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

[UNDER SEAL]		
	Plaintiffs,	**CIVIL CASE NO.**
v.		**FILED UNDER SEAL**
[UNDER SEAL]		**JURY TRIAL DEMANDED**
	Defendant.	

FALSE CLAIMS ACT COMPLAINT

DO NOT FILE ON PACER

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

UNITED STATES OF AMERICA EX REL. MARK D. NOVICK, M.D., the STATE OF NEW JERSEY, and the STATE OF NEW YORK	
Plaintiffs,	
	CIVIL CASE NO.
v.	**FILED UNDER SEAL**
DOSHI DIAGNOSTIC IMAGING SERVICES, P.C.	
	JURY TRIAL DEMANDED
Defendant.	

Qui Tam Plaintiff/Relator Dr. Mark Novick brings this civil fraud action against Doshi Diagnostic Imaging Services, P.C. on behalf of the United States of America, the State of New Jersey, and the State of New York and alleges, based upon personal knowledge and relevant documents, as follows:

I. INTRODUCTION

1. This is an action to recover damages and civil penalties on behalf of the United States of America, the State of New Jersey, and the State of New York arising from false and/or fraudulent records, statements and claims made, used and caused to be made, used or presented by Defendant Doshi Diagnostic Imaging Services, P.C. ("Doshi"), and/or its agents and employees in violation of the Federal Civil False Claims Act ("FCA"), 31 U.S.C. § 3729, *et seq.*, the New Jersey False Claims Act ("NJFCA"), N.J.S.A. § 2A:32C-1 *et seq.*, and the New York False Claims Act ("NYFCA"), N.Y. State Finance Law § 187 *et seq.*

2. Defendant Doshi, a provider of outpatient radiological and nuclear medicine studies in New Jersey, New York, and Florida, has, since at least July of 2006, engaged in a pattern and practice of intentionally submitting false and fraudulent claims for reimbursement to the federal and state-funded health insurance programs of New Jersey and New York.

3. Relator discovered a pattern and practice of double billing and billing for medically unnecessary procedures during his tenure as Associate Medical Director of Doshi.

4. Specifically, Doshi routinely and improperly bills for two complete ultrasound scans when the images captured during the scan support a bill for only one complete ultrasound.

5. Doshi also routinely adds color Doppler studies and three dimensional multiplanar reconstructions of radiological images, and bills Medicare and Medicaid for those studies, although they are not medically necessary. The sole reason they do so is to increase reimbursement.

6. In perpetrating this scheme, Doshi has fraudulently obtained reimbursement from public funds.

7. As a direct result of Defendant's improper practices, federal and state health insurance programs including, but not limited to, Medicare and Medicaid, have paid false or fraudulent claims as reimbursement for diagnostic radiological procedures that would not have been paid but for Defendant's illegal business practices.

8. The FCA was originally enacted during the Civil War, and later substantially amended in 1986. Congress amended the Act to enhance the Government's ability to recover losses sustained as a result of fraud against the United States after finding that fraud in federal programs was pervasive and that the Act, which Congress characterized as the primary tool for combating government fraud, was in need of modernization. Congress intended that the

amendments create incentives for individuals with knowledge of fraud against the government, to disclose the information without fear of reprisals or Government inaction and to encourage the private bar to commit legal resources in prosecuting fraud on the Government's behalf.

9. The Act provides that any person who knowingly submits, or causes the submission of a false or fraudulent claim to the U.S. Government for payment or approval, is liable for a civil penalty of up to $11,000 for each such claim, plus three times the amount of damages sustained by the Government. Liability attaches when a defendant knowingly seeks payment, or causes others to seek payment, from the Government that is unwarranted.

10. The Act allows any person having information about a false or fraudulent claim against the Government to bring an action for both himself and the Government, and to share in any recovery. The Act requires that the complaint be filed under seal for a minimum of 60 days (without service on the defendant during that time), to allow the Government time to conduct its own investigation and determine whether to join suit.

11. Based on these provisions, qui tam Plaintiff seeks through this action to recover on behalf of the United States, the State of New Jersey, and the State of New York that authorizes similar qui tam actions, damages and civil penalties arising from Defendant's making or causing to be made false or fraudulent records, statements and/or claims in connection with its practice of billing for procedures that were never performed and billing for medical procedures that were performed but were not medically necessary.

II. PARTIES

A. Relator Mark Novick, M.D.

12. Relator Mark Novick is a resident of New York and citizen of the United States, residing at 4 Hunt Drive, Jericho, New York 11753.

13. Relator is a Medical Doctor ("M.D."). He received his medical degree in 1978 from the University of Tennessee Center for Health Sciences in Memphis, Tennessee. Following his four-year residency in diagnostic radiology at the University of Tennessee, Relator completed visiting fellowships in Neuro MRI and Whole Body MRI at The University of California, San Francisco. Relator, a board certified radiologist, is licensed to practice medicine in New York, New Jersey and Florida.

14. Relator has been named as one of the top doctors in the New York Metro Area for the past five years.

15. Relator worked for Defendant Doshi from July 1, 2006 through November 15, 2007 as Associate Medical Director of the entire organization. After his departure in November of 2007, Relator continued to review studies electronically until March 15, 2008, as an independent contractor for Doshi.

16. In his role as Associate Medical Director, Relator's responsibilities included the supervision of the quality and quantity of physician staffing at the various Doshi facilities. Relator also evaluated and supervised technicians performing procedures within the Doshi organization to assess their competency and quality. This put Relator in a unique position to observe the systemic practices of the Doshi organization. It was not long after joining Doshi that Relator discovered these fraudulent practices.

17. Relator had contact with each of the Doshi locations, and estimates he visited approximately 90% of the locations personally.

18. In his capacity as Doshi's Associate Medical Director, Relator reviewed a substantial number of patient files and he observed the systemic improprieties that have led to fraudulent billing of the publically funded Medicare and Medicaid programs.

19. Relator objected to Doshi's fraudulent practices, but his objections were ignored, and he was threatened that raising further objections might result in his termination from Doshi.

20. Relator currently practices as a diagnostic radiologist in New York and is no longer employed by Doshi.

B. Defendant Doshi Diagnostic Imaging Services, P.C.

21. Defendant Doshi is a New York Domestic Professional Corporation, with its corporate headquarters located at 560 South Broadway, Hicksville, New York 11801.

22. Doshi owns and operates forty free-standing diagnostic imaging centers, located in New Jersey, New York and Florida.

23. Doshi performs more than 1,000,000 outpatient radiological and nuclear medicine studies per year, approximately 30 to 50% of which are billed directly to Medicare, Medicaid, or other publically funded health insurance programs.

24. Doshi was originally founded by Dr. Lena Doshi in and around 1985, and expanded rapidly to produce annual revenues of approximately $130 million by 2005.

25. Dr. Lena Doshi serves as the Chairman and Chief Executive Officer of Doshi.

26. During the time period at issue in this Complaint, Doshi, has owned and operated facilities within New Jersey at the following locations:

434 New Jersey Avenue
Absecon, NJ 08201

420 Church Street
Absecon, NJ 08201

13 Mechanic Street
Cape May Court House, NJ 08210

108 Dennisville Road
Cape May Court House, NJ 08210

2800 Route 130 North
Cinnaminson, NJ 08077

1113 Beacon Avenue
Manahawkin, NJ 08050

27. Within New York, Doshi currently owns and operates facilities at the following locations:

410 East 189th Street
Bronx, NY 10458

3250 Westchester Avenue
Bronx, NY 10461

6740 3rd Avenue
Brooklyn, NY 11220

2215 79th Street
Brooklyn, NY 11214

1783 Stillwell Avenue
Brooklyn, NY 11223

1014 Brooklyn Avenue
Brooklyn, NY 11203

9 Bond Street
Brooklyn, NY 11201

1230 Avenue R
Brooklyn, NY 11229

2475 Ralph Avenue
Brooklyn, NY 11234

6301 Mill Lane
Brooklyn, NY 11234

132 Bowery
New York, NY 10013

1825 Madison Avenue
New York, NY 10035

130 West 79th Street
New York, NY 10024

4120 Broadway
New York, NY 10033

1137 Broadway
Hewlett, NY 11557

1184 Broadway
Hewlett, NY 11557

165 N. Village Avenue
Rockville Center, NY 11570

43-55 147 Street
Flushing, NY 11355

147-05 Elm Avenue
Flushing, NY 11355

37-17 76 Street
Jackson Heights, NY 11372

80-02 Kew Garden Road
Suite L1
Kew Gardens, NY 11415

28. Within Florida, Doshi currently owns and operates facilities at the following locations:

6500 Fort Caroline Road
Suite B
Jacksonville, FL 32277

1215-4 Dunn Avenue
Jacksonville, FL 32218

2020 Professional Center Drive
Orange Park, FL 32073

4171 Roosevelt Boulevard
Jacksonville, FL 32210

4063 Salisbury Road
Suite 100
Jacksonville, FL 32216

1590 NW 10th Avenue
Suite 202
Boca Raton, FL 33486

610 Glades Road
Boca Raton, FL 33431

2230 N. University Drive
Coral Springs, FL 33071

4461 N. Federal Highway
Oakland Park, FL 33308

701 NW 179th Avenue
Suite 102
Pembroke Pines, FL 33029

8300 W. Sunrise Boulevard
Plantation, FL 33322

7800 S.W. 87th Avenue
Building A
Suite 110
Miami, FL 33173

414 Robertson Street West
Brandon, FL 33511

4807 U.S. Highway 19
Suite 102
New Port Richey, FL 34652

6016 Park Boulevard
Pinellas Park, FL 33781

4325 Henderson Boulevard
Tampa, FL 33629

29. Doshi employs more than 1,800 employees, including as many as 50 doctors, at its various locations.

30. In approximately May of 2005, Evercore Partners, a private equity firm, acquired

a 65% interest in Diagnostic Imaging Group, LLC, a newly created entity owning and operating 15 Doshi diagnostic imaging centers in New York and 14 Doshi diagnostic imaging centers in Florida. As a result of the transaction with Evercore Partners, Doshi was valued at $255 million.

III. JURISDICTION AND VENUE

31. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331, 28 U.S.C. § 1367 and 31 U.S.C. § 3732, the last of which specifically confers jurisdiction on this Court for actions brought pursuant to 31 U.S.C. §§ 3729 and 3720. Under 31 U.S.C. § 3730(e), there has been no statutorily relevant public disclosure of the "allegations or transactions" in this Complaint. Relator, moreover, would qualify under that section of False Claims Act as an "original source" of the allegations in this Complaint, even had such a public disclosure occurred.

32. The Court has subject matter jurisdiction over Defendant's violation of the NJFCA and the NYFCA pursuant to 31 U.S.C. § 3732(b) because Defendant's violation of the NJFCA, the NYFCA and the FCA all arise out of a common nucleus of operative facts. See also 31 U.S.C. § 3732(b) (granting district courts jurisdiction over any action brought under the laws of any state for the recovery of funds paid by a state if the action arises from the same transaction or occurrence as an action brought under the federal FCA).

