to participate in the Medicare program. When a provider signs an enrollment application, the provider agrees to comply with Medicare program policies, instructions, and guidelines, including those issued by MACs, along with other federal laws and regulations. Specifically, on the Medicare enrollment form, CMS 855I, the "Certification Statement" that the medical provider signs states: "You MUST SIGN AND DATE the certification statement below in order to be enrolled in the Medicare program. In doing so, you are attesting to meeting and maintaining the Medicare requirements stated below." Those requirements include:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to me . . . . The Medicare laws, regulations and program instructions are available through the Medicare Administrative Contractor. 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, 42 U.S.C. section 1320a-7b(b) (section 1128B(b) of the Social Security Act) . . . . I 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 their truth or falsity.

21. The CMS 855B enrollment form, which must be completed by certain clinics, group practices, and suppliers, including the Practice, similarly requires compliance with Medicare laws, regulations, and instructions.

22. Medicare regulations require providers and suppliers to certify that they meet, and will continue to meet, the requirements of the Medicare statute and regulations. 42 C.F.R. § 424.516(a)(1).

23. During the relevant period, the Mittal Defendants were enrolled and participating Medicare providers and had executed Medicare enrollment agreements.

B. The Medicaid Program

24. Pursuant to the provisions of Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq*., the Medicaid program was established in 1965 as a joint federal and state program created to provide financial assistance to individuals with low income to enable them to receive medical care. Under Medicaid, each state establishes its own eligibility standards, benefit packages, payment rates, and program administration rules in accordance with certain federal statutory and regulatory requirements. The state directly pays the health care providers for services rendered to Medicaid recipients, including physician-based services, with the state obtaining the federal share of the Medicaid payment from accounts which draw on the United States Treasury. *See* 42 C.F.R. §§ 430.0 *et seq*. The federal portion of each state's Medicaid payments, known as the Federal Medical Assistance Percentage ("FMAP"), is based on the state's per capita income compared to the national average. *See* 42 U.S.C. § 1396d(b).

25. The majority of states, including New York, award contracts to private companies to evaluate and process claims for payment on behalf of Medicaid recipients. Typically, after processing the claims, these private companies then generate funding requests to the state Medicaid programs. Before the beginning of each calendar quarter, each state submits to CMS an estimate of its Medicaid federal funding needs for the quarter. CMS reviews and adjusts the quarterly estimate as necessary, and determines the amount of federal funding each state will be permitted to draw down as it incurs expenditures during the quarter. The state then draws down federal funding as actual provider claims, including claims from physicians seeking payment for services, are presented for payment. After the end of each quarter, the state then submits to CMS a final expenditure report, which provides the basis for adjustment to the quarterly federal

funding amount (to reconcile the estimated expenditures to actual expenditures). *See* 42 C.F.R. § 430.30.

26. Providers who participate in the Medicaid program, including physicians, must sign enrollment agreements with the State that certify compliance with state and federal Medicaid requirements. The agreements require, in substance, that the Medicaid providers agree to comply with all state and federal laws and Medicaid rules and regulations in connection with providing services and care to patients and billing the state Medicaid program for services or supplies furnished. In New York, providers may only submit Medicaid claims for services provided in compliance with Title 18 of the Official Compilation of Codes, Rules and Regulations of New York State. 18 NYCRR § 504.6(d).

27. Medicaid providers, including physicians, must also affirmatively certify, as a condition of payment of the claims submitted for reimbursement by Medicaid, compliance with applicable federal and state laws and regulations.

28. During the relevant period, the Mittal Defendants were enrolled and participating Medicaid providers and executed Medicaid enrollment agreements.

C. Medical Necessity Requirement and Claims Process

29. To obtain Medicare or Medicaid reimbursement, health care providers submit a claim form known as the CMS 1500 form or its electronic equivalent known as the 837P format.

30. When submitting claims, providers certify, among other things, that: (a) the services rendered are "medically indicated and necessary" to the health of the patient "and were personally furnished by me or my employee under my personal direction"; (b) the information in the claim is "true, accurate, and complete"; (c) the provider has provided or

will provide sufficient information required to allow the government to make an informed eligibility and payment decision; (d) the provider understands that "payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material fact, may be prosecuted under applicable Federal and State laws"; and (e) the claim complies "with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute . . . ." The CMS 1500 form also requires providers to acknowledge that: "Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties."

31. To submit electronic claims via the 837P format, a provider must complete and submit to CMS an Electronic Data Interchange Enrollment Form ("EDI"). The EDI may be completed by the provider or an authorized individual who has the legal authority "to commit the provider to abide by the laws, regulations, and the program instructions of Medicare." On the EDI, the provider agrees to "submit claims that are accurate, complete, and truthful" and certifies that the use of the provider's NPI on a claim "constitutes the provider's legal electronic signature and an assurance that services were performed as billed." The provider's EDI certification then serves as the signature for every electronic claim submitted by the provider thereafter.

32. Among the information the provider includes on a CMS 1500 or the 837P electronic claim are Current Procedural Terminology Codes ("CPT codes"), CMS Healthcare Common Procedure Coding System ("HCPCS") codes, and/or modifiers to such codes. These codes are the providers' express identification of the services rendered and certification that such services are reimbursable.

33. In New York, Medicaid providers must periodically submit a "Certification Statement for Provider Billing Medicaid," in which the provider certifies that claims submitted "to the State's Medicaid fiscal agent, for services or supplies furnished," "will be subject to the following certification. . . . I (or the entity) have furnished or caused to be furnished the care, services, and supplies itemized and done so in accordance with applicable federal and state laws and regulations." Providers also certify that all statements, data, and information transmitted in connection with a claim for reimbursement are "true, accurate, and complete" and that "no material fact has been omitted."

34. Medicare and Medicaid will only provide reimbursement for medical services that are reasonable and medically necessary. Medicare prohibits payment for services that are not "reasonable and necessary for the diagnosis or treatment of illness or injury . . . ." 42 U.S.C. § 1395y(a)(l)(A); *see also* 42 C.F.R. § 424.5(a)(6). Similarly, Medicaid limits coverage to "medical care, services, and supplies which are medically necessary and appropriate." 18 NYCRR § 500.1(b); *see also* N.Y. Soc. Serv. Law § 365-a(2) (defining Medicaid "standard coverage" to include "the cost of medically necessary medical . . . care, services, and supplies").

35. Private insurers and managed care organizations may offer Medicare coverage to Medicare beneficiaries through Medicare Part C Medicare Advantage Organizations ("MAOs"), and may offer Medicaid benefits as Medicaid Managed Care Organizations ("MCOs"). MAOs enter into contracts with CMS under which Medicare benefits are provided, and MCOs contract with states to provide Medicaid benefits. Pursuant to those contracts, the MAOs or MCOs are paid a capitated rate based on the number of Medicare and Medicaid beneficiaries they service and the level of sickness of those beneficiaries. Medical procedures undergone by the beneficiaries who receive Medicare or Medicaid benefits through an MAO or MCO are

furnished or paid for by the MAO or MCO if covered.[1] The MAO or MCO makes the initial determination, subject to appeal, as to whether the services are covered by Medicare or Medicaid.

36. Medicare and Medicaid also require providers to maintain sufficient medical records to justify the services rendered and each claim billed, including records supporting the medical necessity of the services. The Medicare statute requires providers to document the provision of services. Section 1833(e) of the statute provides: "No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due provider or other person[.]" 42 U.S.C. §13951(e); *see also* 42 C.F.R. § 424.5(a)(6).

37. It is the obligation of every health care provider seeking payment under the Social Security Act (therefore payment from Medicare or Medicaid) to assure that the services "(1) will be provided economically and only when, and to the extent, medically necessary; (2) will be of a quality which meets professionally recognized standards of health care; and (3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing quality improvement organization in the exercise of its duties and responsibilities." 42 U.S.C. §1320c-5(a).

38. A provider may only submit a claim for a diagnostic test to Medicare if it was ordered for the beneficiary to treat a specific problem and it was used by the provider to treat that problem. *See* 42 C.F.R. § 410.32. Similarly, Medicare only covers a test performed by an

[1] Any references in this Complaint to claims for payment submitted to Medicare or Medicaid, or payments made by Medicare or Medicaid, should be interpreted to include claims for payment submitted to MAOs and MCOs, or payments made by MAOs and MCOs.

independent diagnostic testing facility if it is ordered to treat a beneficiary's specific medical problem and the ordering physician uses the test results in the management of the beneficiary's specific medical problem. *See* 42 C.F.R. § 410.33. Medicare will not reimburse the provider for tests that do not meet these requirements. Similarly, Medicaid only covers medically necessary radiology services. 18 NYCRR § 505.17(b).

39. Furthermore, Medicaid providers are required to certify that the care and services for which reimbursement is sought "are medically necessary for the treatment" of the patient. Medicaid requires physicians to complete patient records, which must include, among other things, the "patient's chief complaint or reason" for the visit, the findings obtained from the physical examination of the patient, a description of any diagnostic tests ordered or performed and a notation of the results, and "[a] chart entry giving the medical necessity for any ancillary diagnostic procedures." *See* New York State Medicaid Program Physician Policy Guidelines.

