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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA, STATE OF NEW YORK, *ex rel.* NIKI PATEL,

Plaintiffs,

v.

ORANGE MEDICAL CARE, P.C., MANISH A. RAVAL, M.D., ASHIKKUMAR A. RAVAL, M.D., and ENABLE HEALTHCARE, INC.,

Defendants.

UNITED STATES OF AMERICA,

Plaintiff-Intervenor,

v.

ORANGE MEDICAL CARE, P.C., MANISH A. RAVAL, M.D., and ASHIKKUMAR A. RAVAL, M.D.,

Defendants.

16 Civ. 8589 (PGG)

COMPLAINT-IN-INTERVENTION OF THE UNITED STATES OF AMERICA

JURY TRIAL DEMANDED

Plaintiff the United States of America (the "United States"), by and through its attorney, Damian Williams, United States Attorney for the Southern District of New York, brings this

action against Orange Medical Care, P.C. ("Orange Medical"), Dr. Manish A. Raval and Dr. Ashikkumar A. Raval (together, the "Ravals") (collectively "Defendants") alleging as follows:

PRELIMINARY STATEMENT

1. This is a civil fraud action brought by the United States against the Ravals and Orange Medical under the False Claims Act, 31 U.S.C. § 3729-33 (the "FCA"), to recover damages and civil penalties arising from Defendants' submission of false claims to Medicare and Medicaid for physician services provided to patients enrolled in those federal health care programs. The United States also seeks to recover damages under the common law for unjust enrichment and payment by mistake.

2. Orange Medical is a family medicine practice that provides primary care services to patients in Newburgh, New York. The Ravals are family medicine physicians who own and operate Orange Medical. Orange Medical, through a third-party billing company, submitted claims to Medicare and Medicaid for physician services provided to patients at its Newburgh office. During the period from November 4, 2006 through December 31, 2022 (the "Relevant Period"), Defendants violated the FCA by knowingly submitting and/or causing the submission of false claims for payment to Medicare and Medicaid for medical services that were not rendered or supervised by the physician identified in the claim for payment.

3. Defendants understood that they were prohibited from submitting claims for reimbursement to New York's Medicaid program for physician services if the physician listed as the rendering provider on the claim for reimbursement had not actually rendered the services. Defendants further understood that they were prohibited from submitting claims for physician services to Medicare if the services were not, at minimum, rendered "incident to" the services actually provided by the physician listed on the claim. Nonetheless, Orange Medical frequently

submitted claims to Medicaid and Medicare for primary care services that listed one of the Ravals as the rendering provider, even though the services had been rendered by non-credentialed providers, and without the direct supervision of the Ravals. On many such occasions, the Ravals were traveling outside of the United States at the time that the patient received the treatment. In other instances, the services had actually been performed by providers who had not enrolled in the Medicare or Medicaid programs. Nonetheless, Defendants submitted claims, or caused claims to be submitted, for primary care services to Medicare or Medicaid by falsely stating that the Ravals had rendered the services.

4. By engaging in the above-referenced conduct, Defendants submitted, or caused to be submitted, at least hundreds of false claims to federal health care programs in violation of the FCA.

JURISDICTION AND VENUE

5. This Court has jurisdiction over the claim 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.

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

7. Venue lies in the Southern District of New York pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. §§ 1391(b) and 1391(c), because the Ravals reside in this District, Orange Medical does business in this District, and Defendants' misconduct occurred in this District.

PARTIES

8. Plaintiff is the United States of America. The Centers for Medicare & Medicaid Services ("CMS"), a component within the United States Department of Health and Human Services ("HHS"), administers and oversees the Medicare and Medicaid programs.

9. Defendant Orange Medical Care, P.C. is a New York-based corporation that operates a family medicine practice located in Newburgh, New York.

10. Defendant Manish A. Raval, M.D. is a co-owner of Defendant Orange Medical and, together with Defendant Ashikkumar A. Raval, operates Orange Medical's practice. Manish A. Raval is a resident of Orange County, New York.