33. This Court has personal jurisdiction and venue over Defendant pursuant to 28 U.S.C. §§ 1391(b) and 31 U.S.C. § 3732(a) because that section authorizes nationwide service of process and because Defendant has minimum contacts with the United States. Moreover, Defendant can be found in, resides and transacts business in the District of New Jersey. Specifically, Doshi owns two facilities each in Absecon and Cape May, New Jersey. Doshi also owns and operates one facility each in Manahawkin and Cinnaminson, New Jersey.

34. Venue is proper in this District pursuant to 31 U.S.C. § 3731(a) because Defendant can be found in and transacts business in the District of New Jersey. At all times relevant to this Complaint, Defendant regularly conducted substantial business within the District of New Jersey, maintained employees and offices in New Jersey and performed a significant number of procedures on patients within New Jersey. In addition, statutory violations as alleged herein, occurred in this district.

IV. APPLICABLE LAW

A. Background on Federal and State-Funded Health Insurance Programs

i. Medicare

35. In 1965, Congress enacted Title XVIII of the Social Security Act, which established the Medicare Program to provide health insurance for the elderly and disabled. Medicare is a health insurance program that provides coverage for: people age 65 or older; people under age 65 with certain disabilities; and people of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or kidney transplant).

36. Medicare has two parts: Part A, the Basic Plan of Hospital Insurance; and Part B, which covers physicians' services and certain other medical services not covered by Part A.

37. Medicare Part A (Hospital Insurance) helps cover inpatient hospital care in critical access hospitals and skilled nursing facilities excluding custodial and/or long-term care. Medicare Part A also helps cover hospice care and some home health care.

38. Medicare Part B (Medical Insurance) helps cover doctors' services and outpatient care. It also covers some other medical services that Part A does not cover (i.e., physical and occupational therapist services, etc.). Part B helps pay for covered health services and supplies when medically necessary.

39. Payments from the Medicare Program come from a trust fund – known as the Medicare Trust Fund – which is funded through payroll deductions taken from the work force, in addition to government contributions. Over the last forty years, the Medicare Program has enabled the elderly and disabled to obtain necessary medical services from medical providers throughout the United States.

40. The Medicare Program is administered through the United States Department of Health and Human Services ("HHS") and, specifically, through the Centers for Medicare and Medicaid Services ("CMS"), an agency of HHS.

41. Much of the daily administration and operation of the Medicare Program is managed through private insurers under contract with the federal government, particularly CMS.

42. Under Medicare Part A, contractors serve as "fiscal intermediaries," administering Medicare in accordance with rules developed by the Health Care Financing Administration ("HCFA"), now known as the Centers for Medicare and Medicaid Services (CMS).

43. Under Medicare Part B, the federal government contracts with insurance companies and other organizations known as "carriers" to handle payment for physicians' services in specific geographic areas. These private insurance companies, or "Medicare Carriers," are charged with and responsible for accepting Medicare claims, determining coverage, and making payments from the Medicare Trust Fund.

44. The principal function of both the intermediaries and the carriers is to make and audit payments for Medicare services, to assure that federal funds are spent properly.

45. To participate in Medicare, providers must certify that their services are provided only when, and to the extent, they are medically necessary. Soc. Sec. Act § 1862(a)(1)(A).

Medicare will only reimburse costs for medical services that are needed for the prevention, diagnosis, or treatment of a specific illness or injury.

ii. **Medicaid**

46. Medicaid was created in 1965, at the same time as Medicare, when Title XIX was added to the Social Security Act. The Medicaid program aids the states in furnishing medical assistance to eligible needy persons, including indigent and disabled people. Medicaid is the largest source of funding for medical and health-related services for America's poorest people.

47. The Medicaid program was established in 1965 when Congress enacted Title VII of the Social Security Act. The Medicaid program aids the states in furnishing medical assistance to eligible needy persons, including indigent and disabled people. Medicaid is the largest source of funding for medical and health-related services for America's poorest people.

48. Medicaid is a cooperative federal-state public assistance program which is administered by the states.

49. Funding for Medicaid is shared between the federal government and those state governments that choose to participate in the program. Federal support for Medicaid is significant.

50. Title XIX of the Social Security Act allows considerable flexibility within the States' Medicaid plans and therefore, specific Medicaid coverage and eligibility guidelines vary from state to state.

51. However, in order to receive federal matching funds, a state Medicaid program must meet certain minimum coverage and eligibility standards. A state must provide Medicaid coverage to needy individuals and families in five broad groups: pregnant women; children and teenagers; seniors; people with disabilities; and people who are blind. In addition, the state

Medicaid program must provide medical assistance for certain basic services, including inpatient and outpatient hospital services.

52. The New Jersey Medical Assistance and Health Services Program (New Jersey Medicaid) is administered by the New Jersey Department of Human Services (NJDHS), and specifically by the Division of Medical Assistance and Health Services (DMAHS), an agency of NJDHS.

53. DMAHS administers the New Jersey Medicaid program and provides health insurance to over 1 million low-income parents, children and people who are blind or disabled. The program pays for hospital services, doctor visits, prescriptions, nursing home care, and other healthcare needs. New Jersey Medicaid is the largest social services program in state government.

54. The Federal Medicaid Assistance Percentage ("FMAP") for the State of New Jersey is currently 50%. This means that the federal government provides 50% of the funding for New Jersey Medicaid, and the remaining 50% of the fund is paid by the State of New Jersey.

55. The New York Medicaid program is administered by the New York State Department of Health ("DOH"). Determinations of enrollee eligibility are made by the fifty-eight (58) county New York Departments of Social Services ("LDSS") and the New York City Human Resources Administration ("HRA").

56. The Federal Medicaid Assistance Percentage ("FMAP") for the State of New York is currently 50%. This means that the federal government provides 50% of the funding for New York Medicaid, and the remaining 50% of the fund is paid by the State of New York.

iii. **Certification**

57. Each and every bill submitted by healthcare providers for Medicare and Medicaid reimbursement is certified by signature of the treating physician or provider.

58. For ease of use, CMS publishes uniform health insurance claim form 1500.

59. CMS form 1500, signed by the physician or provider, whether filed electronically or by hard copy via U.S. Mail, contains a certification that the services for which the request for reimbursement being submitted, were "medically indicated and necessary for the health of the patient and were personally furnished by me or my employee under my personal [direction or supervision]."

B. **Federal False Claims Act**

60. The federal FCA provides, in pertinent part:

> (a) Any person who: (1) knowingly presents, or causes to be presented, to an officer or employee of the United States government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false claim allowed or paid, is liable to the United States Government for a civil penalty of not less than $5,500 and not more than $11,000, plus three (3) times the amount of damages which the Government sustains as a result of the act of that person.
>
> (b) For purposes of this section, the term "knowing" and "knowingly" mean that a person, with respect to information: (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent is required.

C. **New Jersey False Claims Act**

61. The New Jersey False Claims Act (NJFCA) became effective on March 13, 2008 and is modeled after the federal False Claims Act.

62. The NJFCA provides, in pertinent part:

> (a) A person who: (1) knowingly presents, or causes to be presented, to employee, officer or agent of the State, or to any contractor, grantee, or other recipient of State funds, a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the State; (3) conspires to defraud the State by getting a false or fraudulent claim allowed or paid by the state, is jointly and severally liable to the State for a civil penalty of not less than and not more than the civil penalty allowed under the federal False Claims Act (31 U.S.C. § 3729 et seq.). NJFCA, § 2A:32C-3.

> (b) For purposes of the NJFCA, the terms "knowing" and "knowingly" mean that a person, with respect to information: (1) has actual knowledge of the information; or (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required. NJFCA § 2A:32C-2.

63. The NJFCA provides for civil penalties of not less than $5,500 and not more than $11,000, plus three (3) times the amount of damages which the government sustains as a result of the act of that person.

D. New York False Claims Act

64. The New York False Claims Act (NYFCA) became effective in April of 2007 and is modeled after the federal False Claims Act.

65. The NYFCA provides, in pertinent part:

> (c) A person who: (1) knowingly presents, or causes to be presented, to any employee, officer or agent of the state or local government, a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the state or a local government; (3) conspires to defraud the state or a local government by getting a false or fraudulent claim allowed or paid, shall be liable to the state and local government for a civil penalty of not less than six thousand

> dollars and not more than twelve thousand dollars, plus three (3) times the amount of damages which the state and/or local government sustains.

66. For purposes of the NYFCA, the terms "knowing" and "knowingly" mean that with respect to a claim, or information relating to a claim, a person: (a) has actual knowledge of such claim or information; (b) acts in deliberate ignorance of the truth or falsity of such claim or information; or (c) acts in reckless disregard of the truth or falsity of such claim or information.

V. DOSHI'S PROCESS FOR DIAGNOSTIC RADIOLOGICAL PROCEDURES

67. Defendant Doshi provides outpatient radiological and nuclear medicine services to patients in New Jersey, New York, and Florida.

68. Doshi receives patients through referrals from the patients' physicians or licensed medical provider.

69. Physicians refer patients to Doshi in two main ways: (1) writing a prescription for diagnostic imaging services on the physician's own prescription pad; or (2) completing the Doshi referral form.

70. Doshi's referral form is distributed to referring physicians by Doshi's marketing representatives and is also available on Doshi's web site. Doshi employees also frequently fill-out the Doshi referral forms when they receive telephone referrals from a physician's office.

71. Upon arrival at one of the Doshi diagnostic imaging centers, a Doshi technician performs the diagnostic imaging studies, and electronically forwards those images to a Doshi physician for interpretation.

72. Relator, during the time he was employed as Doshi's Associate Medical Director, would interpret diagnostic images taken at Doshi facilities and draft reports that Doshi forwarded to the applicable patient's physician.

73. Doshi physicians, in turn, interpret the patient's diagnostic images and drafts a report that is sent by Doshi to the patient's physician.

74. Doshi creates internal billing sheets listing the procedures to be billed per patient per day. From those sheets, bills are then generated for the diagnostic imaging studies and those bills are submitted either electronically or via mail to the patients' private or publically funded health plans for payment.

VI. DIAGNOSTIC IMAGING PROCEDURES AT ISSUE

75. Each year the American Medical Association publishes a new edition of Current Procedural Terminology ("CPT").

76. CPT codes represent the standard method for the billing and reporting of medical procedures nationwide, by assigning each procedure within the medical, osteopathic, and chiropractic literature a number. Insurance plans, including Medicare and Medicaid, set reimbursement rates for each coded procedure.

77. In 1983, Congress empowered the U.S. Secretary of Health and Human Services to enter into an agreement with the American Medical Association to use CPT codes for reporting physicians' services, including diagnostic procedures, under the Medicare Program (See American Society of Dermatology v. Shalala, 962 F.Supp. 141, 144 (D.D.C. 1996), aff'd, 116 F.3d 941 (D.C. Cir. 1997); 42 U.S.C. § 1395w-4(c)(5)).