40. Many cardiology and vascular diagnostic studies and tests, including those regularly performed and billed by the Mittal Defendants, are covered by Medicare and Medicaid only if there are documented signs and symptoms or other clinical indications to justify providing the service.

41. The Secretary of HHS (the "Secretary") is responsible for specifying services covered under the "reasonable and necessary" standard and has wide discretion in selecting the means for doing so. See 42 U.S.C. § 1395ff(a). The Secretary may decide whether or not to reimburse for certain types of treatments or tests by promulgating National Coverage Determinations ("NCDs"), which set forth standards for determining whether a given procedure is medically reasonable and necessary. MACs may also issue policies, such as Local Coverage Determinations ("LCDs") and Medical Policy Articles, which specify when a procedure is

deemed reasonable and necessary and covered within their jurisdiction. *See* 42 U.S.C. § 1395ff(c). National Government Services, Inc. ("NGS") is the MAC that covers New York. As a general matter, NCDs and LCDs set forth specific clinical indications that would justify medical procedures, such as particular diagnoses, symptoms, conditions, or prior test results.

42. For example, the LCD applicable to cardiovascular nuclear imaging studies, which were routinely performed and billed for by the Mittal Defendants, states:

- Myocardial perfusion studies performed based on the presence of risk factors in the absence of cardiac symptoms, cardiac abnormalities on physical examination, or abnormalities on cardiac testing (*e.g.*, electrocardiographic tests, echocardiography, etc.) will be considered screening and denied as not covered by Medicare.

- Tests that are anticipated to provide information duplicative of another test already performed will be denied as not medically necessary.

- Tests performed when the results would not be anticipated to influence medical management decisions will be denied as not medically necessary.

- Tests performed unrelated to changes in a patient's signs or symptoms, or for immediate pre-operative evaluation will be denied as medically unnecessary.

(*See* https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=33560&ver=33&) The patient's medical record must contain documentation that "fully supports the medical necessity" of the services, including the "relevant medical history, physical examination, and results of the pertinent diagnostic tests or procedures." *See* https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=56743&ver=18&. In the absence of an LCD, MACs still decide what is reasonable and necessary for payment of claims. Pursuant to CMS Ruling 95.1, MACs look to locally "accepted standards of practice." *See also* CMS Manual System, Pub 100-04, Medicare Claims Processing Manual, Ch. 30, sec. 30.2.3. Providers are

deemed to know that MACs will deny coverage if services do not meet locally acceptable standards of practice. *Id.*

43. In addition, in many instances, providers must obtain prior authorization determinations in order to secure insurance coverage for outpatient tests and procedures, including many of the cardiology and peripheral vascular procedures regularly performed and billed by the Mittal Defendants (*e.g.*, peripheral angiograms, cardiac PET scans, and stress tests). To obtain prior authorization, providers must submit clinical information to the payor, or the payor's agent, establishing that objective medical criteria are met and that the test or procedure is medically necessary and reasonable. Providers are required to provide information about the patient's conditions and symptoms, which can include office visit notes, prior test results, or other documentation. Medicare and Medicaid, including MAOs and MCOs, rely on the accuracy and truthfulness of the clinical information submitted by the provider to determine whether coverage should be approved for the proposed test or procedure.

II. Relevant Statutes

A. The False Claims Act

44. The FCA establishes civil penalties and treble damages liability to the United States for an individual who, or entity that, "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval," or "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim." 31 U.S.C. § 3729(a)(1).

45. "Knowingly" is defined to include actual knowledge, reckless disregard, and deliberate ignorance. 31 U.S.C. § 3729(b)(1). No proof of specific intent to defraud is required. *Id.*

46. The submission of a claim for payment to Medicare or Medicaid for medical tests or procedures that are not reasonable and medically necessary, or otherwise do not comply with coverage standards, constitutes a false claim actionable under Section 3729(a)(1)(A) of the FCA. The creation of medical records that contain false information to make it appear that the test or procedure was reasonable and medically necessary, and otherwise complied with coverage standards, in order to justify a reimbursement request to Medicare or Medicaid constitutes the creation of a false record or statement material to a false claim and is actionable under Section 3729(a)(1)(B) of the FCA.

47. In addition to treble damages, the FCA also provides for assessment of a civil penalty for each violation or false claim.

B. The Anti-Kickback Statute

48. The AKS prohibits any person or entity from knowingly and willfully offering or paying any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, to any person to induce such person to, *inter alia*, "refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program." 42 U.S.C. § 1320a-7b(b)(2).

49. The scienter element of the AKS is established by showing that "one purpose" of the remuneration at issue was to induce purchases or referrals, even if the remuneration also had other purposes that were legitimate. *United States v. Narco Freedom, Inc.*, 95 F. Supp.3d 747, 759 (S.D.N.Y. 2015). The AKS provides: "With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section." 42 U.S.C. § 1320a-7b(h).

50. Pursuant to the AKS, "a claim that includes items or services resulting from a violation of [the AKS] constitutes a false or fraudulent claim for purposes of [the FCA]." 42 U.S.C. § 1320a-7b(g). Accordingly, a person violates the FCA when they knowingly submit or cause to be submitted claims to federal health care programs that result from violations of the AKS.

51. The HHS Office of Inspector General has promulgated "safe harbor" regulations that define practices that are not subject to the AKS because such practices are unlikely to result in fraud or abuse. 42 C.F.R. § 1001.952. The safe harbors set forth specific conditions that, if met, assure persons involved of not being sanctioned for the arrangement qualifying for the safe harbor. However, safe harbor protection is an affirmative defense that is afforded to only those arrangements that meet all requirements of the safe harbor.

52. Under the "space rental" safe harbor, a payment made to lease medical office space is not remuneration for purposes of the AKS only if the rental arrangement satisfies all of the following six requirements:

> (1) The lease agreement is set out in writing and signed by the parties.
>
> (2) The lease covers all of the premises leased between the parties for the term of the lease and specifies the premises covered by the lease.
>
> (3) If the lease is intended to provide the lessee with access to the premises for periodic intervals of time, rather than on a full-time basis for the term of the lease, the lease specifies exactly the schedule of such intervals, their precise length, and the exact rent for such intervals.
>
> (4) The term of the lease is for not less than one year.
>
> (5) The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid, or other Federal health care programs.

> (6) The aggregate space rented does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental.

42 C.F.R. § 1001.952(b). Pursuant to this safe harbor provision, the term "*fair market value* means the value of the rental property for general commercial purposes, but shall not be adjusted to reflect the additional value that one party (either the prospective lessee or lessor) would attribute to the property as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in whole or in part under Medicare, Medicaid and all other Federal health care programs." *Id.*

FACTUAL ALLEGATIONS

I. Defendants' Fraudulent Billing Practices

53. From at least January 2012 through the present, Defendants routinely knowingly submitted, or caused to be submitted, claims to Medicare and Medicaid for unreasonable and medically unnecessary peripheral vascular and cardiac tests and procedures, including invasive peripheral angiograms and revascularization procedures. Defendants fabricated patient medical records to make it appear that the patients' symptoms, medical conditions, and prior test results justified these tests and procedures. As a result of the false claims submitted to Medicare and Medicaid, Defendants received payments to which they were not entitled. In addition, the repeated performance of medically unnecessary procedures harmed vulnerable Medicare and Medicaid patients.

A. Defendants Operated a Patient Mill

54. Defendants' Cardiology Office operated as a patient mill. Defendants' primary goal was to see as many patients as possible and to perform, and bill for, as many tests and

procedures as they could. Defendants churned patients through a cycle of unreasonable and medically unnecessary tests and procedures on a constant basis.

55. The Cardiology Office includes three floors as well as a basement where the PET scans were performed. The Cardiology Office was staffed with a large number of nurse practitioners, physician assistants, medical assistants, technicians, and sonographers who administered the diagnostic imaging and other tests ordered by Mittal. Aside from Mittal, the Cardiology Office only had one other full-time cardiologist during the relevant period, who primarily saw cardiac patients and stopped coming into the office in or around 2020. Starting in or around late 2014, Mittal began operating a catheterization lab on the third floor where peripheral angiography and revascularization procedures were performed by part-time vascular surgeons who were paid based on the number and complexity of the procedures performed.

56. Since 2017, Bansal has worked as a Manager at the Practice and provided a variety of services to the Practice through Vini, his consulting firm. Among other things, Bansal personally supervised and provided direction to Mittal's staff, worked closely with Mittal to make financial decisions related to the Practice, and managed efforts to expand the Practice and establish the satellite offices that are further discussed in Section II below.

57. The Cardiology Office was regularly crowded with patients who often waited for hours as they were shuttled from one test to another. As many as one hundred patients were seen on a given day. The Cardiology Office offered patients sandwiches and juice as they waited for their tests.