11. Defendant Ashikkumar A. Raval, M.D. is a co-owner of Defendant Orange Medical and, together with Defendant Manish A. Raval, operates Orange Medical's practice. Ashikkumar A. Raval is a resident of Orange County, New York.

12. Relator Niki Patel, M.D. is Board-certified in internal medicine. Relator worked for Orange Medical from June 2015 to August 2016. On or about November 4, 2016, Relator filed a complaint under the *qui tam* provisions of the FCA and an analogous New York State false claims statute alleging, among other things, that Defendants submitted claims to Medicare and Medicaid using the names of credentialed providers when, in fact, the services were rendered by non-credentialed providers.

BACKGROUND

I. Relevant Statutes

A. The False Claims Act

13. The FCA establishes 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," 31 U.S.C. § 3729(a)(1)(A); 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)(B).

14. "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.*

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

II. Relevant Federal Health Care Programs

16. ***Medicare.*** In 1965, Congress enacted Title XVIII of the Social Security Act, commonly known as "Medicare," to pay for health-care services and items for the elderly and disabled. 42 U.S.C. § 1395 *et seq.* 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. Medicare has several parts, including Part B, which provides coverage for outpatient medical services, including primary care. *See generally* 42 U.S.C. §§ 1395j–1395w-6.

17. Medicare regulations require providers 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).

18. ***Medicaid.*** 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 qualified 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 states directly pay the health care providers for services rendered to Medicaid recipients, with the states 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, is based on the state's per capita income compared to the national average. 42 U.S.C. § 1396d(b).

19. The majority of states 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 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.

20. Providers who participate in the Medicaid program 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.

21. Medicaid providers 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.

III. The Relevant Federal Health Care Program Requirements

22. ***Relevant Medicare Requirements.*** Physicians must enroll in the Medicare program in order to be paid for services rendered to Medicare beneficiaries. *See* 42 C.F.R. § 424.505. In order for a physician to enroll in Medicare, a physician must provide their active license and certification information for their specialty. *See* 42 C.F.R. § 424.510(d)(2)(iii); CMS, *Medicare Enrollment Application, Physician and Non-Physician Practitioners*, *CMS-855I* (May 2023). When a physician signs a Medicare enrollment application, the physician agrees to comply with Medicare program policies, instructions, and guidelines, along with other federal laws and regulations. *See id.*

23. Physicians must also obtain a National Provider Identifier ("NPI") to identify themselves in their federal health care program claim submissions. *See* 42 C.F.R. § 424.506. The NPI is a unique 10-digit identification number for health care providers that is used by all health plans, including federal health care programs, in the submission of claims for reimbursement. When a practice submits claims for reimbursement to Medicare, they are required to identify the provider who rendered the services by providing their NPI.

24. Claims for Medicare Part B services are submitted on CMS form 1500 or its electronic equivalent. The CMS 1500 form requires the provider who signs the form to represent that: "[i]n submitting this claim for payment from federal funds, I certify that: . . . the services on this form were . . . personally furnished by me." Under the line, "Signature of Physician (or Supplier)," the individual is also directed to represent: "I certify that the services listed above were personally furnished by me."

25. CMS has published manuals that provide guidance to health care providers. In the Medicare Program Integrity Manual, for example, CMS identified the following example of a

fraudulent practice: misrepresenting the identity of the individual who furnished the services. *See* Medicare Program Integrity Manual, Pub. 100-08, Ch. 4.2.1.

26. In certain defined circumstances, Medicare will pay for a physician's services even though the services-at-issue were rendered by a non-physician practitioner ("NPP"), such as a physician assistant or nurse practitioner. As relevant here, in order to qualify for such treatment, the NPP's services must, among other things, be "incident to" the services that are personally rendered by a physician, and also be performed under the direct supervision of a physician. *See* 42 C.F.R. § 410.26.