78. In 2000, following the passage of the Health Insurance Portability and Accountability Act (HIPAA), the CPT was designated as the national coding standard for physician and other healthcare professional services, including the outpatient radiological and imaging services described in this Complaint.

79. A diagnostic ultrasound, also referred to as medical sonography, uses sound

waves to create an image of internal structures of the human body.

80. In the case of diagnostic ultrasounds, the CPT codes give providers the ability to bill either "complete" scans of certain anatomic regions, or "limited" scans of individual organs.

81. According to the CPT, "if less than the required elements for a 'complete' exam are reported (e.g., limited number of organs or limited portion of [an anatomic] region evaluated), the 'limited' code for that anatomic region should be used once per patient exam session. A 'limited' exam of an anatomic region should not be reported for the same exam session as a 'complete' exam of that same region.

A. **Abdominal Complete Ultrasound**

82. CPT code 76700 corresponds to a "complete" ultrasound examination of the abdomen.

83. According to the CPT, the requisite elements of an Abdominal Complete Ultrasound, CPT code 76700, include scans of the liver, gall bladder, common bile duct, pancreas, spleen, kidneys, and the upper abdominal aorta and inferior vena cava.

84. The current Medicare reimbursement rate for CPT code 76700, depending on exact geographic location, is approximately $160.00 per procedure.

B. **Retro Peritoneum Complete Ultrasound**

85. CPT code 76770 corresponds to a "complete" ultrasound of the retro peritoneum.

86. According to the CPT, the requisite elements of a Retro Peritoneum Ultrasound, CPT code 76770, includes scans of the kidneys, abdominal aorta, common iliac artery origins, and inferior vena cava. CPT also allows for this procedure to include scans of the urinary bladder, if the patients' clinical histories suggest urinary tract pathology.

87. The current Medicare reimbursement rate for CPT code 76770, depending on

exact geographic location, is approximately $160.00 per procedure.

C. **Color Doppler Studies**

88. Another technology at issue that was repeatedly used by Doshi is color Doppler studies. These studies generally display the flow of blood within organs and systems of the body.

89. CPT code 93976 corresponds to a limited "duplex scan" of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs.

90. According to the CPT, " Duplex scan (e.g., 93880, 93882) describes an ultrasonic scanning procedure for characterizing the pattern and direction or blood flow in arteries or veins with the production of real time images integrating B-mode two-dimensional vascular structure with spectral and/or color flow Doppler mapping or imaging."

91. The current Medicare reimbursement rate for CPT code 93976, depending on exact geographic location, is approximately $260.00 per procedure.

D. **Multiplanar Reconstruction**

92. Multiplanar reconstruction is a function available on Doshi's radiological equipment that reconstructs the images captured during the course of a radiological scan into a three dimensional rendering of the applicable anatomy.

93. Multiplanar reconstruction is generally used in conjunction with Computer Tomography ("CT") scans and, in very limited circumstances, Magnetic Resonance Imaging ("MRI"s).

94. CPT code 76376 corresponds to corresponds to a three dimensional, or multiplanar, rendering or reconstruction of radiological images from CT scans and MRIs.

95. The current Medicare reimbursement rate for CPT code 76376, depending on

exact geographic location, is approximately $100.00 per procedure.

VII. ALLEGATIONS

A. Defendant has Illegally Billed Medicare and Medicaid for Diagnostic Procedures

96. During his tenure as Doshi's Associate Medical Director, Relator uncovered evidence that Defendant knowingly, systematically, and illegally submitted hundreds to thousands of false and fraudulent bills to Medicare and Medicaid for diagnostic procedures that were not medically necessary in violation of the Federal False Claims Act, New Jersey False Claims Act, and the New York False Claims Act.

a. Doshi Illegally Billed for Abdominal Complete and Retroperitoneal Ultrasounds

97. Doshi has, since at least 2007, knowingly, systematically, and illegally billed for a complete abdominal ultrasound (CPT 76700) and a complete retroperitoneal ultrasound (CPT 76856) when the ultrasound images that were actually taken by Dohi failed to meet the required elements set forth in the CPT Code for billing both procedures, including, but not limited to, medical necessity.

i. Medicare/Medicaid Rules for Billing for Diagnostic Imaging Procedures

98. Although Medicare and Medicaid do not prohibit the billing of complete abdominal ultrasound (CPT 76700) and a complete retroperitoneal ultrasound (CPT 76856) on the same patient on the same day, each of those procedures must be medically necessary in order to bill Medicaid and Medicaid for those procedures.

99. Medicare prices diagnostic imaging procedures in the following three ways: (1) The professional component (PC) represents the physician's interpretation (PC-only services are billed with the 26 modifier); (2) The technical component (TC) represents practice expense and

includes clinical staff, supplies, and equipment (TC-only services are billed with the TC modifier); and (3) The global service represents both PC and TC.

100. In December 2005, Medicare issued new rules entitled "Multiple Procedure Reduction of the Technical Component of Certain Diagnostic Imaging Procedures," (hereafter the "MPR Rules").

101. Pursuant to the MPR Rules, effective January 1, 2006, CMS implemented a multiple procedure payment reduction of certain diagnostic imaging procedures, including, but not limited to the complete abdominal ultrasound (CPT Code 76700) and a complete retroperitoneal ultrasound (CPT Code 76700).

102. For 2006, CMS made full payment of the highest price procedure and payment at seventy-five (75) percent for each additional procedure, when performed during the same session on the same day.

103. For 2007, CMS made full payment of the highest price procedure and payment at fifty (50) percent for each additional procedure, when performed during the same session on the same day.

104. The payment reduction set forth by CMS in the MPR applies only to Technical Services and the Technical Services portion of global services. The payment reduction in the MPR does not apply to Professional Component services.

105. The TC payment reduction in the MPR does not apply when the provider reports a 59 modifier to indicate that the procedures were performed in different sessions.

106. In explaining the reasons for the TC reductions in the MPR, CMS stated, in the Federal Register on November , 2005, its belief that "when multiple images are taken in a single session, most of the clinical labor activities and most supplies are not performed or furnished twice."

ii. Abdominal Complete and Retroperitoneal Ultrasounds Are Rarely Medically Necessary on the Same Patient on the Same Day

107. The medical community has recognized that performing both complete abdominal ultrasound (CPT 76700) and a complete retroperitoneal ultrasound (CPT 76856) on the same patient on the same day will only rarely be medically necessary.

108. In January of 2006, the American College of Radiology ("ACR") instructed its more than 32,000 members that billing for both a complete abdominal ultrasound (76700) and a complete retroperitoneal ultrasound (76700) for the same patient on the same day is considered unusual, and this should only be done when the prescribing physician documents the circumstances of medical necessity. January 2006 ACR Bulletin (Volume 61, Issue 1).

109. In addition to industry guidance, Medicare Carriers from across the United States have also recognized that providers should rarely bill for both for both a complete abdominal ultrasound (76700) and a complete retroperitoneal ultrasound (76700) for the same patient on the same day.

110. Palmetto GBA, for example, issued a Local Carrier Determination ("LCD") in 2008 for California, Nevada, Hawaii, Guam, American Samoa, and the Northern Mariana Islands, which instructed that: "Although CPT codes 76700 (abdominal) and 76770 (retroperitoneal) are not mutually exclusive procedures, it would be unusual to have claims for both codes on the same day for an individual beneficiary. Therefore, only one of the codes will

be paid unless documentation is forwarded indicating medical necessity of both studies."

iii. Doshi Routinely, Illegally Bills for Abdominal Complete and Retroperitoneal Ultrasounds on the Same Patient on the Same Day

111. In contrast to industry guidance and practice, Doshi has, since at least July of 2006, routinely, illegally billed Medicare and Medicaid for complete abdominal ultrasounds (CPT Code 76700) and retroperitoneal ultrasounds (CPT Code 76770) on the same patient on the same day, when both diagnostic imaging procedures were not medically necessary.

112. Relator personally observed, during his tenure as Defendant's Associate Medical Director, that Doshi routinely performed and billed for both complete abdominal ultrasounds (CPT Code 76700) and retroperitoneal ultrasounds (CPT Code 76770) on the same patient on the same day, when both diagnostic imaging procedures were not medically necessary.

113. Doshi, in furtherance of its scheme, knowingly designed its physician referral forms to enable it to systematically and illegally bill Medicare and Medicaid for complete abdominal ultrasounds (CPT Code 76700) and retroperitoneal ultrasounds (CPT Code 76770) on the same patient on the same day, when both diagnostic imaging procedures were not medically necessary.

Dohi's 2003 Referral Form

114. In approximately 2003, Doshi began offering to physicians a pre-printed referral form that Doshi had created.

115. Physicians can use the Doshi pre-printed referral form, in lieu of the physician's own prescription pad, to order diagnostic imaging procedures for their patients.

116. Doshi's 2003 referral form for its facilities in New York and New Jersey ("2003

Referral Form") contained, under the category "Sonography," a single check box for "Abdomen/Retroperitoneum."

117. By using a single check box for "Abdomen/Retroperitoneum" in the 2003 Referral Form, Doshi was intentionally bundling multiple, distinct diagnostic imaging procedures, namely complete abdominal ultrasounds (CPT Code 76700) and retroperitoneal ultrasounds (CPT Code 76770).

118. When a referring physician referred a patient using Doshi's 2003 Referral Form, for either an complete abdominal ultrasounds (CPT Code 76700) or retroperitoneal ultrasounds (CPT Code 76770), they would either have to check the single box for "Abdomen/Retroperitoneum," or they would have to manually handwrite separate instructions somewhere else on the form.

119. When a referring physician checked the single box on the 2003 Referral Form for "Abdomen/Retroperitoneum," Doshi would, perform ultrasound scans of the patient's abdominal region and would submit bills for both a complete abdominal ultrasound (CPT Code 76700) and a retroperitoneal ultrasound (CPT Code 76770) to the patient's insurer, including Medicare and Medicaid.

120. Doshi, upon information and belief, would routinely bill Medicare and Medicaid for both a complete abdominal ultrasound (CPT Code 76700) and a complete retroperitoneal ultrasound (CPT Code 76770) when the ultrasound images that were actually taken by Dohi failed to meet the required elements set forth in the CPT Code for billing both procedures, including, but not limited to, medical necessity.

121. Doshi, upon information and belief, designed the 2003 Referral Form with the understanding and intent that most physicians would, and did in fact, check the single box for

"Abdomen/Retroperitoneum," when they were ordering only an complete abdominal ultrasound (CPT Code 76700) or retroperitoneal ultrasound (CPT Code 76770).

Doshi's 2006 Referral Form

122. In approximately May of 2006, Doshi revised its pre-printed referral forms for its New York and New Jersey facilities ("2006 Referral Form").

123. Doshi's 2006 Referral Form for its facilities in New York and New Jersey contained, under the category "Sonography," a single check box for "Abdomen/Retroperitoneum [with] Doppler."