58. Defendants aggressively recruited patients from the community by operating a call center and obtaining patient referrals from the satellite offices. Call center staff contacted patients and pressured them to come in for follow-up visits, including patients who had not seen

Mittal for years. Mittal directed staff to try to persuade patients to return to the office to undergo additional medically unnecessary testing. Defendants paid for cabs to bring patients to and from their appointments, and even hired a drivers to transport patients to and from the Cardiology Office.

59. Mittal and his staff ordered that patients undergo numerous tests and procedures regardless of the patient's actual condition, symptoms, or medical needs. Patients would often arrive at the Cardiology Office thinking that they were there to undergo a single test, but would end up staying at the office for several hours and undergoing a multitude of unnecessary tests and procedures.

60. Mittal and Bansal pressured staff, including nurse practitioners and physician assistants, to order and perform any diagnostic tests and studies that they could get covered by insurance, including ultrasounds, computerized tomography ("CT") scans, PET scans, stress tests, echocardiograms, and peripheral angiograms. Bansal reviewed patient records and questioned staff if certain tests had not been performed and billed. In short, the tests performed on patients were determined by what Defendants thought they could get paid for by insurance, not based on patients' actual medical conditions or needs.

61. Patients underwent numerous tests and procedures during a single visit, spending much of their day at the Cardiology Office. Even when the initial diagnostic study did not establish any need for further treatment, patients were nonetheless subjected to further testing and procedures. According to a Medicare patient who saw Mittal for several years and underwent numerous diagnostic and interventional procedures including approximately twelve peripheral angiograms and revascularization procedures, you "don't know until you get there what they're going to check."

62. Mittal spent little or no time with patients as they were shuffled from one test to another. Patients referred to Mittal as "Speedy" based on how little time he spent with them. However, if a patient refused to undergo a particular test or procedure, Mittal would talk directly with the patient to persuade them to agree.

63. In addition, when talking to patients, staff mispresented the results of tests in order to persuade patients that they needed to undergo additional medically unnecessary testing. At the direction of Mittal, staff falsely advised patients that they had certain medical problems, such as poor circulation, that required additional testing.

64. A large proportion of the patients were elderly, low-income individuals who did not speak English as their primary language. These vulnerable patients trusted Mittal to provide competent medical care to address their needs, and Mittal betrayed this trust. Mittal and his staff did not fully and adequately explain to patients the nature, reason, risks, and purpose of the tests and procedures before administering them.

65. At the direction of Mittal, staff scheduled follow-up visits for all patients regardless of their conditions or test results. Defendants directed many patients to return to the Cardiology Office on a monthly basis so that they could undergo further testing and procedures, most if not all of which were medically unnecessary and provided no medical benefit to the patient. Many patients underwent cardiac diagnostic tests, such as stress tests and echocardiograms, on an annual basis even if they were asymptomatic and the prior results had been repeatedly normal.

B. Defendants Falsified Patient Records to Justify Tests and Procedures and Obtain Medicare and Medicaid Payments

66. Defendants falsely recorded in patient medical records that patients had symptoms that would justify tests and procedures when the patients actually did not have these symptoms. The patient's symptoms and complaints were routinely fabricated and not based on the patient's actual condition and what the patient had reported during office visits. And in certain instances, despite Defendants' widespread practice of recording false information in patients' charts, there was still insufficient documentation to establish the medical necessity of the tests and procedures and they were thus ineligible for reimbursement.

67. Mittal and Bansal knew that Medicare and Medicaid would only cover medically indicated and necessary tests, and that the Cardiology Office needed to maintain documentation showing medical necessity. Accordingly, they trained staff on the symptoms and indications that needed to be reflected in a patient's chart to justify the medical necessity of the tests and procedures routinely ordered and performed at the Cardiology Office. Mittal would indicate which tests or procedures were to be performed on a patient, and, at Mittal's and Bansal's direction, staff generated office notes that falsely reflected that the patient had reported symptoms or complaints that would justify the test or procedure.

68. Defendants created templates for various conditions that included checklists listing symptoms and complaints. The templates were designed to track the clinical symptoms that were needed to justify the medical necessity of the tests and procedures to obtain insurance payments. These templates were maintained in the Electronic Health Record system. Once staff selected the relevant template and checked off the symptoms and complaints that a patient purportedly had, the system would generate the content of a lengthy office note that included a

detailed description of what the patient had purportedly said. These notes were inconsistent with what patients had actually reported during their typically very brief interaction with Mittal's staff. As a result, the office visit notes contain the same (or virtually the same) boilerplate, generic language describing patients' purported symptoms and complaints. Prior to the creation of these templates, staff would simply copy and paste stock patient symptom and complaint language from Microsoft Word documents into a patient's chart.

69. In these fabricated records, nearly identical language is used to describe a patient's symptoms and complaints over the course of their treatment. The reported symptoms and complaints disappear without reason and then suddenly reappear in the record when necessary to justify performing the same or a similar test again, without any explanation or evidence that the patient had actually received any treatment for the purported symptoms and complaints.

70. Mittal directed one staff member to try to "mix it up" so the office notes for patient visits did not appear exactly the same. Mittal cautioned another staff member to make sure they checked different boxes on the template for different patients so that insurance companies would not become suspicious.

71. Mittal reviewed the entered office notes and scolded staff when they failed to include all the symptoms necessary to ensure insurance coverage for a particular test or procedure. Mittal threatened to stop paying one staff member because he had not "elaborated enough."

72. Defendants submitted the falsified patient medical records, including office visit notes that mispresented the patient's symptoms and functional limitations, to Medicare and Medicaid (including the MAOs and MCOs) to obtain prior authorization for coverage of tests

and procedures. Defendants also mispresented the patient's symptoms and functional limitations on prior authorization request forms.

73. In addition, CMS contractors and Medicaid MCOs periodically conducted audits of a sample of claims submitted by Defendants to assess whether the billed procedures were medically necessary and appropriately billed. In connection with those audits, the plans requested patient medical records. In some instances, Defendants altered the records before providing them to auditors by adding false references to additional patient complaints and symptoms. Defendants made these changes to make it appear that the billed procedures were justified and to ensure that the payors would not deny payment of the audited claims.

74. During the relevant period, outside auditors, including government contractors and the Healthfirst and MetroPlusHealth Medicaid MCOs, conducted reviews of a sample of claims submitted by Defendants and found that a large percentage were not eligible for payment and sought to recoup the overpayments. Despite being advised of these findings, Defendants continued to engage in their fraudulent billing practices.

C. Defendants Submitted, Or Caused to be Submitted, False Claims for Unreasonable and Medically Unnecessary Procedures

75. Defendants knowingly submitted, or caused to be submitted, claims for a wide range of unreasonable and medically unnecessary peripheral vascular and cardiac tests and procedures. Defendants made and used false records, including office visit notes and operative reports reflecting fabricated patient complaints and symptoms, to support the false claims. Medicare and Medicaid, including MAOs and the MCOs, would not have paid the claims if they had known that they were for tests and procedures that were unreasonable and medically unnecessary and supported by fabricated medical records.

76. The following are descriptions of some of the tests and procedures that were most frequently fraudulently billed to Medicare and Medicaid.

1. Fraudulent Billing of Invasive Peripheral Angiograms and Revascularization Procedures

(i) Peripheral Artery Disease

77. Peripheral angiography and intervention procedures are used to diagnose, evaluate, and treat a vascular condition known as peripheral artery disease ("PAD"). PAD refers to the narrowing or blockage of the vessels that carry blood away from the heart to the brain, vital organs, arms, or legs.

78. PAD is typically caused by atherosclerosis, which refers to the buildup of cholesterol and fatty deposits called "plaques" on the inner walls of the arteries. The plaques restrict the blood flow to the limbs and other parts of the body by clogging arteries or causing abnormal artery function. This narrowing or blockage is referred to as a "lesion" or "stenosis."

79. PAD includes a spectrum of syndromes ranging from intermittent "claudication" to "chronic limb-threatening ischemia" ("CLTI"). Claudication is exertional leg pain caused by obstructed arteries. CLTI usually involves ischemic rest pain (*i.e.*, severe pain in the legs and feet when the patient is at rest), non-healing wounds, ulcers, or gangrene. Most patients with PAD have only intermittent claudication, which improves with rest and is typically unlikely to progress to CLTI.

(ii) Standards of Care for the Treatment of PAD

80. The standards of care for the treatment of PAD are straightforward and commonly known, and depend almost entirely on a patient's symptoms. Intermittent claudication requires intervention only in limited circumstances where it significantly impacts a patient's active

lifestyle and where noninvasive measures—such as lifestyle changes, medication, and supervised exercise therapy—have proven unsuccessful in mitigating the patient's symptoms. Peripheral arteries in the leg may be significantly or completely blocked and still not require intervention because more than one artery supplies blood to the peripheral tissue.