27. ***Relevant Medicaid Requirements.*** Under New York's Medicaid program, healthcare providers (including NPPs) must be enrolled with Medicaid in order to be paid for services by Medicaid. *See* 18 NYCRR §§ 504.1(b)(1), 504.1(a); *see also* New York State Medicaid Program, Nurse Practitioner Manual Policy Guidelines, version 2022-3, at 4. New York's Medicaid program also requires that, for a group practice (such as Orange Medical) to submit claims to Medicaid, all individual providers in the group must be enrolled with Medicaid. *See* New York State Medicaid Program, Physician Manual Policy Guidelines, version 2022-1, at 8.

28. When a group practice submits claims for reimbursement to Medicaid, they are required to identify the practitioner who actually rendered the services in the claim form. *See id.* at 10. New York State's Medicaid program will not pay for a physician's services in circumstances where the services were rendered by a non-physician practitioner (even if such services were "incident to" services rendered by a physician).

FACTUAL ALLEGATIONS

I. Defendants Submitted, or Caused to Be Submitted, False Claims to Medicare and Medicaid Listing the Ravals as Rendering Providers When the Ravals Had Not Rendered or Supervised the Services

29. During the Relevant Period, Orange Medical, through its third-party billing company, repeatedly submitted claims to Medicaid and Medicare for primary care services that listed Manish A. Raval or Ashikkumar A. Raval as the rendering provider, even though the Ravals had not rendered the services for which reimbursement was being sought. On many such occasions, the Ravals had no personal involvement in the treatment of the patient, and were traveling outside of the United States at the time that the services were furnished. Further, such services were often provided by providers, including nurse practitioners and physician assistants, who had not enrolled in Medicare or Medicaid.

30. Defendants altered patient records to reflect falsely that one of the Ravals had seen a patient when, in fact, the patient had been seen by a different provider. For example, an Orange Medical treatment record dated August 19, 2016, identifies Manish Raval as the attending physician for services rendered to a patient. Manish Raval, however, did not render these services or otherwise supervise the services rendered. In fact, on August 19, 2016, Manish Raval was outside of the United States. Orange Medical, through its third-party billing company, subsequently submitted a claim for reimbursement to Medicaid for these services, falsely listing Manish Raval as the rendering provider. Medicaid paid this claim.

31. During the Relevant Period, Medicare and Medicaid paid hundreds of thousands of dollars to Orange Medical for claims that listed the Ravals as rendering providers when they had not rendered or supervised the relevant services and, in fact, were traveling outside of the United States when the services were rendered.

32. Further, in Orange Medical's claims to Medicaid, Defendants frequently listed the Ravals as rendering providers when, in fact, the services had actually been performed by providers who had not enrolled in the Medicaid program. Specifically, during the Relevant Period, Orange Medical employed nurse practitioners and physician assistants who had not enrolled with New York's Medicaid program. Orange Medical, however, frequently submitted claims to Medicaid for services actually rendered by these non-credentialed providers and, on the claims submission form, falsely claimed that one of the Ravals had rendered the services.

33. For example, from May 2020 through December 2021, Orange Medical employed a nurse practitioner ("Nurse Practitioner A") who regularly treated Medicaid beneficiaries without the involvement of the Ravals. During this period, Nurse Practitioner A was not enrolled as a provider with Medicaid. On numerous occasions, Orange Medical submitted claims to Medicaid that falsely identified one of the Ravals as the rendering provider, when Nurse Practitioner A had rendered the services.

34. Defendants were well-aware of this improper practice. For example, in an email exchange dated March 14, 2016, Orange Medical's third-party billing company asked Defendant Ashikkumar Raval how billing should be handled when the rendering provider was not credentialed: "[I]n an instance that the rendering provider isn't credentialed with the patient insurance what would you like us to do? Submit with a credited [*sic*] provider or write off the claim?" Defendant Ashikkumar Raval replied: "If rendering provider is not credentialed with the patient insurance, it could be billed under the provider who is credentialed."