124. By using a single check box in the 2006 Referral Form for "Abdomen/Retroperitoneum [with] Doppler," Doshi was bundling multiple, distinct diagnostic imaging procedures, namely complete abdominal ultrasounds (CPT Code 76700), retroperitoneal ultrasounds (CPT Code 76770), and color Doppler (CPT code 93976).

125. When a physician referred a patient to Doshi, using the 2006 Referral Form, for either an complete abdominal ultrasounds (CPT Code 76700) or retroperitoneal ultrasounds (CPT Code 76770), they would either have to check the single box for "Abdomen/Retroperitoneum [with] Doppler," or they would have to manually handwrite separate instructions somewhere else on the form.

126. When a referring physician checked the single box on the 2006 Referral Form for "Abdomen/Retroperitoneum [with] Doppler," Doshi would, perform ultrasound and color Doppler scans of the patient's abdominal region and would submit bills for both an complete abdominal ultrasound (CPT Code 76700), a retroperitoneal ultrasound (CPT Code 76770) and a color Doppler (CPT code 93976) to the patient's insurer, including Medicare and Medicaid.

127. Doshi, upon information and belief, would routinely bill Medicare and Medicaid

for both an complete abdominal ultrasound (CPT Code 76700) and a retroperitoneal ultrasound (CPT Code 76770) when the ultrasound images that were actually taken by Dohi failed to meet the required elements set forth in the CPT Code for billing both procedures.

128. Unless the referring physicians manually crossed-out the word "Doppler" on the single check box for the "Abdomen/Retroperitoneum" ultrasounds, Doshi would routinely add color Doppler and would submit bills for those services to the patient's insurer, including Medicare and Medicaid.

129. Doshi designed the 2006 Referral Form with the understanding and intent that most physicians would, and did in fact, check the single box for "Abdomen/Retroperitoneum [with] Doppler," when they were ordering only an complete abdominal ultrasound (CPT Code 76700) or retroperitoneal ultrasound (CPT Code 76770).

130. Doshi designed the 2006 Referral Form with the understanding and intent that most physicians would, and did in fact, fail to manually cross-out the word "Doppler" on the single check box for the "Abdomen/Retroperitoneum" ultrasounds, even when the referring physician did not believe that color Doppler was medically necessary.

Doshi's 2008 Referral Form

131. In approximately November of 2008, Doshi revised its pre-printed referral forms for its New York and New Jersey facilities ("2008 Referral Form").

132. Doshi's 2008 Referral Form for its facilities in New York and New Jersey contained, under the category "Sonography," a single check box for "Abdomen/Retroperitoneum [with] Doppler." In addition, next to the single check box for "Abdomen/Retroperitoneum [with] Doppler," Doshi's 2008 Referral Form lists CPT Codes "76700+76770+93976."

133. By using a single check box in the 2008 Referral Form for

"Abdomen/Retroperitoneum [with] Doppler," Doshi was bundling multiple, distinct diagnostic imaging procedures, namely complete abdominal ultrasounds (CPT Code 76700), retroperitoneal ultrasounds (CPT Code 76770), and color Doppler (CPT code 93976).

134. Like the 2006 Referral Form, Doshi designed the 2006 Referral Form with the understanding and intent that most physicians would, and did in fact, check the single box for "Abdomen/Retroperitoneum [with] Doppler," when they were ordering only an complete abdominal ultrasound (CPT Code 76700) or retroperitoneal ultrasound (CPT Code 76770).

135. Like the 2006 Referral Form, Doshi designed the 2008 Referral Form with the understanding and intent that most physicians would, and did in fact, fail to manually cross-out the word "Doppler" on the single check box for the "Abdomen/Retroperitoneum" ultrasounds, even when the referring physician did not believe that color Doppler was medically necessary.

136. Doshi knowingly and intentionally used its 2003, 2006 and 2008 Referral Forms as a means to fabricate documentation to support its systematic, illegal scheme to submit false claims to Medicare and Medicaid for complete abdominal ultrasounds (CPT Code 76700), retroperitoneal ultrasounds (CPT Code 76770), and color Doppler (CPT code 93976), that were not medically necessary.

iv. Doshi Routinely, Illegally Bills for Abdominal Complete and Retroperitoneal Ultrasounds on the Same Patient on the Same Day in its New York Facilities

137. During the period of time between November 15, 2007 and March 15, 2008, Doshi sent patient files from its New York facilities to Relator for review.

138. Relator reviewed the files of the following patients from Doshi's New York practices, in which CPT codes 76700 and 76770 were billed on the same day without explanation or justification:

PATIENT'S INITIALS	DATE OF SERVICE	INSURANCE PLAN
C.L.	March 5, 2008	Medicare (Empire) Brooklyn
P.S.	March 4, 2008	Medicare (Empire) Brooklyn
Y.M.	February 27, 2008	Aetna
P.M.	March 5, 2008	Computer Sci. Co.
A.M.	March 5, 2008	Americhoice/Medicaid
L.L.	March 5, 2008	Computer Sci. Co.
T.B.	March 2, 2008	Health Plus
F.G.	March 6, 2008	Computer Sci. Co./Medicare
V.T.	March 7, 2008	1199
G.B.	March 7, 2008	1199
A.M.	March 6, 2008	Metro Plus
M.N.	March 7, 2008	Carecore/HIP of NY
M.R.	March 7, 2008	(unknown)
B.M.	March 7, 2008	(unknown)
S.P.	March 7, 2008	Computer Sci. Co./Americhoice
Y.R.	March 1, 2008	United Healthcare
M.M.	March 1, 2008	Carecore/HIP of NY
V.C.	March 6, 2008	(unknown)
E.S.	March 6, 2008	(unknown)
Y.L.	March 1, 2008	Carecore/Oxford
J.G.	February 18, 2008	(unknown)
B.G.	February 18, 2008	(unknown)
B.A.	March 1, 2008	Empire BCBS
K.B.	March 1, 2008	Medfocus 1199 National B
I.A.	March 1, 2008	Oxford
M.A.	March 1, 2008	HCPIPA
C.G.	March 1, 2008	Healthnet
T.A.	March 1, 2008	(unknown)
I.H.	February 20, 2008	(unknown)

139. Relator is also in possession of internal billing sheets of 64 other patients of Doshi facilities in New York, for whom CPT codes 76700 and 76770 were billed on the same day during the period of time between November 15, 2007 and March 15, 2008. However, for those additional 64 patients, Relator is not currently in possession of the corresponding scans.

140. Of the 129 complete abdominal ultrasounds performed by Doshi at it New York facilities reviewed by Relator, a complete retroperitoneal ultrasounds were simultaneously billed 93 times.

141. In none of these 93 cases where Doshi billed for both abdominal complete and retroperitoneal ultrasounds on the same patient on the same day were both scans medically necessary.

142. Defendant knew, or acted in reckless disregard, of the fact that it was ineligible to receive payment from federal and/or state-funded programs for billing for complete abdominal ultrasounds (CPT Code 76700) and retroperitoneal ultrasounds (CPT Code 76770) that were not medically necessary.

143. Each of the foregoing instances of billing Medicare and/or Medicaid for complete abdominal ultrasounds (CPT Code 76700) and retroperitoneal ultrasounds (CPT Code 76770) that were not medically necessary constitutes a false claim for payment in violation of the FCA and the NYFCA.

144. The 93 cases from Doshi's New York facilities identified herein are examples of Doshi's systemic, illegal practice of billing for complete abdominal ultrasounds (CPT Code 76700) and retroperitoneal ultrasounds (CPT Code 76770) that were not medically necessary.

v. Doshi Routinely, Illegally Bills for Abdominal Complete and Retroperitoneal Ultrasounds on the Same Patient on the Same Day in its New Jersey Facilities

145. In the course of Relator's employment with Doshi, and specifically in his role as Associate Medical Director, Relator was routinely in contact with personnel at Doshi's New Jersey locations.

146. Relator reviewed productivity reports, as well as patient files, from these

locations, and he visited most, if not all, of Doshi's New Jersey locations multiple times.

147. Upon information and belief, Doshi's New Jersey facilities followed the same pattern and practice of systematically and illegally billing Medicare and Medicaid for complete abdominal ultrasounds (CPT Code 76700), retroperitoneal ultrasounds (CPT Code 76770), and color Doppler (CPT code 93976), that were not medically necessary.

148. Defendant knew, or acted in reckless disregard, of the fact that it was ineligible to receive payment from federal and/or state-funded programs for billing for complete abdominal ultrasounds (CPT Code 76700) and retroperitoneal ultrasounds (CPT Code 76770) that were not medically necessary.

149. Each of the foregoing instances of billing Medicare and/or Medicaid for complete abdominal ultrasounds (CPT Code 76700) and retroperitoneal ultrasounds (CPT Code 76770) that were not medically necessary constitutes a false claim for payment in violation of the FCA and the NJFCA.

b. Doshi Illegally Billed for Medically Unnecessary Doppler Studies

150. Doshi has, since at least 2007, knowingly, systematically, and illegally billed for a color Doppler studies (CPT Code 97936) when those procedures were not medically necessary.

151. Color Doppler vascular studies (CPT 93976) are performed simultaneously with other ultrasound studies, such as abdominal ultrasounds. The study displays the flow of blood within the organs and systems of the body, and is of limited usefulness in the vast majority of these examinations.

ii. Medicare/Medicaid Rules for Billing for Color Doppler Procedures

152. In approximately January of 2006, CMS implemented the National Correct

Coding Initiative ("NCCI") to promote national correct coding methodologies for the Medicare program and to control improper coding leading to inappropriate payment in Part B claims.

153. According to CMS, the purpose of the NCCI is to prevent improper payment when incorrect code combinations are reported.

154. The NCCI contains two tables of edits. The "Column One / Column Two Correct Coding Edits Table" and the "Mutually Exclusive Edits Table" include code pairs that should not reported together for the same patient on the same day of service.

155. The NCCI pairs together a number of CPT Codes related to diagnostic imaging and color Doppler procedure, including but not limited to:

- Abdominal Complete Ultrasound (CPT 76700) & Color Doppler (CPT 93976)
- Retroperitoneal Ultrasound (CPT 76770) & Color Doppler (CPT 93976)
- Female Pelvis Ultrasound (CPT 76856) & Color Doppler (CPT 93976)

156. Many of the ultrasound CPT codes paired together by the NCCI can still be reported together by using an NCCI Associated CPT Modifier to identify a "separate and distinct procedural service."

157. According to the NCCI Policy Manual, "Abdominal ultrasound examinations (CPT codes 76700-76775) and abdominal duplex examinations (CPT codes 93975, 93976) are generally performed for different clinical scenarios although there are some instances where both types of procedures are medically reasonable and necessary. In the latter case, the abdominal ultrasound procedure CPT code should be reported with an NCCI-associated modifier." NCCI Policy Manual, Chapter 9, Section H.11.