81. Accordingly, "interventions for claudication are done to improve function in the setting of significant ongoing disability in an active person . . . . Performing prophylactic interventions in patients with [intermittent claudication] that is minimally symptomatic or well tolerated has no benefit, may cause harm, and is never indicated." Conte *et al.*, "*Society for Vascular Surgery practice guidelines for atherosclerotic occlusive disease of the lower extremities: Management of asymptomatic disease and claudication*," 61 Journal of Vascular Surgery S2, 15S (2015). Professional guidelines caution that endovascular procedures should not be performed in patients with intermittent claudication solely to prevent progression of the disease. *See*, *e.g.*, 2016 AHA/ACC Guideline on the Management of Patients with Lower Extremity Peripheral Artery Disease.

82. PAD can be diagnosed through medical tests such as an ankle-brachial index ("ABI") (a simple screening test that compares the blood pressure in a patient's upper and lower limbs), ultrasounds like arterial doppler studies, and CT angiography. However, even if PAD is identified through these tests, intervention is not always necessary or appropriate.

83. Patients with asymptomatic PAD typically do not need to undergo extensive testing or an intervention. If a patient's symptoms are not lifestyle limiting, intervention is not indicated. Because some peripheral tissue is supplied with blood from multiple arteries, even a significant blockage in one artery may not require further action if the patient's symptoms are adequately controlled. In general, only after a provider has exhausted non-invasive tests and

treatments—and after symptoms prove to be recurrent and disabling—should invasive procedures be performed on patients with severe PAD.

84. The most common location of arterial stenosis/occlusion for patients with intermittent claudication is the superficial femoral artery ("SFA"), which is located between the hip and the knee. Revascularization procedures, which restore blow flow in blocked arteries, may be appropriate to address severe lesions of the SFA when the stenosis is greater than 70%. Arterial stenosis/occlusion in the lower leg arteries (*i.e.*, below the knee, called tibial arteries) typically does not cause claudication, and interventions on these blood vessels for claudication are contraindicated. Interventions involving the tibial arteries may be justified when patients are experiencing more severe symptoms such as ischemic rest pain, ulcers, or gangrene.

85. If non-invasive tests corroborate the severity of the PAD and the patient is experiencing disabling claudication or CLTI (including rest pain or tissue loss), a physician may perform an angiogram to determine whether revascularization is necessary.

86. A peripheral angiogram of the lower extremities is an invasive diagnostic imaging procedure that uses x-rays and contrast dye to determine whether there are blockages in the arteries that supply blood to one's legs and feet. During an angiogram, the patient lies on an x-ray table and is sedated. An anesthetic is injected into the patient's groin area. A needle is then inserted into the artery, and a wire is passed through the needle into the artery. Over the wire, a catheter is then inserted into the artery. Dye is then injected into the catheter and x-ray images are taken reflecting the blood flow.

87. If a blockage is identified and further action is deemed medically necessary, the physician may perform a revascularization procedure to improve blood flow. Revascularization procedures are typically not medically necessary unless there is substantial arterial blockage.

The determination of whether to perform an intervention is based on the severity of the patient's functional impairment caused by the arterial insufficiency and its effect on the patient's quality of life.

88. When intervention is clinically indicated based on the above criteria, revascularization procedures can include angioplasty (the use of a balloon that is inserted into and expanded within the artery to widen the space for blood to flow through), the placement of a stent (a small metallic mesh tube placed inside a blocked or narrowed artery to keep the vessel open), or atherectomy (the use of a sharp blade, burr, or laser at the end of a catheter to shave off plaques from within an artery). These interventional procedures may be done alone or in combination, depending on the patient's specific needs.

89. Medically unnecessary angiograms and revascularization procedures present a serious risk of patient harm. The most common risk during and after a procedure is the risk of major bleeding. This can be caused by the catheter that is inserted into the artery at the artery puncture site, or during the course of advancing wire and catheters into an affected limb. Additionally, any invasive procedure can lead to "restenosis," the re-narrowing of an artery due to scar build-up at the site of intervention. This can lead to a cycle of repeated interventions. A catheter can also dislodge plaques from the arterial wall that can travel downstream or "embolize" into the circulation and lead to stroke, heart attack, or poor blood flow to a limb, potentially requiring amputation. In addition, the dye injected into the arteries during the catheterization can cause allergic reactions or kidney injury or failure. The radiation used for imaging can also lead to injuries ranging from dermatitis to cancer.

90. Stents can trap or "jail" other arteries depending on their placement, sometimes cutting off important alternative avenues of collateral circulation. If dislodged, stents can cause

damage to other vessels or require major open surgery to retrieve them. Stents can also limit surgical options for revascularization. Excessive stenting can limit the number of viable, un-stented arteries into which a bypass can be connected.

91. Further, data confirms that revascularization procedures carry risks beyond those posed by the complications that typically come with invasive interventions. In patients with intermittent claudication, the risk of limb loss within five years without intervention is 1% to 2%. However, if a claudication patient has an invasive procedure—including atherectomy, angioplasty, and stent placement—their risk of limb loss within five years goes up to 5% to 10%. Vashists Marabous *et al.*, *Revascularization of intermittent claudicants leads to more chronic limb-threatening ischemia and higher amputation rates*, 74 J. Vasc. Surg. 771-779 (2021). Medically unnecessary PAD procedures are thus not only a drain on taxpayer dollars, but also put patients at unnecessary risk of serious and potentially permanent harm.

(iii) High Reimbursements Rates for PAD Interventional Procedures

92. The reimbursement amounts for revascularization procedures are extremely high. During the relevant period, the average Medicare reimbursement amounts for CPT codes associated with these procedures were approximately $10,000 to $15,000. These codes included CPT Codes 37225, 37227, 37229, and 37231.

93. Given the lucrative reimbursement rates for these procedures in outpatient settings, practitioners have recognized the overtreatment of intermittent claudication, particularly in vulnerable minority populations, as a significant source of false claims and potential patient harm. *See*, *e.g.*, Katie Thomas *et al.*, “They Lost Their Legs. Doctors and Health Care Giants Profited,” New York Times, July 15, 2023; Sumathi Reddy, “Doctors Sound an Alarm Over Leg-Stent Surgery,” Wall Street Journal, Sept. 10, 2019.

94. To receive these high reimbursement rates, providers must clinically establish and sufficiently document that each of the interventions is medically necessary under the applicable standards of care. Medicare and Medicaid providers are not entitled to bill or receive payment for any PAD procedure, including angioplasty, stent implantation, and atherectomy, that is not reasonable and medically necessary. *See* 42 U.S.C. § 1395y(a)(1)(A); *see also* 42 U.S.C. § 1320c-5(a)(l). Like any procedure, Medicare and Medicaid, including MAOs and MCOs, pay for revascularization procedures only when the provider's medical documentation establishes medical necessity.

(iv) Defendants' Submission of False Claims for Peripheral Angiograms and Revascularization Procedures

95. Defendants engaged in a pattern and practice of subjecting Medicare and Medicaid patients to unnecessary, medically unjustified, invasive, and potentially harmful peripheral vascular intervention procedures in order to receive lucrative payments from the Government. Mittal and Bansal directed their staff to prepare fabricated office visit notes reflecting functional limitations and symptoms that would justify these invasive procedures when patients had not actually reported these limitations and symptoms. Defendants used these falsified medical records to obtain authorization for insurance coverage, and to support the claims for payment submitted to Medicare and Medicaid.

96. Starting in or around late 2014, Mittal began operating a catheterization lab on the third floor of the Cardiology Office where peripheral angiography and revascularization procedures were performed. Instead of referring patients to hospitals to have these interventional procedures, Defendants were now able to perform (and bill for) these procedures at the Cardiology Office.

97. The peripheral angiograms and revascularization procedures quickly became the cash cow of the Practice, making up the bulk of the Medicare and Medicaid payments received. Mittal's primary focus became maximizing the number of high-reimbursement interventional procedures performed on his patients.

98. Mittal contracted with vascular surgeons to perform peripheral angiograms in his office (the "Operators"). The Operators were generally hired solely to perform these procedures, and did not otherwise evaluate or treat patients. The first time the Operator saw the patient was in the catheterization lab on the day of the procedure. Mittal often hired inexperienced physicians as Operators, and there was a high level of turnover.

99. Mittal paid the Operators per procedure performed, with higher pay for more complex procedures. He paid them approximately $400 per diagnostic angiogram, and approximately $1500 to $2000 per revascularization procedure. The Operators regularly performed ten to fifteen procedures a day in the catheterization lab, with patients being seen six days a week during much of the relevant period. In a large percentage of the cases where diagnostic peripheral angiograms were performed at the Cardiology Office, the Operator also performed a revascularization procedure.

100. Mittal's patients underwent peripheral angiograms and revascularization procedures when the procedures were not medically necessary or clinically indicated. A large percentage of these medically unnecessary invasive procedures were performed on the patient's tibial arteries even though the patient did not suffer from tissue loss (*e.g.*, ulcers, gangrene) or rest pain, which are the typical indications for these procedures.

101. In numerous instances, patients underwent more than ten peripheral angiograms and revascularization procedures during their course of treatment at the Cardiology Office.