35. Similarly, in a February 17, 2016 email sent by Defendant Ashikkumar Raval to Orange Medical's third-party billing company, Ashikkumar Raval specifically instructed Orange Medical's billing company to seek reimbursement for services rendered by non-credentialed

providers by using the identities of credentialed providers, stating: "Until all the providers are credentialed [Orange Medical] will have to bill under the provider who is credentialed. Please do not hold any billing for that reason." In another email that same day, Defendant Ashikkumar Raval instructed the clerical staff of Orange Medical to falsely list himself or Defendant Manish Raval as the rendering provider when non-credentialed providers at Orange Medical had, in fact, rendered the relevant services to the patients.

36. During the Relevant Period, Medicaid paid hundreds of thousands of dollars to Orange Medical for claims that listed the Ravals as rendering providers when, in fact, the services had been rendered by non-credentialed providers.

CLAIMS FOR RELIEF

COUNT ONE: PRESENTING FALSE CLAIMS FOR PAYMENT VIOLATION OF THE FALSE CLAIMS ACT

37. The United States repeats and realleges the allegations in paragraphs 1 through 36.

38. The United States asserts claims against Defendants under Section 3729(a)(1)(A) of the False Claims Act.

39. Through the acts set forth above, Defendants, acting with actual knowledge or with deliberate ignorance or reckless disregard of the truth, presented, or caused to be presented, false or fraudulent claims for payment or approval to the government when requesting reimbursements for services or procedures.

40. The Government made payments to Defendants under the Medicare and Medicaid programs because of the false or fraudulent claims.

41. If payors such as CMS had known about the improper practices set forth above, they would have not paid the claims.

42. By reason of the false or fraudulent claims, the United States 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.

COUNT TWO: USE OF FALSE STATEMENTS
VIOLATION OF THE FALSE CLAIMS ACT

43. The United States repeats and realleges the allegations in paragraphs 1 through 36.

44. The United States asserts claims against the Defendants under Section 3729(a)(1)(B) of the False Claims Act.

45. As a result of the improper practices set forth above in connection with the provision and billing of medical services to federal health care programs, Defendants made and used, or caused to be made and used, false records and statements that were material to the payment of false or fraudulent claims by federal health care programs in violation of 31 U.S.C. § 3729(a)(1)(B). These false records and statements included but are not limited to false statements regarding the identity of the rendering provider and false certifications that the claims complied with applicable laws, regulations, and program instructions.

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

47. By reason of the false or fraudulent claims, the United States 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.

COUNT THREE: UNJUST ENRICHMENT

48. The United States repeats and realleges the allegations in paragraphs 1 through 36.

49. Through the acts set forth above, Defendants have received Medicare and Medicaid reimbursements to which they were not entitled and therefore have been 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 are to be determined at trial.

COUNT FOUR: PAYMENT BY MISTAKE

50. The United States repeats and realleges the allegations in paragraphs 1 through 36.

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

52. The Government paid claims for medical services provided to federal health care program beneficiaries based on the mistaken and erroneous belief that the rendering provider listed on the claims submitted to the federal health care programs was accurate, and that such provider had actually provided the service to the listed beneficiary. These erroneous beliefs were material to the determination to pay for the claims submitted.

By reason of the foregoing, the Government has been damaged in a substantial amount to be determined at trial.

PRAYER FOR RELIEF

53. WHEREFORE, the United States respectfully requests judgment to be entered in its favor as follows:

(i) On Counts One and Two (FCA violations), a sum equal to treble the Government's damages in an amount to be determined at trial, civil penalties to the maximum extent allowed by law, and an award of costs pursuant to 31 U.S.C. § 3729(a).

(ii) On Counts Three and Four (Unjust Enrichment and Payment by Mistake), a sum equal to the damages as allowed by law.

(iii) Such further relief as the Court may deem proper.

Dated: August 13, 2024
New York, New York

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