158. If an approved NCCI Associated CPT Modifier (which consists of two alphanumeric characters, for example the "59" Modifier) is not used, one of the paired CPT

codes will be rejected for payment by Medicare.

159. The NCCI Policy Manual provides that "Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI edit if the clinical circumstances do not justify its use. If the Medicare program imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI edit if the Medicare restrictions are fulfilled." NCCI Policy Manual, Chapter 1, Section E.1.

160. NCCI Associated Modifiers are not permitted to be used unless there are valid indications and medical necessity for performing both an imaging exam and a separate exam to evaluate blood flow. Documentation of the valid indications and medical necessity for both procedures must be maintained in the patient's medical record.

161. In addition to the NCCI's requirements, a diagnostic imaging center in the nonhospital setting, including Doshi, must receive an order from the referring physician for both a diagnostic imaging procedure and a color Doppler in order to bill Medicare and/or Medicaid for those procedures.

ii. Doshi Routinely, Illegally Bills for Medically Unnecessary Doppler Studies

162. Doshi's 2006 Referral Form for its facilities in New York and New Jersey contained, under the category "Sonography," a single check box for "Abdomen/Retroperitoneum [with] Doppler."

163. Doshi's 2006 Referral Form for its facilities in New York and New Jersey also contained, under the category "Sonography," a single check box for "Female Pelvis/Transabdomen/Transvaginal [with] Doppler."

164. Doshi's 2008 Referral Form for its facilities in New York and New Jersey

contained, under the category "Sonography," a single check box for "Abdomen/Retroperitoneum [with] Doppler." In addition, next to the single check box for "Abdomen/Retroperitoneum [with] Doppler," Doshi's 2008 Referral Form lists CPT Codes "76700+76770+93976."

165. Doshi's 2008 Referral Form for its facilities in New York and New Jersey contained, under the category "Sonography," a single check box for "Female Pelvis/Transabdomen/Transvaginal [with] Doppler." In addition, next to the single check box for "Female Pelvis/Transabdomen/Transvaginal [with] Doppler," Doshi's 2008 Referral Form lists CPT Codes "76856+76830+93976."

166. Unless the referring physicians manually crossed-out the word "Doppler" on the single check box for the "Abdomen/Retroperitoneum" ultrasounds on the 2006 and 2008 Referral Forms, Doshi would routinely add color Doppler and would submit bills for those services to the patient's insurer, including Medicare and Medicaid.

167. Unless the referring physicians manually crossed-out the word "Doppler" on the single check box for the ""Female Pelvis/Transabdomen/Transvaginal" ultrasounds, Doshi would routinely add color Doppler and would submit bills for those services to the patient's insurer, including Medicare and Medicaid.

168. Doshi designed the 2006 and 2008 Referral Forms with the understanding and intent that most physicians would, and did in fact, fail to manually cross-out the word "Doppler" on the single check box for the "Abdomen/Retroperitoneum" ultrasounds, even when the referring physician did not believe that color Doppler was medically necessary.

169. Doshi designed the 2006 and 2008 Referral Forms with the understanding and intent that most physicians would, and did in fact, fail to manually cross-out the word "Doppler" on the single check box for the "Female Pelvis/Transabdomen/Transvaginal" ultrasounds, even

when the referring physician did not believe that color Doppler was medically necessary.

170. In a further effort to manufacture documentation supporting these medically unnecessary color Doppler procedures, Doshi instructed its technicians to complete a short form during the course of performing the color Doppler procedure. This form included a checklist of conditions that would allegedly justify color Doppler, including: Fatty Liver, Abnormal Liver Function, Abnormal Liver Size, Abnormal Kidney Function, Abnormal Kidney Size, Enlarged Pancreas, Portal Hypertension, Splenomegaly, Mass.

171. Doshi technicians, none of whom were physicians, were not in a position to properly diagnose the medical conditions listed on the Doshi Doppler form, nor was this form sufficient to establish that Doshi's routine billing for color Doppler procedures was medically necessary.

172. Relator has reviewed numerous scans onto which color Doppler was added, and in most, if not all, of the cases, the conditions checked on the Doshi Doppler form to justify the procedure were not present in the patients' scans.

173. Defendant attached these forms to patients' files for the sole purpose of fabricating documentation to support its systematic submission of false claims to Medicare and Medicaid for medically unnecessary color Doppler procedures.

174. In a further effort to manufacture documentation supporting these medically unnecessary color Doppler procedures, Doshi, upon information and belief, repeatedly directed its employees, in particular medical records transcribers, to alter the reports of Doshi's radiologists by adding fabricated information indicating that the radiologist had found the color Doppler procedures medically necessary to their interpretation of the patient's diagnostic images.

iii. Doshi Performed and Billed for Medically Unnecessary Doppler Studies in New York

175. Doshi illegally and systematically performed and billed for medically unnecessary Doppler studies in New York.

176. Relator reviewed files of patients who underwent studies at Doshi's New York facilities from November 15, 2007 through March 15, 2008.

177. Color Doppler was performed on each of the patients listed above in paragraph 138.

178. Although color Doppler is listed on the internal billing sheets for these patients, the files contain no request, prescription, or other authorization for this added procedure.

179. There is no medical reason why Doshi would add color Doppler to these studies; the procedure adds no diagnostic or therapeutic benefit to these studies or to the patients on whom they were performed.

180. In addition to the 29 patients listed in paragraph 138, Relator reviewed 182 additional New York patient files in which color Doppler was unnecessarily added.

181. Defendant knew, or acted in reckless disregard, of the fact that it was ineligible to receive payment from federal and/or state-funded programs for billing for color Doppler procedures (CPT Code 93976) that were not medically necessary.

182. Each of the foregoing instances of billing Medicare and/or Medicaid for color Doppler procedures (CPT Code 93976) that were not medically necessary constitutes a false claim for payment in violation of the FCA and the NYFCA.

183. The 211 cases from Doshi's New York facilities identified herein are examples of Doshi's systemic, illegal practice of billing for color Doppler procedures (CPT Code 93976) that were not medically necessary.

iv. Doshi Performed and Billed for Medically Unnecessary Doppler Studies in New Jersey

184. Doshi illegally and systematically performed and billed for medically unnecessary color Doppler studies in New Jersey.

185. Of the New Jersey patient files Relator reviewed from November 15, 2007 through March 15, 2008 for Doshi, Relator discovered color Doppler imaging added to 5 New Jersey patient files without medical necessity or prescription.

186. There is no medical reason why Doshi would add color Doppler to these studies; the procedure adds no diagnostic or therapeutic benefit to these studies or to the patients on whom they were performed.

187. Defendant knew, or acted in reckless disregard, of the fact that it was ineligible to receive payment from federal and/or state-funded programs for billing for color Doppler procedures (CPT Code 93976) that were not medically necessary.

188. Each of the foregoing instances of billing Medicare and/or Medicaid for color Doppler procedures (CPT Code 93976) that were not medically necessary constitutes a false claim for payment in violation of the FCA and the NYFCA.

189. The 5 cases from Doshi's New Jersey facilities identified herein are examples of Doshi's systemic, illegal practice of billing for color Doppler procedures (CPT Code 93976) that were not medically necessary.

c. Doshi Performed and Billed for Medically Unnecessary Multiplanar Reconstruction

190. Doshi has, since at least 2007, knowingly, systematically, and illegally billed for 3D Multiplanar Reconstruction studies (CPT Code 76376) when those procedures were not medically necessary.

iii. Medicare/Medicaid Rules for Billing for Multiplanar Reconstruction Procedures

191. Multiplanar reconstruction of radiological studies, also known as "3D reconstruction," provides for the automated reformatting of two-dimensional images into three-dimensional images.

192. For many radiological procedures, the review of images in alternative display formats is contemplated in the definition of the CPT code for the imaging procedure being performed.

193. For selected imaging procedures, however, the CPT coding system generally provides for separate coding for image reformatting when such reformatting entails complex 3D reconstruction of the original image.

194. The American Medical Association announced, effective January 1, 2006, that 3D rendering is to be reported using two new CPT Codes, 76376 and 76377.

195. CPT Codes for 3D rendering services differentiate between those studies in which reformatting is performed on the acquisition scanner (CPT 76376) and those performed on an independent workstation (CPT 76377).

196. Both of the 3D codes (CPT 76376 and CPT 76377) require concurrent supervision of image post-processing.

197. For 3D reconstructions not requiring image post-processing on an independent workstation (CPT 76376), the physician will discuss with the technologist the need for 3D imaging and supervise the technologist in creating the 3D images.

198. 3D reconstructions, under CPT Code 76376 and CPT Code 76377, must be supported by medically necessary in order to bill those services to Medicare or Medicaid.

199. Medicare Carriers, for example Palmetto GBA, have recognized that 3D

Multiplanar Reconstruction is not routinely necessary.

200. CPT Codes 76376 and 76377 may be considered medically unnecessary and denied by Medicare if equivalent information to be obtained from the 3D Multiplanar Reconstruction has already been provided by another procedure (magnetic resonance imaging, ultrasound, angiography, etc.) or could be provided by a standard CT scan (two-dimensional) without reconstruction.

201. The American College of Radiology advised its members, in or around January of 2006, that when providing 3D rendering services, particularly in the outpatient setting, a specific order is helpful in establishing medical necessity.

202. Medicare Carriers, for example Palmetto GBA, advise that "Medicare expects that the referring physician generate a written request indicating the clinical need for the add on 3-D imaging; that a copy of that request be maintained by the interpreting physician and the interpreting physician's report address those specific clinical issues." LCD Number L28229.

203. Moreover, "a radiologist may order 3D imaging only when it is clearly essential to interpret a case at hand and answer questions with clear clinical impact and necessity. Otherwise the national CMS restrictions on ordering tests by 'testing' rather than 'treating' physicians are very strict." LCD Number L28229.

ii. Doshi Routinely, Illegally Bills for Medically Unnecessary Multiplanar Reconstruction Studies

204. Doshi's 2006 and 2008 Referral Forms for its facilities in New York and New Jersey contained, under the category "CT Scan" contained check boxes for 14 different types of CT Scans. For each one of these 14 types of CT Scans listed on the 2006 and 2008 Referral Forms, Doshi automatically included a Multiplanar Reconstruction (CPT Code 76376).

205. For example, Doshi's 2006 and 2008 Referral Forms, under the category "CT

Scan," contain a check box for "Pelvis w/3D." In addition, next to the single check box for "Pelvis w/3D," Doshi's 2006 and 2008 Referral Forms list CPT Codes "72194+76376."

206. Unless the referring physicians manually crossed-out the word "w/3D" on the check box for the "Pelvis" or other CT Scan on the 2006 and 2008 Referral Forms, Doshi would routinely add 3D Multiplanar Reconstruction (CPT Code 76376) and would submit bills for those services to the patient's insurer, including Medicare and Medicaid.

207. Doshi, upon information and belief, designed the 2006 and 2008 Referral Forms with the understanding and intent that most physicians would, and did in fact, fail to manually cross-out the word "w/3D" on the check box for the 14 CT Scans, even when the referring physician did not believe that 3D Multiplanar Reconstruction was medically necessary.