Further, patients frequently underwent repeated interventions on the same vascular artery over the course of just a few months. The patients derived no medical benefit from these repeated invasive procedures, and instead were subjected to a risk of serious harm. In addition, according to patient medical files, patients often continued to suffer from the same alleged symptoms with little demonstrated improvement despite the repeated interventions.

102. In addition, to the extent that the initial intervention ordered by Mittal may have been arguably justified by the patient's condition, there was no medical basis to offer and repeatedly perform additional revascularization procedures when there was no indication that the patient's symptoms or condition had improved as a result of prior interventions.

103. The Operators routinely performed atherectomies when performing peripheral vascular interventions, as opposed to just performing a balloon angioplasty or an angioplasty with stent placement. As discussed above, atherectomies involve the use of a special tool to remove calcium deposits in the arteries. The CPT codes associated with atherectomies result in significantly higher reimbursement rates.

104. In order to make it appear that the peripheral angiograms and revascularization procedures were medically necessary, Mittal and Bansal directed staff to falsely report in office visit notes that the patients experienced the type of functional limitations and symptoms that would justify these invasive procedures. The notes for the office visit that preceded the scheduling of the angiography were internally referred to as "angio notes." Using the applicable template, staff used boiler-plate, general language to describe the patient's symptoms in such a way that it would appear that the angiograms and revascularization procedures were medically necessary. One Operator complained to Mittal that the description of patients' conditions were "exactly all the same" and needed to be more specific.

105. For example, in order to make it appear that the procedures were medically indicated and necessary, staff were directed to record that patients reported experiencing leg pain while at rest or "ischemic rest pain," when that was often false. Specifically, Mittal and Bansal directed staff to falsely report that patients had a condition referred to as "Fontaine III," which is a severe form of arterial circulation failure due to arterial blockages that is characterized by rest pain in the legs and which can lead to gangrene or limb loss if left untreated. Mittal advised his staff that Fontaine III and the symptom of leg pain at rest were needed to secure coverage. Thus, staff regularly recorded that patients suffered from Fontaine III even though they had not indicated that they suffered from leg pain while at rest. In addition, Mittal directed staff to falsely report that patients had other lower extremity symptoms that would justify the interventions, such as cramping, edema, and a diminished pulse in the pedal arteries (which are located in the foot).

106. On some occasions, the notes in the patient's clinical record indicate that the patient purportedly reported experiencing pain in one leg but the revascularization procedure was performed on the other leg. This further inconsistency demonstrates the falsity of the records used to justify the procedures.

107. Bansal told the staff responsible for inputting the office visit notes what needed to be included to obtain coverage for peripheral angiograms and revascularization procedures. He reviewed the notes to make sure that the necessary symptoms and functional limitations were included. In certain instances, Bansal told staff to "add more story" to ensure that they obtained prior authorization for the coverage.

108. Prior to undergoing peripheral angiograms, patients would undergo various non-invasive diagnostic screening tests that are supposed to be used to detect possible PAD. For

example, Mittal's staff administered ABI tests which, as discussed above, compare the blood pressure in a patient's upper and lower limbs. However, due to the equipment used by Mittal's staff and/or how these tests were administered or reported, the tests often generated unreliable and inconsistent results. Moreover, even when the initial ABI results were reported as normal, Mittal would often order that the test be repeated. In addition, the results of the tests were sometimes inaccurately recorded in the patient's chart as being abnormal when they actually were not. The purportedly abnormal ABI test reports were used to justify further diagnostic testing and ultimately the need for a peripheral angiogram and intervention.

109. After the ABI test, patients often underwent arterial doppler studies and CT angiograms (a non-invasive imaging test that involves the injection of dye through an intravenous line). Mittal exerted pressure on staff to conclude that this imaging revealed abnormalities when they did not, in order to manufacture a medical justification for ordering a peripheral angiogram. One sonographer who performed arterial doppler tests reported that when the studies were normal Mittal and other managers would try to get staff to fabricate numbers in the reports and falsely state that the studies revealed moderate or severe stenosis. Another employee reported that Mittal also altered the contrast of the CT angiograms to make it appear that the extent of the artery blockage was greater than it actually was.

110. The Operators relied on the falsely reported patient symptoms and conditions and the inaccurate diagnostic test results when performing the angiograms, including when making the decision as to whether to perform a revascularization procedure. The Operators did not typically review the underlying images generated by the diagnostic arterial doppler studies and CT angiograms but instead relied on the written reports and findings that had been prepared by

Mittal and his staff. Boilerplate operative reports were prepared after each revascularization procedure, which typically included inaccurate information about the patient's symptoms.

111. In many instances, there was insufficient stenosis or occlusion based on the peripheral angiogram to justify the revascularization procedure. In these cases, the operative reports falsely recorded the extent of the blockage in order to make it appear that revascularization was necessary.

112. Defendants submitted, or caused to be submitted, records reflecting fabricated patient symptoms and functional limitations—including office visit notes, the operative report for the patient's last vascular procedure, and forms that payors required to be completed—to obtain prior authorization for coverage of peripheral angiograms and revascularization procedures performed on Medicare and Medicaid beneficiaries. For example, when seeking prior authorization from the Medicaid MCO Healthfirst, Mittal's staff submitted falsified office visit notes and a recent peripheral vascular operative report (as well as any diagnostic testing reports) as "supporting clinical documentation" to establish medical need. Defendants also used these false records to establish medical necessity to support coverage for claims submitted for payment.

113. In addition, the claims seeking reimbursement for peripheral angiograms and revascularization procedures performed on Medicare and Medicaid beneficiaries often falsely identified Mittal as the provider instead of the Operator who actually performed the procedure. The operative reports also inaccurately listed Mittal as having performed the procedure, and falsely stated that Mittal "was present for key and crucial portions of the procedure." In reality, Mittal was rarely present for these procedures. Indeed, Defendants improperly billed Medicare

and Medicaid for procedures under Mittal's name and NPI number even when he was out of the country.

114. When ordering peripheral angiograms, Mittal did not fully explain the nature of the procedure or the potential risks to the patient. He typically told patients that they had a circulation problem in their leg and required a small test involving taking pictures of their leg.

115. When a patient refused to consent to undergo a peripheral angiogram, Mittal tried to persuade the patient to agree by telling them that they needed to address the problem before it was too late and that the patient risked losing their leg. Mittal instructed nurse practitioners and other staff to contact him if a patient declined to have an angiogram so that he could talk to them directly. Mittal also offered to have his drivers transport patients to and from the Cardiology Office in order to persuade them to agree to schedule a procedure.

116. Starting in or around late 2018, at the direction of Bansal, staff included the notation "DADM" on certain patient charts, which stood for "Discuss Angio with Dr. Mittal." Mittal made sure he saw these patients himself when they came to the Cardiology Office so he could personally persuade them to undergo angiograms.

117. In addition, Mittal and Bansal directed staff to review patient charts to identify potential peripheral angiogram candidates. Bansal told staff to run reports to identify patients who had prior abnormal arterial doppler reports and to reach out to these patients to try to schedule angiograms.

118. Mittal sought to maximize the number of peripheral angiograms performed in the catheterization lab every day. For example, when a scheduled angiogram did not go forward for some reason (*e.g.*, the patient cancelled the appointment), Mittal directed his staff to identify other patients coming to the Cardiology Office that day who were candidates for angiograms and

could fill the empty slot. These patients were told that they needed to undergo angiograms that day even though they had not been previously scheduled for the procedure.

119. Cardiology Office staff repeatedly expressed concerns with the volume of peripheral interventional procedures being performed. For instance, the other cardiologist at the Practice told Mittal that he was ordering too many of these procedures unnecessarily.

120. When staff questioned whether a patient actually needed to undergo an angiogram, Mittal and Bansal dismissed their concerns and ordered them to proceed with scheduling the procedure.

121. The frequency with which patients underwent peripheral angiograms and revascularization procedures was so high that Mittal's staff joked that he was going to have angiograms performed on staff as well.

122. In many instances, Mittal's patients experienced complications as a result of the repeated medically unnecessary peripheral angiograms and revascularization procedures. The initial procedure sometimes resulted in scar build-up and restenosis of the patient's artery, leading to additional revascularization procedures. Patients also sometimes experienced difficulty walking, pain, and bleeding following the procedures.

123. One of Mittal's patients, who underwent at least seven medically unnecessary peripheral interventions on the tibial arteries of both of her legs, died due to complications following a procedure performed in April 2022.

124. Mittal also regularly directed patients to undergo medically unnecessary groin ultrasound tests when patients returned to the Cardiology Office for follow-up after a revascularization procedure. In order to justify and bill these procedures, staff were instructed to falsely record that patients were suffering from mild pain and swelling in their groin area (the

access site for the angiogram). There was no clinical indication for performing these ultrasounds on patients following each peripheral vascular intervention, which were themselves frequently medically unnecessary.