208. Upon Relator's information and belief, Defendant trained and instructed its technicians to perform multiplanar reconstruction prior to the instruction of the reviewing radiologist.

209. On many occasions, Relator reviewed studies of patient performed by Doshi technicians that included multiplanar reconstruction even though Relator, as the reviewing radiologist, never requested it.

210. On many occasions, Relator reviewed studies of patient performed by Doshi technicians that included multiplanar reconstruction that were not medically necessary.

i. Doshi Performed and Billed for Medically Unnecessary Multiplanar Reconstruction in New Jersey

211. Doshi illegally and systematically performed and billed for medically unnecessary multiplanar reconstruction in New Jersey.

212. Relator reviewed files of patients that underwent studies at Doshi's New Jersey locations from November 15, 2007 through March 15, 2008.

213. Relator discovered multiplanar reconstruction added to the following 74 New Jersey patient files without medical necessity or prescription:

PATIENTS INITIALS	DATE OF SERVICE	INSURANCE PLAN
R.S.	December 3, 2007	Unknown
D.B.	February 22, 2008	Horizon BCBS NJ
R.W.	March 10, 2008	Unknown
F.R.	March 3, 2008	MC/AARP
R.M.	February 19, 2008	BCBS
M.E.	February 20, 2008	Horizon BCBS NJ
M.B.	February 22, 2008	Americhoice
C.T.	January 3, 2008	Raytel
P.C.	January 3, 2008	N.J Health
R.W.	December 10, 2007	Medicare Part B
L.P	December 10, 2007	Horizon HMO
A.S.	February 29, 2008	Horizon BCBS NJ
D.I.	January 9, 2008	Medicare Part B
J.G.	January 14, 2008	Healthnet
N.N.	January 11, 2008	Horizon NJ Health
G.R.	January 11, 1008	Horizon BCBS NJ
D.D.	January 15, 2008	BC PPO
B.R.	January 15, 2008	Horizon NJ BCBS
N.C.	January 18, 2008	Medicare Part B/AARP
A.A.	January 17, 2008	Aetna HMO
L.G.	January 21, 2008	Horizon BCBS NJ
R.F.	January 25, 2008	Horizon in state National Carecore
J.V.	January 25, 2008	Healthnet Medicaid
E.N.	January 25, 2008	Medicare Part B/Aetna
M.B.	January 25, 2008	Horizon BCBS NJ
U.G.	January 31, 2008	Unknown
D.O.	February 4 2008	Medicare Part B United HC
J.B.	February 4, 2008	Medicare part B/ United AARP
M.R.	February 4, 2008	Medicare/BCBS
J.S.	February 4, 2008	GHI
N.B.	February 11, 2008	BCBS
J.R.	February 11, 2008	Medicare
W.M.	February 11, 1008	Aetna/Carecore
D.L.	February 11, 2008	BCBS
F.C.	February 15, 2008	Atena/Carecore
C.A.	February 18, 2008	Horizon

T.H.	February 18, 2008	Horizon
L.P.	February 18, 2008	Aetna HMO
L.D.	February 19, 2008	Medicare Part B./Horizon Medigap
P.M.	February 19, 2008	Healthnet/Carecore
M.N.	February 19, 2008	Medicare Part B/Horizon
J.R.	February 25, 2008	Horizon BCBS NJ
L.M.	February 25, 2008	NJP
E.M.	February 25, 2008	Medicaid/Medicare
V.K.	February 25, 2008	Medicare/Horizon Medigroup
P.S.	February 25, 2008	Horizon BCBS NJ;Medicare
C.G.	February 27, 2008	Aetna HMO
R.S.	February 27, 2008	Medicare Part B
D.M.	February 27, 2008	CIGNA
J.B.	February 27, 2008	Healthnet/Carecore
S.C.	March 10, 2008	Horizon BCBS NJ
G.S.	March 10, 2008	BCBS PPO
M.E.	December 7, 2007	Horizon NJ Health
D.S.	December 17, 2007	Medicare/AARP
A.F.	December 18, 2007	Horizon BCBS NJ
M.M.	December 21, 2007	Healthnet
J.A.	December 21, 2007	Medicare/Aetna
E.A.	December 27, 2007	Medicare/Healthnet
T.C.	December 27, 2007	Horizon BCBS NJ
D.A.	January 18, 2008	Busch/NJ Plus
E.J.	December 7, 2007	Medicare
D.D.	January 4, 2008	Aetna M/C PPP
J.H.	January 10, 2008	Medicare Tricare
M.L.	February 14, 2008	Horizon NJ Health
C.M.	February 19, 2008	CIGNA/AIM
D.S.	February 22, 2008	Unknown
C.E.	February 26, 2008	Medicare
A.R.	February 26, 2008	Horizon BCBS NJ
D.S.	December 28, 2007	Great West/Med Solutions
J.K.	December 31, 2007	Medicare/Horizon
F.V.	March 13, 2008	Medicare Part B
D.J.	March 14, 2008	Medicare Part B
M.B.	March 5, 2008	MVA
R.K.	March 5, 2008	Medicare Part B

214. There is no medical reason why Doshi would add this procedure to these patient

studies; the procedure adds no diagnostic or therapeutic benefit to these studies or to the patients on whom they were performed.

215. Defendant knew, or acted in reckless disregard, of the fact that it was ineligible to receive payment from federal and/or state-funded programs for billing for 3D Multiplanar Reconstruction (CPT Code 76376) that were not medically necessary.

216. Each of the foregoing instances of billing Medicare and/or Medicaid for 3D Multiplanar Reconstruction (CPT Code 76376) that were not medically necessary constitutes a false claim for payment in violation of the FCA and the NJFCA.

217. The 74 cases from Doshi's New Jersey facilities identified herein are examples of Doshi's systemic, illegal practice of billing for 3D Multiplanar Reconstruction (CPT Code 76376) that were not medically necessary.

ii. Doshi Performed and Billed for Medically Unnecessary Multiplanar Reconstruction in New York

218. Doshi illegally and systematically performed and billed for medically unnecessary multiplanar reconstruction in New York.

219. Relator reviewed the following 366 patient files from Doshi's New York facilities from November 15, 2007 through March 15, 2008, to which multiplanar reconstruction was added without medical necessity:

PATIENT'S INITIALS	DATE OF SERVICE	INSURANCE PLAN
M.Y.	December 7, 2007	Empire (Medicare)
N.D.	December 7, 2007	Empire (Medicare)
D.S.	November 27, 2007	Unknown
T.D.	November 26, 2007	HIP
J.H.	November 26, 2007	HIP
N.D.	November 27, 2007	Health Plus
A.M.	November 27, 2007	HIP
C.S.	November 27, 2007	HIP (Medicare)
I.S.	November 27, 2007	HIP (Medicare)

J.B.	November 26, 2008	Unknown
J.D.	November 26, 2007	HIP (Medicaid)
L.H.	November 26, 2007	HIP (Medicaid)
S.M.	November 26, 2007	HIP (Medicaid
M.M.	November 26, 2007	Metro Plus
D.P.	November 26, 2007	HIP of NY
L.S.	November 26, 2007	HIP
P.H.	December 6, 2007	HCP
G.J.	December 6, 2007	HIP (Medicare)
A.J.	December 6, 2007	Metro Plus
G.L.	December 6, 2007	Americhoice (Medicaid)
B.L.	December 6, 2007	Healthcare
M.R.	December 8, 2007	PCMS INC
N.B.	December 14, 2007	Health Plus
M.C.	November 28, 2007	HIP Preferred
Y.B.	January 14, 2008	Computer Sci
R.S.	January 14, 2008	Medicare (Empire)
J.B.	January 14, 2008	Medicare
S.O.	January 14, 2008	Affinity Health Plan
A.A.	January 13, 2008	Medicare (Empire)
F.N.	December 18, 2007	Empire BCBS
R.G.	December 18, 2007	Medicare (Empire
S.K.	December 18, 2007	Medicare
M.C.	December 18, 2007	GHI (Medicare)
E.S.	December 18, 2007	Healthcare Partners
V.V.	December 18, 2007	Carecore
L.C.	December 6, 2007	HIP Preferred
F.S.	December 27, 2007	Self Pay
O.P.	December 27, 2007	Health plus
M.B.	December 27, 2007	Empire
S.B.	December 27. 2007	Unknown
M.A.	January 3, 2008	Metro Plus
I.R.	January 3, 2008	Wellcare of New York, Inc
M.J.	January 3, 2008	Medicare
H.T.	December 17, 2007	Empire (Medicare)
Y.K.	December 17, 2007	Unknown
L.D.	December 17, 2007	Unknown
A.S.	December 17, 2007	Computer Science
S.N.	December 17, 2007	Carecore/HIP of New York
T.B.	March 2, 2008	Health Plus
Y.N.	December 6, 2007	Aetna
S.B.	December 6, 2007	Americhoice/Medicaid
M.B.	December 6, 2007	Medicare (Empire)

P.M.	December 12, 2007	Computer Science
M.R.	January 12, 2008	Empire H. Choice
R.L.	January 12, 2008	Empire H. Choice (Out of State)
L.B.	February 29, 2008	Computer Science Co.
M.M.	February 18, 2008	Medfocus 1199 National B
S.S.	February 18, 2008	Medicare Empire
O.T.	February 18, 2008	Health Plus
Q.L.	February 18, 2008	Medicare (Empire)
R.X.	February 16, 2008	Unknown
A.B.	February 16, 2008	Americhoice/Medicaid
E.S.	February 18, 2008	Medicare (Empire)
E.K.	February 14, 2008	Computer Science
R.L.	February 17, 2008	Computer Science
F.F.	December 21, 2007	Touchstone
T.Z	December 21, 2007	Medicare (Empire)
V.H.	February 23. 2008	NY Pres Community H. Plan
B.B.	February 27, 2008	Americhoice/Medicaid
R. S.	February 27, 2008	WellCare MCD, CHP FHP- Brn
Y.R.	February 27, 2008	Medicare (Empire)
V.S.	February 27, 2008	Unknown
K.M.	February 29, 2008	Health plus
D.P.	December 17, 2007	Empire H. Choice
Y.M.	December 7, 2007	Medicare (Empire
C.B.	December 27, 2007	Unknown
H.K.	December 27, 2007	NY Press Community Health plan
N.M.	December 27, 2007	Affinity H. Plan
L.B.	December 27, 2007	Health plus
M.H.	December 27, 2007	Computer Science
W.J.	December 7, 2007	Computer Science
R.P.	December 7, 2007	Medicare (Empire)
G.N.	December 7, 2007	Americhoice/Medicaid
O.I.	December 8, 2007	Americhoice/Medicaid
K.B.	December 8, 20097	Unknown
F.A.	December 8, 2007	Health Plus
V.S.	December 8, 2007	Medicare
F.P.	December 8, 2007	Magnacare HMO
S.J.	January 30, 2008	Metro plus
G.O.	January 30, 2008	Empire H.Choice
V.L.	January 30, 2008	Self pay
V.K.	January 30, 2008	Hartford

S.S.	January 30, 2008	Medicare (Empire)
M.V.	January 30, 2008	Medicare (Empire)
I.G.	January 30, 2008	Medicare (Empire)
V.B.	December 15, 2007	Medicare (Empire)
A.B.	December 15, 2007	Americhoice/Medicaid
N.A.	December 15, 2007	Computer Science
M.B.	February 2, 2008	Unknown
S.A.	February 2, 2008	Americhoice/Medicaid
A.B.	February 2, 2008	Health Plus
F.G.	January 30, 2008	Medicare (Empire)
V.V.	December 28, 2007	Health Plus
B.O.	February 29, 2008	Americhoice
A.P.	December 10, 2007	Medicare (Empire)
A.L.	December 10, 2007	Health first
R.E.	December 9, 2007	Metro Plus
L.B.	December 9, 2007	Aetna
T.S.	December 9, 2007	Wellcare of N.Y., Inc.
S.A.	December 10, 2007	Metro plus
A.B.	December 10, 2007	Computer Science Americhoice
H.H.	March 7, 2008	Wellcare
N.K.	March 7, 2008	Metro Plus
Y.Y.	December 14, 2007	Carecore
M.P.	December 21, 2007	Americhoice Medicaid
F.F.	December 14, 2007	Medicare
N.B.	December 14, 2007	Medicaid
R.C.	December 14, 2007	Unknown
C.S.	December 14, 2007	Wellcare of N.Y., Inc.
A.E.	December 14, 2007	Medicare (Empire)
O.D.	December 14, 2007	Medicare (Empire)
R.S.	January 10, 2008	Medicare (Empire)
K.N.	January 10, 2009	Amerigroup/Medicaid
M.N.	January 10, 2008	Americhoice/Medicaid
R.V.	January 10, 2008	Americhoice/Medicaid
Y.S.	January 10, 2008	BCBS
G.M.	January 10, 2008	Computer Science
A.R.	December 26, 2007	Computer Science
A.D.	December 26, 2007	Wellcare
B.F.	December 26, 2007	Unknown
R.L.	December 12, 2007	Empire Medi Blue Plan
R.I.	December 13, 2007	Unknown
T.K.	December 13, 2007	None Listed
M.O.	December 13, 2007	Medicare (Empire)
P.N.	December 30, 2007	Wellcare of NY, Inc.
G.S.	December 31, 2007	Americhoice/Medicaid

A.K.	December 18, 2007	Computer Science
L.N.	December 18, 2007	Carecore
M.S.	December 18, 2007	Computer Science
A.F.	December 18, 2007	Wellcare of NY, Inc.
B.R.	January 31, 2008	Medicare (Empire
Y.M.	January 31, 2008	Unknown
N.H.	January 31, 2008	Medicare (Empire)
B.V.	January 31, 2008	Unknown
M.M.	January 31, 2008	Unknown
J.D.	December 21, 2007	HIP
T.M.	December 19, 2007	Americhoice/Medicaid
S.G.	December 19, 2007	Medicare (Empire)
J.Z.	December 19, 2007	Affinity
N.F.	December 19, 2007	Wellcare of NY, Inc.
D.O.	December 13, 2007	Health Plus
Y.S.	December 11, 2007	Carecore
V.S.	December 11,2007	Medicare
Y.B.	February 14, 2008	Medicare (Empire)
P.A.	February 14, 2008	Health Plus
L.S.	February 14, 2008	Americhoice/Medicaid
I.N.	February 14, 2008	Medicare/(Empire)
S.A.	December 28, 2007	Health plus
A.P.	March 11, 2008	Unknown
R.S.	March 11, 2008	Empire/H.Choice
Y.K.	March 11, 2008	Unknown
S.I.	March 11, 2008	Wellcare
T.K.	March 11, 2008	GHI
R.C.	November 23, 2007	Carecore
B.I.	November 21, 1007	Health Plus
E.K.	November 23, 2007	Aetna
E.K.	November 20, 2007	Affinity
M.M.	November 23, 2007	Americhoice/Medicaid
M.P.	November 23, 2007	HIP Preferred
A.R.	November 23, 2007	Health Plus
L.W.	November 21, 2007	Health First
B.F.	December 28, 2007	Self Pay
S.L.	December 28, 2007	Americhoice/Medicaid
C.G.	December 27, 2007	Empire
R.P.	January 3, 2008	Medicare (Empire)
R.K.	January 3, 2008	Americhoice/Medicaid
L.P.	January 3, 2008	Unknown
A.D.	January 3, 2008	Unknown
V.F.	January 3, 2008	HIP Preferred Health Partners
R.G.	January 13, 2008	Medicare(Empire)

J.N.	January 13, 2008	Computer Science
A.H.	January 12, 2008	Medicare (Empire)
M.B.	December 30, 2007	Wellcare of NY, Inc.
M.B.	November 23, 2007	Empire Plan
P.F.	February 1, 2008	Medicare (Empire)
F.G.	February 1, 2008	Unknown
A.S.	February 4, 2008	Medicaid/Medicare
M.R.	February 4, 2008	Medicare (Empire)
G.I.	February 4, 2008	Unknown
B.S	February 4, 2008	Comprehensive Care Mgmt
M.A.	February 1, 2008	Metro Plus
E.G.	February 1, 2008	Medicare (Empire)
R.G.	February 1, 2008	Medicare (Empire)
R.C.	February 1, 2008	Carecore
O.T.	February 4, 2008	Americhoice/Medicaid
R.E.	February 4, 2008	Aetna
M.E.	February 4, 2008	Unknown
G.S.	February 28, 2008	Magnacare
R.J.	February 28, 2008	Federal Employee Gov't
L.C.	January 9, 2008	Computer Science
K.P.	January 9, 2008	HIP
V.S.	February 29, 2008	
H.T.	February 2,2008	United Healthcare
A.V.	March 7, 2008	Computer Science
S.Z.	March 7, 2008	Unknown
F.M.	March 7, 2008	Americhoice/Medicaid
C.B.	January 31, 2008	United Healthcare
A.W.	January 31, 2008	Wellcare
Z.C	January 31, 2008	Medicaid
J.R.	January 31, 2008	United Healthcare
D.P.	December 27, 2007	BCBS
N.H.	December 29, 2007	Medicare
D.R.	December 29, 2007	Amerigroup
J.R.	December 31, 2007	Aetna
P.D.	December 3, 2007	Medicare
X.Z.	December 3, 2007	PRI
F.A.	December 1, 2007	Carecore
D.S.	December 1, 2007	Metro Plus
A.C.	December 1, 2007	Neighborhood
L.P.	November 30, 2007	GHI
A.C.	December 1, 2007	Empire BCBS
L.C.	December 3, 2007	Health Plus
A.R.	December 6, 2007	Carecore
C.H.	December 12, 2007	HIP

D.A.	December 12, 2007	Carecore
J.J.	December 12, 2007	Aetna
J.V.	December 21, 2007	Health First 65 +
Z.F.	January 11, 2008	Health First
N.L.	January 11, 2008	Affinity
N.K.	January 11, 2008	Metro Plus
Z.Z.	December 14, 2007	Carecore
M.L.	December 18, 2007	HIP
K.K.	January 30, 2008	Amerigroup
M.A.	January 31, 2008	Wellcare
J.M.	January 31 2008	Empire H. Choice
J.P.	January 31, 2008	Health Plus
H.S.	January 31, 1008	Amerigroup
S.M.	January 31, 2008	Empire Plan/UHC Corp.
G.Q.	January 31, 2008	Empire
C.A.	January 31, 2008	Worker's Comp
D.B.	December 17, 2007	HIP
L.M.	January 3, 2008	Aetna
A.R.	January 3, 2008	Carecore
M.W.	January 3, 2008	Carecore
N.N.	January 14, 2008	Medicare
J.L	January 14, 2008	Medicare
K.K.	January 14, 2008	Fidelis
T.J.	January 14, 2008	Medicare
K.R.	January 14, 2008	CIGNA
J.D.	January 14, 2008	Amerigroup
X.X.	November 30, 2007	Wellcare of N.Y., Inc.
H.F.	December 3, 2007	Carecore
H.L.	December 4, 2007	Carecore/Aetna
W.E.	December 4, 2007	PRI
S.L.	December 4, 2007	GHI
J.L.	December 4, 2007	Carecore
B.T.	December 5, 2007	Medicare
D.L.	December 5, 2007	Aetna
M.B.	December 5, 2007	HIP
H.K	December 7, 2007	Health First
R.P.	December 10, 2007	Carecore/Aetna
M.M.	December 10, 2007	United Health
A.S.	December 22, 2007	BCBS
N.R.	December 26, 2007	Fidelis
G.C.	December 26, 2007	Wellcare of NY, Inc.
Y.M.	December 27, 2007	Fidelis
M.A.	November 3. 2007	Carecore
M.W.	December 3, 2007	Healthcare Partner (non Cap)

O.F.	December 5, 2007	HIP
M.W.	December 5, 2007	Magnacare
M.C.	December 6, 2007	Medfocus 1199 Natl. B
M.A.	December 7, 2007	Empire Plan
M.T.	December 12, 2007	Amerigroup
R.G.	December 10, 2007	Wellcare of NY
J.C.	December 14, 2007	Neighborhood
V.F.	December 14, 2007	NY City Law Dept
I.R.	December 17, 2007	Carecore
K.J.	December 17, 2007	Medicare
G.A.	December 19, 2007	MC/Wellcare
S.S.	November 26, 2007	Self pay
F.G.	November 23, 2007	Unknown
S.T.	November 28, 2007	Health First
I.I.	November 28, 2007	Americhoice Medicaid
R.J.	November 24, 2007	Affinity
M.Z.	December 13, 2007	Health First
R.G.	December 13, 2007	Wellcare
R.R.	March 1, 2008	Carecore
J.S.	December 28, 2007	PRI
S.D.	December 28, 2007	Amerigroup
S.K.	December 29,2007	Wellcare of NY
H.F.	December 28, 2007	Healthcare Partners
P.B.	January 12, 2008	Health Plus
J.S.	January 12, 2008	Wellcare
A.B.	January 12, 2008	Self Pay
S.L.	January 28, 2008	Unknown
A.R.	January 31, 2008	Metro Plus
L.H.	January 31, 1008	Wellcare of NY, Inc.
C.R.	February 1, 2008	Metro Plus
J.G.	February 1, 2008	Empire Fed Gov't Employee
D.M.	February 1, 2008	Health First
C.G.	February 1, 2008	Metro Plus
G.C.	February 1, 2008	Unknown
H.L.	February 1, 2008	Aetna
J.D.	February 1, 2008	Health First
F.Y.	December 11, 2007	Americhoice/Medicaid
G.K.	December 12, 2007	Metro Plus
S.F.	December 11, 2007	MC
S.S.	December 11, 2007	Unknown
L.G.	December 3, 2007	Meddows/1199 Home Care
I.S.	December 3, 2007	GHI
S.U.	December 11, 2007	Metro Plus