125. During the relevant period, Defendants submitted, or caused to be submitted, over two thousand claims for Medicare and Medicaid patients using the lucrative CPT codes 37225, 37227, 37229, and 37231 (codes associated with revascularization procedures), and received millions of dollars in payments. A significant number of these claims were for procedures that were not medically indicated or necessary and constitute false claims for payment**.**

2. Fraudulent Billing of Cardiac Diagnostic Tests

126. Defendants also engaged in a pattern and practice of billing Medicare and Medicaid for medically unnecessary cardiac diagnostic imaging studies. The Mittal Defendants repeatedly performed the same or similar cardiac tests on the same patients without any clinical basis to do so and without taking into account the results of the prior, duplicative tests. There was often scant evidence in the medical record that the results of these cardiac tests actually affected the type of treatment or care provided.

127. Mittal and Bansal directed staff to falsely document information in the patient's chart to make it appear that the cardiac tests were medically indicated. Defendants falsely reported patient cardiac symptoms, patient complaints, and physical findings. Patient records were replete with virtually the same boilerplate, generic descriptions of symptoms, which reappeared each time the patient underwent the same cardiac test again.

128. Notably, a patient's previously-reported cardiac symptoms (*e.g.*, chest pain, shortness of breath) often disappeared and were replaced by symptoms related to leg pain during the period when the patient underwent peripheral angiograms and revascularization procedures.

The cardiac symptoms then reappeared again in the office visit notes —described with the same stock phrases and language—when Mittal ordered the cardiac diagnostic tests to be repeated.

129. Mittal ordered a wide range of medically unnecessary cardiac diagnostic imaging studies, including but not limited to echocardiograms, nuclear stress tests, PET stress tests, FDG PET myocardial viability tests, and carotid doppler studies.

Echocardiograms

130. Defendants repeatedly administered and billed for medically unnecessary echocardiograms for Medicare and Medicaid patients.

131. An echocardiogram is an ultrasound test that generates images of the heart's valves and chambers. An echocardiogram is used to assess the structure and function of the heart, and can aid in diagnosing a range of heart diseases and conditions. Mittal ordered patients to undergo echocardiograms based on the calendar (*i.e.*, the time that passed since the last echocardiogram) and what Medicare and Medicaid would cover instead of a patient's actual symptoms and condition. He typically directed patients to undergo echocardiograms on an annual basis, regardless of medical need, because he understood that tests conducted once a year would usually be covered.

132. In order to justify the excessive number of echocardiograms, Mittal and Bansal directed staff to record that the patient complained of shortness of breath on the day the echocardiogram was administered, which was frequently untrue.

Nuclear Stress Tests and Myocardial Perfusion PET Stress Tests

133. Defendants repeatedly administered and billed for medically unnecessary nuclear stress tests and myocardial perfusion PET stress tests for Medicare and Medicaid patients.

134. Nuclear stress tests are used to determine how well blood flows to the patient's heart and to detect obstructive coronary artery disease. The medical provider intravenously injects radioisotopes that serve as tracers, and then compares images of the patient's heart at rest to images of the heart when blood flow is increased. In lieu of conducting an exercise stress test where patients exercise on a treadmill to increase blood flow, Mittal's staff infused a chemical agent (often Persantine) into the patient to simulate exercise by causing coronary vasodilatation (the opening of the coronary arteries that supply the heart muscle with blood). Areas of poor myocardial perfusion reflecting a narrowed coronary artery can be identified by appearing to take up less radioisotope. Mittal referred to this test as a "P Myo" when ordering it.

135. Mittal also frequently ordered myocardial perfusion PET stress tests which, like nuclear stress tests, also evaluate a patient's blood flow to the heart using a radioactive tracer and are used to detect obstructive coronary artery diseases. These tests also involved the intravenous injection of radioactive tracers. A PET scanner is used to generate images showing the distribution of the tracer in the heart at rest and with stress. Defendants typically used the isotopes Rubidium-82 and N-13 ammonia when conducting these PET imaging studies.

136. In order to justify the repeated stress tests, Mittal and Bansal directed staff to falsely indicate in the medical records that patients had reported experiencing symptoms such as chest pain (often described as radiating "to the jaw" or "as tightness and diffuse") or shortness of breath (often described to be "better with rest" and often reported with "skipping beats of the heart"). This was frequently untrue. In reality, Defendants typically automatically administered

and billed for these tests at least every year, regardless of whether the patient had symptoms that necessitated the testing and regardless of whether prior test results had been normal. The reported symptoms of chest pain and shortness of breath often suddenly reappeared in the patient's record at the time of the test, and then did not appear again until it was time for the next nuclear or PET stress test.

137. In addition, Defendants frequently falsely reported in the patient's medical record that the results of the nuclear stress test were "equivocal," in order to justify performing a follow-up cardiac PET scan which was billed separately.

FDG PET Myocardial Viability Studies

138. Defendants repeatedly administered and billed for medically unnecessary FDH PET myocardial viability studies.

139. After conducting nuclear and PET stress tests, Mittal frequently ordered an FDG PET myocardial viability study, which is designed to determine whether cardiac tissue is dead or whether it is still alive and can be reopened by a coronary intervention procedure. Importantly, this test is typically indicated only when cardiac function is depressed, such as following an extensive heart attack.

140. The FDG PET myocardial viability tests performed on Medicare and Medicaid patients were frequently not medically necessary. The patients who underwent these tests typically did not suffer from conditions that would justify them, such as a heart failure or depressed cardiac function. Nevertheless, as a matter of course, Mittal ordered patients to undergo FDG PET myocardial viability tests based on a possible "defect" that was purportedly found during the stress test.

141. Tellingly, the results of the myocardial viability tests were typically normal and did not reveal any dead cardiac tissue, and the patient was not referred for a follow-up cardiac intervention procedure. This cycle would often repeat itself. Mittal ordered and billed for a nuclear stress test, the report of the study stated that a "defect" was allegedly detected, that result was then used as a basis to order and bill for an FDG PET myocardial viability test which was normal, and then Mittal ordered and billed for another stress test the following year restarting the testing cycle.

Carotid Artery Doppler Studies

142. Defendants repeatedly administered and billed for medically unnecessary carotid artery doppler imaging studies for Medicare and Medicaid patients.

143. There are two carotid arteries, one on each side of the neck, that deliver blood from a person's heart to their brain. A carotid doppler is an ultrasound procedure that examines this blood flow and is used to detect and estimate the severity of any narrowing of the right and left internal carotid arteries. Severe stenosis (*i.e.,* narrowing) of the carotid arteries can create a risk of stroke. Providers typically order a carotid doppler test when they hear a carotid bruit upon examination of the patient, which is an audible sound heard through a stethoscope placed over the arteries as the patient is asked to hold their breath. Patients suffering from carotid artery disease are often asymptomatic, but may experience neurological symptoms such as dizziness due to the shortage of blood flowing to the brain.

144. In order to justify performing and billing for carotid doppler tests, Mittal and Bansal directed staff to indicate in the medical record that the patient had reported dizziness and that a carotid bruit had been detected. This was often false. Tellingly, after the carotid doppler test was performed and found to be normal, the notes for the patient's subsequent office visits

typically omitted any reference to the alleged dizziness or the purported carotid bruit (and in fact often stated that no carotid bruit was present), even though the patient received no treatment for the dizziness or bruit. Instead, new symptoms appeared, which were used to justify further testing and procedures. Later, when Mittal ordered another carotid doppler test, the symptom and sign justifying the test—dizziness and the carotid bruit—suddenly reappeared together in the record.

145. Mittal also frequently ordered patients to undergo medically unnecessary CT angiograms based on the purported results of the carotid doppler tests, even when the findings did not support the need for further testing. This is yet another example of how Mittal used one medically unnecessary test to justify performing further unnecessary tests.

3. Patient Examples

146. Patient A[2] was a Medicare patient of the Practice. Defendants knowingly submitted, or caused to be submitted, false claims for payment for numerous invasive and non-invasive peripheral vascular and cardiac tests and procedures performed on Patient A that were not reasonable or medically necessary. Specifically, for example, Patient A underwent at least sixteen peripheral angiograms with fifteen invasive revascularization procedures, twenty groin ultrasounds, eleven echocardiograms, three FDG PET myocardial viability studies, eleven stress tests (six nuclear and five PET), and seven carotid artery doppler studies. Many, if not all, of these tests and procedures were not reasonable or medically necessary and were fraudulently billed to Medicare. In a number of instances, at the direction of Mittal and/or Bansal, staff fabricated symptoms and other information in Patient A's medical record to make it appear that

[2] In order to protect the confidentiality of patients' personal health information, this Complaint omits the names of specific patients.

such tests and procedures were medically necessary in order to secure Medicare reimbursements. The symptoms were described using substantially the same language repeatedly throughout Patient A's medical record. In other instances, there was insufficient documentation in Patient A's medical record to justify the medical necessity of the billed test or procedure. As a result of the foregoing fraudulent practices, Medicare reimbursed the Mittal Defendants for numerous medically unnecessary peripheral vascular and cardiac tests and procedures performed on Patient A.

147. Patient B was a Medicaid patient of the Practice. Defendants knowingly submitted, or caused to be submitted, false claims for payment for numerous invasive and non-invasive peripheral vascular and cardiac tests and procedures performed on Patient B that were not reasonable or medically necessary. Specifically, for example, Patient B underwent at least fifteen peripheral angiograms with fifteen invasive revascularization procedures, ten groin ultrasounds, five echocardiograms, six nuclear stress tests, and three carotid artery doppler studies. Many, if not all, of these tests and procedures were not reasonable or medically necessary and were fraudulently billed to Medicaid. In a number of instances, at the direction of Mittal and/or Bansal, staff fabricated symptoms and other information in Patient B's medical record to make it appear that such tests and procedures were medically necessary in order to secure Medicaid reimbursements. The symptoms were described using substantially the same language repeatedly throughout Patient B's medical record. In other instances, there was insufficient documentation in Patient B's medical record to justify the medical necessity of the billed test or procedure. As a result of the foregoing fraudulent practices, Medicaid reimbursed the Mittal Defendants for numerous medically unnecessary peripheral vascular and cardiac tests and procedures performed on Patient B.

148. Patient C was a Medicare patient of the Practice. Defendants knowingly submitted, or caused to be submitted, false claims for payment for numerous invasive and non-invasive peripheral vascular and cardiac tests and procedures performed on Patient C that were not reasonable or medically necessary. Specifically, for example, Patient C underwent at least thirteen peripheral angiograms with eleven invasive revascularization procedures, eleven groin ultrasounds, fifteen echocardiograms, one FDG PET myocardial viability study, twenty-eight stress tests (nine nuclear and nineteen PET), and four carotid artery doppler studies. Many, if not all, of these tests and procedures were not reasonable or medically necessary and were fraudulently billed to Medicare. In a number of instances, at the direction of Mittal and/or Bansal, staff fabricated symptoms and other information in Patient C's medical record to make it appear that such tests and procedures were medically necessary in order to secure Medicare reimbursements. The symptoms were described using substantially the same language repeatedly throughout Patient C's medical record. In other instances, there was insufficient documentation in Patient C's medical record to justify the medical necessity of the billed test or procedure. As a result of the foregoing fraudulent practices, Medicare reimbursed the Mittal Defendants for numerous medically unnecessary peripheral vascular and cardiac tests and procedures performed on Patient C.

149. Patient D was a Medicare and Medicaid patient of the Practice. Defendants knowingly submitted, or caused to be submitted, false claims for payment for numerous invasive and non-invasive peripheral vascular and cardiac tests and procedures performed on Patient D that were not reasonable or medically necessary. Specifically, for example, Patient D underwent at least ten peripheral angiograms with nine invasive revascularization procedures, seventeen groin ultrasounds, fourteen echocardiograms, one FDG PET myocardial viability study, ten

stress tests (nine nuclear and one PET), and six carotid artery doppler studies. Many, if not all, of these tests and procedures were not reasonable or medically necessary and were fraudulently billed to Medicare and Medicaid. In a number of instances, at the direction of Mittal and/or Bansal, staff fabricated symptoms and other information in Patient D's medical record to make it appear that such tests and procedures were medically necessary in order to secure Medicare and Medicare reimbursements. The symptoms were described using substantially the same language repeatedly throughout Patient D's medical record. In other instances, there was insufficient documentation in Patient D's medical record to justify the medical necessity of the billed test or procedure. As a result of the foregoing fraudulent practices, Medicare and Medicaid reimbursed the Mittal Defendants for numerous medically unnecessary peripheral vascular and cardiac tests and procedures performed on Patient D.

150. Patient E was a Medicaid patient of the Practice. Defendants knowingly submitted, or caused to be submitted, false claims for payment for numerous invasive and non-invasive peripheral vascular and cardiac tests and procedures performed on Patient E that were not reasonable or medically necessary. Specifically, for example, Patient E underwent at least twelve peripheral angiograms with twelve invasive revascularization procedures, four groin ultrasounds, seven echocardiograms, one FDG PET myocardial viability study, seven nuclear stress tests, and two carotid artery doppler studies. Many, if not all, of these tests and procedures were not reasonable or medically necessary and were fraudulently billed to Medicaid. In a number of instances, at the direction of Mittal and/or Bansal, staff fabricated symptoms and other information in Patient E's medical record to make it appear that such tests and procedures were medically necessary in order to secure Medicaid reimbursements. The symptoms were described using substantially the same language repeatedly throughout Patient E's medical record. In other

instances, there was insufficient documentation in Patient E's medical record to justify the medical necessity of the billed test or procedure. As a result of the foregoing fraudulent practices, Medicaid reimbursed the Mittal Defendants for numerous medically unnecessary peripheral vascular and cardiac tests and procedures performed on Patient E.

151. Patient F was a Medicare patient of the Practice. Defendants knowingly submitted, or caused to be submitted, false claims for payment for numerous invasive and non-invasive peripheral vascular and cardiac tests and procedures performed on Patient F that were not reasonable or medically necessary. Specifically, for example, Patient F underwent at least eleven peripheral angiograms with eleven invasive revascularization procedures (including seven procedures within less than six months), seven groin ultrasounds, two FDG PET myocardial viability studies, and nine stress tests (six nuclear and three PET). Many, if not all, of these tests and procedures were not reasonable or medically necessary and were fraudulently billed to Medicare. In a number of instances, at the direction of Mittal and/or Bansal, staff fabricated symptoms and other information in Patient F's medical record to make it appear that such tests and procedures were medically necessary in order to secure Medicare reimbursements. The symptoms were described using substantially the same language repeatedly throughout Patient F's medical record. In other instances, there was insufficient documentation in Patient F's medical record to justify the medical necessity of the billed test or procedure. As a result of the foregoing fraudulent practices, Medicare reimbursed the Mittal Defendants for numerous medically unnecessary peripheral vascular and cardiac tests and procedures performed on Patient F.

152. Patient G was a Medicare patient of the Practice. Defendants knowingly submitted, or caused to be submitted, false claims for payment for numerous invasive and non-

invasive peripheral vascular and cardiac tests and procedures performed on Patient G that were not reasonable or medically necessary. Specifically, for example, Patient G underwent at least twelve peripheral angiograms with eleven invasive revascularization procedures, ten groin ultrasounds, six echocardiograms, eight stress tests (three nuclear and five PET), and three carotid artery doppler studies. Many, if not all, of these tests and procedures were not reasonable or medically necessary and were fraudulently billed to Medicare. In a number of instances, at the direction of Mittal and/or Bansal, staff fabricated symptoms and other information in Patient H's medical record to make it appear that such tests and procedures were medically necessary in order to secure Medicare reimbursements. The symptoms were described using substantially the same language repeatedly throughout Patient G's medical record. In other instances, there was insufficient documentation in Patient G's medical record to justify the medical necessity of the billed test or procedure. As a result of the foregoing fraudulent practices, Medicare reimbursed the Mittal Defendants for numerous medically unnecessary peripheral vascular and cardiac tests and procedures performed on Patient G.

153. Patient H was a Medicare and Medicaid patient of the Practice. Defendants knowingly submitted, or caused to be submitted, false claims for payment for numerous invasive and non-invasive peripheral vascular tests and procedures performed on Patient H that were not reasonable or medically necessary. Specifically, for example, Patient H underwent at least twelve peripheral angiograms with eleven invasive revascularization procedures (including eight procedures within less than thirteen months) and seventeen groin ultrasounds. Many, if not all, of these procedures were not reasonable or medically necessary and were fraudulently billed to Medicare and Medicaid. In a number of instances, at the direction of Mittal and/or Bansal, staff fabricated symptoms and other information in Patient H's medical record to make it appear that

such tests and procedures were medically necessary in order to secure Medicare and Medicaid reimbursements. The symptoms were described using substantially the same language repeatedly throughout Patient H's medical record. In other instances, there was insufficient documentation in Patient H's medical record to justify the medical necessity of the billed test or procedure. As a result of the foregoing fraudulent practices, Medicare and Medicaid reimbursed the Mittal Defendants for numerous medically unnecessary peripheral vascular tests and procedures performed on Patient H.

II. Defendants Generated Patient Referrals Through Illegal Kickbacks

154. Defendants paid illegal kickbacks to physicians in order to generate patient referrals to the Cardiology Office. These kickbacks took the form of sham "rent" payments made to dozens of primary care physicians, podiatrists, and other doctors located in Brooklyn, Queens, and the Bronx.

155. Mittal and Bansal entered into arrangements with these physicians under which the Practice would "lease" office space from them—usually one or two exam rooms for certain days or hours each month. Defendants referred to these locations as "satellite offices" or "accounts."

156. The amount of "rent" paid to the physicians varied. Lease agreements often stated that the physicians would be paid $500 for half a day or $1000 for a full day. However, the rental payments did not reflect the fair market value of the leased space and were not commercially reasonable. Instead, the payments were based on the anticipated number of patient referrals that would be generated by the physician. Indeed, Defendants never conducted any analysis to assess what fair market rent would be for the space. For example, Mittal entered a "sublease" agreement with a physician under which he agreed to pay monthly rent of $2750

(starting in May 2016) to use the office for just four hours per week, which was only slightly less than the total monthly amount the physician paid their landlord ($3125 plus utilities).