H.G.	February 2, 2008	Carecore/HIP of NY
S.R.	February 2, 2008	Unknown
R.G.	February 14, 2008	Self Pay
E.N.	January 31, 2008	Unknown
T.B.	January 18, 2008	Elder Plan
H.N.	January 22, 2008	Medicare/Medicaid
K.C.	January 22, 2008	Computer Science
G.S.	January 16, 2008	Empire H. Choice
C.S.	January 25, 2008	PRI
F.C	January 25, 2008	PRI
T.R.	January 25, 2008	Empire H.Choice
S.L.	January 29, 2008	Medicare/Medicaid
Q.B.	January 29, 2008	Wellcare of NY, Inc.
A.V.	January 29, 2008	Unknown
L.M.	January 29, 2008	NY Pres. Community Plan
V.G.	January 30, 2008	Empire H. Choice
D.M.	February 2008	PRI
L.Y.	February 1, 2008	Empire Plan
W.E.	February 8, 2008	PRI
A.M.	February 8, 2008	Empire
E.D.	February 8, 2008	Computer Science Co/PRI Affinity
A.D.	February 8, 2008	PRI
J.P.	February 8, 2008	PRI
C.L.	February 12, 2008	Unknown
F.M.	February 12, 2008	Medfocus 1199 National B
M.A.	February 11, 2008	PRI
D.L.	February 11, 2008	PRI
I.G.	February 13, 2008	Medicare (Empire)
F.P.	February 13 2008	Health First
M.B.	February 7, 2008	PRI
J.D.	February 7, 2008	Unknown
C.J.	February 7, 2008	NY Pres Community Health Plan
C.M.	February 7, 2008	Medicare/Medicaid
I.R.	February 6, 2008	PRI
C.B.	February 18, 2008	Medicare/Medicaid
M.E.	February 15, 2008	Metro Plus
D.F.	February 18, 2008	Metro Plus
X.M.	February 20, 2008	Empire H.Choice
P.V.	February 19, 2008	Empire H.Choice
M.L.	January 15, 2008	Medicaid
I.P.	January 15, 2008	Health First
L.C.	January 15, 2008	Medicaid/Health First

D.O.	January 15, 2008	Medicare (Empire)
E.V.	January 14, 2008	Unknown
A.K.	December 3, 2007	Wellcare
C.A.	December 12, 2008	Worker's Comp
L.R.	February 28, 2008	Self Pay
R.L.	November 26, 2007	Coresource
M.S.	December 6, 2007	Medicare (Empire)
T.K.	February 1, 2008	Americhoice/Medicaid
L.T.	November 27, 2007	Unknown
Y.K.	December 3, 2007	Americhoice/Medicaid
Z.Z.	December 14, 2007	Carecore/HIP of NY

220. There is no medical reason why Doshi would add this procedure to these patient studies; the procedure adds no diagnostic or therapeutic benefit to these studies or the patients on whom they were performed.

221. Defendant knew, or acted in reckless disregard, of the fact that it was ineligible to receive payment from federal and/or state-funded programs for billing for 3D Multiplanar Reconstruction (CPT Code 76376) that were not medically necessary.

222. Each of the foregoing instances of billing Medicare and/or Medicaid for 3D Multiplanar Reconstruction (CPT Code 76376) that were not medically necessary constitutes a false claim for payment in violation of the FCA and the NYFCA.

223. The 366 cases from Doshi's New Jersey facilities identified herein are examples of Doshi's systemic, illegal practice of billing for 3D Multiplanar Reconstruction (CPT Code 76376) that were not medically necessary.

B. Defendant's Ignored Relator's Complaints About Defendant's False and Fraudulent Practices

224. Shortly after joining Doshi in July of 2006, Relator became concerned that Doshi was, as described herein, systematically billing Medicare, Medicaid and other publically funded insurance plans for ultrasound, color Doppler and 3D Multiplanar Reconstruction procedures that were not medically necessary.

225. Relator immediately brought his concerns to the attention of Mark Gelfand, Esquire, in-house counsel for Doshi.

226. Gelfand brought Relator's concerns to Dr. Lena Doshi founder of Defendant Doshi, who also shared those concerns with Anish Berry, President of Doshi.

227. Anish Berry approached Relator following his report of concern, and Anish Berry asked Relator, "What are you doing?" and "Do you want to get fired so quickly?" This confirmed Relator's concerns that false billing practices were ongoing.

228. Doshi did not change its practices in response to Relator's reports regarding Doshi's illegal double billing and billing for services that were not medically necessary.

229. On or about August 15, 2007 Relator was approached by administrators of Doshi with a request that the nature of Relator's job within the organization be changed from a supervisor employed by Doshi to one of a radiologist solely reviewing studies as an independent contractor. Relator found this suggestion unacceptable and immediately gave the requisite ninety days notice to terminate his contract with Doshi.

230. Following the termination of Relator's contract on November 15, 2007, Relator routinely reviewed studies sent to him electronically by Doshi, as an independent contractor. This practice continued for approximately four months and ended on or about March 15, 2008.

Count I
VIOLATION OF FALSE CLAIMS ACT
31 USC § 3729(a)(1), (2)

231. Relator realleges Paragraphs 1 through 230 as though fully set forth herein.

232. Defendant Doshi knowingly presented, and/or caused to be presented claims for payment for diagnostic radiological studies to the federally-funded New Jersey and New York

health insurance programs.

233. The claims Defendant submitted relating to reimbursement for ultrasounds, Doppler studies, and multiplanar reconstruction were false claims submitted in violation of the FCA. Defendant knew, or acted in reckless disregard, of the fact that it was ineligible for the payments demanded due to double billing and billing for procedures that were not medically necessary.

234. Claims submitted by Defendant to federally-funded health insurance programs (including Medicare and Medicaid) relating to all procedures billed in Doshi's New Jersey, New York, and Florida locations constitute violations of the federal False Claims Act, 31 U.S.C§ 372 (a)(1).

235. Defendant, through its concerted efforts to carry out its systematic scheme to obtain fraudulent payments from Medicaid and Medicare, caused to be made or used false records or statements, including but not limited to the Medicare enrollment forms, the Medicaid enrollment forms, CMS 1500 forms, billing sheets, and internal records to get false or fraudulent payments in violation of the federal False Claims Act, 31 U.S.C.§ 371(a)(2).

236. All of Defendant's conduct described in the Complaint was knowing, as that term is used in the federal False Claims Act.

WHEREFORE, Relator requests the following relief:

A. Judgment against Defendant in an amount equal to:

(1) Damages of up to three (3) times the amount of damages sustained by the United States as a result of Defendant's actions;

(2) A civil penalty of $11,000 for each violation of the federal False Claims Act.

B. 25% of the proceeds of this action if the United States elects to intervene,

and 30% of the proceeds of this action if the United States elects not to intervene.

C. Relator's attorneys' fees, costs and expenses.

D. Such other relief as the Court deems appropriate.

Count II
VIOLATION OF NEW JERSEY FALSE CLAIMS ACT
N.J.S.A. § 2A:32C-3(a), (b)

237. Relator realleges Paragraphs 1 through 236 as though fully set forth herein.

238. Defendant Doshi knowingly presented, and/or caused to be presented claims for payment for diagnostic radiological studies to the New Jersey state-funded health insurance programs.

239. The claims Defendant submitted relating to reimbursement for ultrasounds, Doppler studies, and multiplanar reconstruction were false claims submitted in violation of N.J.S.A. § 2A:32C-3(a). Defendant knew, or acted in reckless disregard, of the fact that it was ineligible for the payments demanded due to double billing and billing for procedures that were not medically necessary.

240. Claims submitted by Defendant to the New Jersey state-funded health insurance programs (including Medicare and Medicaid) relating to all procedures billed in Doshi's New Jersey locations, constitute violations of the NJFCA.

241. Defendant, through its concerted efforts to carry out its systematic scheme to obtain fraudulent payments from Medicaid and Medicare, caused to be made or used false records or statements, including the Medicaid enrollment forms, CMS 1500 forms, billing sheets, and internal records to get false or fraudulent payments in violation of the NJFCA § 2A:32C-

3(a).

242. All of Defendant's conduct described in this Complaint was knowing, as that term is used in the New Jersey False Claims Act.

WHEREFORE, Relator requests the following relief:

A. Judgment against the Defendant in an amount equal to:

(1) Damages of up to three (3) times the amount of damages sustained by the State of New Jersey as a result of Defendant's acts;

(2) A civil penalty of $11,000 for each violation of the New Jersey False Claims Act;

B. 25% of the proceeds recovered in this action if the State of New Jersey elects to intervene, and 30% if it does not.

C. Relator's attorneys' fees, costs and expenses.

D. Such other relief as the Court deems just and appropriate.

COUNT III
VIOLATION OF NEW YORK FALSE CLAIMS ACT
N.Y. State Finance Law § 189(a), (b)

243. Relator realleges Paragraphs 1 through 242 as though fully set forth herein.

244. Defendant Doshi knowingly presented, and/or caused to be presented claims for payment for diagnostic radiological studies to the New York state-funded health insurance programs.

245. The claims Defendant submitted relating to reimbursement for ultrasounds, Doppler studies, and multiplanar reconstruction were false claims submitted in violation of NYFCA § 189(a). Defendant knew, or acted in reckless disregard, of the fact that it was ineligible for the payments demanded due to double billing and billing for procedures that were not medically necessary.

246. Claims submitted by Defendant to New York state-funded health insurance programs (including Medicare and Medicaid) relating to all procedures billed in Doshi's New York locations, constitute violations of the NYFCA.

247. Defendant, through its concerted efforts to carry out its systematic scheme to obtain fraudulent payments from Medicaid and Medicare, caused to be made or used false records or statements, including the Medicaid enrollment forms, CMS 1500 forms, billing sheets, and internal records to get false or fraudulent payments in violation of the NYFCA § 189(a).

248. All of Defendant's conduct described in this Complaint was knowing, as that term is used in the New York False Claims Act.

WHEREFORE, Relator requests the following relief:

A. Judgment against the Defendant in an amount equal to:

(1) Damages of up to three (3) times the amount of damages sustained by the State of New York as a result of Defendant's acts;

(2) A civil penalty of no less than $6,000 and no more than $12,000 for each violation of the New York False Claims Act;

B. 25% of the proceeds recovered in this action if the State of New York elects to intervene, and 30% if it does not.

C. Relator's attorneys' fees, costs and expenses.

D. Such other relief as the Court deems just and appropriate.

JURY DEMAND

Relator demands trial by jury for all claims for which such jury is available.

Respectfully Submitted,

PIETRAGALLO GORDON ALFANO
BOSICK & RASPANTI, LLP

BY: _____

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