157. In addition, in many instances, the terms of the purported lease arrangement were not memorialized in a written agreement signed by the physician.

158. Moreover, even where there were written lease agreements, the payments to the referring physicians did not correspond with the "rent" payments referenced in the lease. The payments were frequently not made on a regular monthly basis as specified in the agreements, and the payments sometimes significantly exceeded the amounts referenced in the agreements and other times were significantly less. In reality, Mittal and Bansal determined the payment amounts to be made to the referring physicians based on the volume of patients they referred to Mittal, and not the fair market value of the space used by Mittal's staff.

159. Mittal and Bansal structured and characterized the stream of payments made to the referring physicians as "rent" payments for the use of office space because they understood that paying doctors for patient referrals was illegal.

160. Mittal and Bansal sent medical assistants, physician assistants, technicians, and nurse practitioners to the satellite offices to see patients referred by the physicians. Mittal's existing patients were not seen at these satellite offices.

161. At the satellite offices, Mittal's staff performed basic diagnostic tests on patients, including ABIs, sonograms, and echocardiograms. Mittal's staff would then typically advise the patients that they needed to be seen by Mittal at the Cardiology Office for further testing, including peripheral angiograms. Patients were sometimes even told that they needed to go to the Cardiology Office to receive the results of tests performed at the satellite office.

162. Mittal pressured staff deployed to these satellite offices to send as many patients as possible to the Cardiology Office for follow-up appointments. He repeatedly told staff that the Cardiology Office needed "more patient flow." On many occasions, patients were referred to the Cardiology Office for further cardiac and peripheral vascular testing without regard to their medical need or the actual results of the diagnostic tests performed at the satellite office.

163. Mittal tracked the volume of referrals received from the various satellite offices. He berated staff when the number of patients referred for follow-up appointments at the Cardiology Office did not meet his expectations.

164. Mittal also tracked the number of patients referred from each satellite office who underwent a peripheral angiogram and revascularization procedure at the Cardiology Office.

165. In many cases, the patients seen at the satellite offices resided in the Bronx or Queens far from the Cardiology Office, which was located in Bay Ridge, Brooklyn. Defendants offered to pay for the transportation costs of referred patients, or offered to send Mittal's drivers to pick them up and take them home.

166. Mittal and Bansal solicited physicians who they thought would likely generate a large volume of patient referrals based on their practice and patient population. They specifically targeted podiatrists because they see a large number of patients with diabetes, who are at higher risk for PAD. In some instances, physicians were cold called to gauge their interest in entering into patient referral arrangements. Mittal tried to confirm that the physician's office was sufficiently busy before entering into any agreement.

167. A large percentage of the Cardiology Practice's Medicare and Medicaid patients were referred by physicians at these satellite offices. Defendants submitted claims, and received

millions of dollars in Medicare and Medicaid reimbursements, for tests and procedures performed on the more than one thousand patients referred by these physicians.

168. When the volume of new patients referrals decreased, Mittal and Bansal stopped making the "rent" payments to the physicians and terminated the arrangements.

169. The AKS provides a safe harbor for legitimate office rental agreements. However, to qualify for the safe harbor, the agreement must be in writing and signed by the parties; the rental fees must be set in advance, consistent with fair market value, and not be determined in a manner that takes into account the volume of any referrals; and the lease must be commercially reasonable in the absence of referrals. Here, because the payments to the physicians were actually kickbacks structured as "rent" payments," they failed to meet these criteria. As described above, there was no written lease agreement with some of the satellite offices, and when there was a written agreement that set forth a monthly rent amount, the payments made to the referring doctors often did not correspond with that amount and instead fluctuated based on the volume of referrals. In many cases, Mittal's payments to the referring physicians were substantially in excess of the fair market value for the office space. And the agreements were not commercially reasonable in the absence of referrals; indeed, when the value of the referrals did not meet the expectations of Mittal and Bansal, they ended the arrangement with the physician.

170. Some physicians who entered into these kickback "office rental" arrangements with Mittal received more than $100,000 in exchange for the dozens of patient referrals they generated, including:

- A cardiologist who "leased" their office space located on Wyckoff Avenue in Brooklyn, New York;

- An internist who "leased" their office space located on Glenwood Road in Brooklyn, New York; and
- An internist who "leased" their office space located on Classon Avenue in Brooklyn, New York.

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171. As a result of the fraudulent and illegal conduct discussed above, Defendants knowingly presented or caused to be presented false or fraudulent claims for payment to Medicare and Medicaid, including MAOs and MCOs, for peripheral vascular and cardiac tests and procedures and received millions of dollars to which they were not entitled. Medicare and Medicaid, including MAOs and MCOs, would not have paid these amounts had they known of the fraudulent and illegal conduct discussed above.

FIRST CLAIM

Violations of the False Claims Act: Presenting False Claims for Payment 31 U.S.C. § 3729(a)(1)(A)

172. The Government incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

173. The Government seeks relief against Defendants under 31 U.S.C. § 3729(a)(1)(A).

174. Through the acts set forth above, Defendants knowingly presented or caused to be presented false or fraudulent claims for payment for peripheral vascular and cardiac tests and procedures performed on Medicare and Medicaid beneficiaries. These claims were false or fraudulent and not eligible for reimbursement because (a) the tests and procedures were unreasonable and medically unnecessary and supported by medical records that included false

information about the patient's symptoms and conditions, and/or (b) were the result of patient referrals by physicians who received kickbacks in violation of the AKS.

175. If Medicare and Medicaid had known that the claims presented for payment were for (a) tests and procedures that were unreasonable and medically unnecessary and supported by medical records that included false information about the patient's symptoms and conditions, and/or (b) were the result of patient referrals by physicians who received kickbacks in violation of the AKS, they would not have paid the claims.

176. Defendants presented or caused to be presented these claims with actual knowledge of their falsity, or indeliberate ignorance or reckless disregard of whether or not they were false.

177. By reason of these false or fraudulent claims, the Government has sustained damages in a substantial amount to be determined at trial, and is entitled to treble damages plus a civil penalty for each violation.

SECOND CLAIM

Violations of the False Claims Act: Use of False Statements
31 U.S.C. § 3729(a)(1)(B)

178. The Government incorporates by reference each of the preceding paragraphs as if fully set forth herein.

179. The Government seeks relief against Defendants under 31 U.S.C. § 3729(a)(1)(B).

180. Through the acts set forth above, Defendants knowingly made, used, or caused to be made and used, false records and statements material to the payment of false or fraudulent

claims for payment for peripheral vascular and cardiac tests and procedures performed on Medicare and Medicaid beneficiaries. These false records and statements included but are not limited to medical records that contained fabricated information about the patient's symptoms, functional limitations, and conditions, false statements regarding the medical necessity of the tests and procedures, and false certifications that the claims complied with applicable laws, regulations, and program instructions for payment and were true, accurate, and complete.

181. These false records and statements were material to the false or fraudulent claims because Medicare and Medicaid would not have paid the claims absent the records and statements.

182. Defendants made, used, or caused to be made and used, these false records and statements with actual knowledge of their falsity, or indeliberate ignorance or reckless disregard of whether or not they were false.

183. By reason of these false records and statements, the Government has sustained damages in a substantial amount to be determined at trial, and is entitled to treble damages plus a civil penalty for each violation.

THIRD CLAIM

Payment by Mistake of Fact

184. The Government incorporates by reference each of the preceding paragraphs as if fully set forth herein.

185. The Government seeks relief against Defendants to recover monies paid under mistake of fact.

186. The Government paid for claims for peripheral vascular and cardiac tests and procedures performed on Medicare and Medicaid beneficiaries based on the mistaken and

erroneous belief that the tests and procedures were reasonable and medically unnecessary and supported by accurate medical records, and were not the result of patient referrals by physicians who received kickbacks in violation of the AKS. These erroneous beliefs, as well as the false records made or caused to be made by Defendants, were material to the determination to pay for the services billed.

187. By reason of the foregoing, the Government has sustained damages in a substantial amount to be determined at trial.

FOURTH CLAIM

Unjust Enrichment

188. The Government incorporates by reference each of the preceding paragraphs as if fully set forth herein.

189. Through the acts set forth above, Defendants have received Medicare and Medicaid payments to which they were not entitled and therefore were unjustly enriched. The circumstances of these payments are such that, in equity and good conscience, Defendants should not retain those payments, the amount of which is to be determined at trial.

PRAYER FOR RELIEF

WHEREFORE, the Government respectfully requests judgment to be entered in its favor against Defendants as follows:

a. On the First and Second Claims (FCA violations), for a sum equal to treble damages and civil penalties to the maximum amount allowed by law;

c. On the Third and Fourth Claims (Payment by Mistake of Fact and Unjust Enrichment), a sum equal to the damages to the extent allowed by law; and

d. Granting the Government costs and such further relief as the Court may deem proper.

Dated: December 14, 2023
New York, New York

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