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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 19-80181-CR-RUIZ/REINHART(s)
18 U.S.C. § 1349
18 U.S.C. § 1347
18 U.S.C. § 371
42 U.S.C. § 1320a-7b(b)(2)(A)
18 U.S.C. § 2
18 U.S.C. § 1956(h)
18 U.S.C. § 982(a)(1), (a)(7)

UNITED STATES OF AMERICA

vs.

MINAL PATEL, a/k/a "Minalkumar Patel,"

Defendant.
_______________________________________/

SUPERSEDING INDICTMENT

The Grand Jury charges that:

GENERAL ALLEGATIONS

At all times material to this Superseding Indictment:

MEDICARE PROGRAM

1. The Medicare Program ("Medicare") was a federally funded program that provided free or below-cost health care benefits to certain individuals, primarily the elderly, blind, and disabled. The benefits available under Medicare were governed by federal statutes and regulations. The United States Department of Health and Human Services ("HHS"), through its agency, the Centers for Medicare and Medicaid Services ("CMS"), oversaw and administered Medicare. Individuals who received benefits under Medicare were commonly referred to as Medicare "beneficiaries."

2. Medicare was a "health care benefit program," as defined by Title 18, United States Code, Section 24(b), and a "Federal health care program," as defined by Title 42, United States Code, Section 1320a-7b(f).

3. Medicare covered different types of benefits and was separated into different program "parts." Medicare "Part A" covered health services provided by hospitals, skilled nursing facilities, hospices, and home health agencies. Medicare "Part B" was a medical insurance program that covered, among other things, medical services provided by physicians, medical clinics, laboratories, and other qualified health care providers, such as office visits, minor surgical procedures, and laboratory testing, that were medically necessary and ordered by licensed medical doctors or other qualified health care providers. Medicare Advantage, formerly known as "Part C," is described in further detail below.

4. Physicians, clinics, laboratories, and other health care providers (collectively, "providers") that provided services to Medicare beneficiaries were able to apply for and obtain a "provider number." A provider that received a Medicare provider number was able to file claims with Medicare to obtain reimbursement for services provided to beneficiaries.

5. A Medicare claim was required to contain certain important information, including: (a) the Medicare beneficiary's name and Health Insurance Claim Number ("HICN"); (b) a description of the health care benefit, item, or service that was provided or supplied to the beneficiary; (c) the billing codes for the benefit, item, or service; (d) the date upon which the benefit, item, or service was provided or supplied to the beneficiary; and (e) the name of the referring physician or other provider, as well as a unique identifying number, known either as the Unique Physician Identification Number ("UPIN") or National Provider Identifier ("NPI"). The claim form could be submitted in hard copy or electronically via interstate wire.

6. When submitting claims to Medicare for reimbursement, providers were required to certify that: (a) the contents of the forms were true, correct, and complete; (b) the forms were prepared in compliance with the laws and regulations governing Medicare; and (c) the items and services that were purportedly provided, as set forth in the claims, were medically necessary.

7. Medicare claims were required to be properly documented in accordance with Medicare rules and regulations. Medicare would not reimburse providers for claims that were procured through the payment of kickbacks and bribes.

PART B COVERAGE AND REGULATIONS

8. CMS acted through fiscal agents called Medicare administrative contractors ("MACs"), which were statutory agents for CMS for Medicare Part B. The MACs were private entities that reviewed claims and made payments to providers for services rendered to Medicare beneficiaries. The MACs were responsible for processing Medicare claims arising within their assigned geographical area, including determining whether the claim was for a covered service.

9. Novitas Solutions, Inc. ("Novitas") was the MAC for the consolidated Medicare jurisdictions that covered Louisiana, Mississippi, Oklahoma, Texas, and Pennsylvania. Palmetto GBA ("Palmetto") was the MAC for the consolidated Medicare jurisdictions that included Georgia, Alabama, Tennessee, South Carolina, North Carolina, Virginia, and West Virginia.

10. To receive Medicare reimbursement, providers had to make appropriate application to the MAC and executed a written provider agreement. The Medicare provider enrollment application, CMS Form 855B, was required to be signed by an authorized representative of the provider. CMS Form 855B contained a certification that stated:

> I agree to abide by the Medicare laws, regulations, and program instructions that apply to this provider. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim by

> Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations and program instructions (including, but not limited to, the federal anti-kickback statute and the Stark law), and on the provider's compliance with all applicable conditions of participation in Medicare.

11. CMS Form 855B contained additional certifications that the provider "will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity."

12. Payments under Medicare Part B were often made directly to the provider rather than to the beneficiary. For this to occur, the beneficiary would assign the right of payment to the provider. Once such an assignment took place, the provider would assume the responsibility for submitting claims to, and receiving payments from, Medicare.

THE MEDICARE ADVANTAGE PROGRAM

13. Medicare Advantage provided Medicare beneficiaries with the option to receive their Medicare benefits through a wide variety of private managed care plans, including health maintenance organizations ("HMOs"), provider sponsored organizations ("PSOs"), preferred provider organizations ("PPOs"), and private fee-for-service plans ("PFFS"), rather than through original Medicare (Parts A and B).

14. Private health insurance companies offering Medicare Advantage plans were required to provide Medicare beneficiaries with the same services and supplies offered under Medicare Parts A and B. To be eligible to enroll in a Medicare Advantage plan, a person had to have been entitled to benefits under Medicare Parts A and B.

15. A number of companies, including UnitedHealth Group, Inc. ("UnitedHealth"), Humana Inc. ("Humana"), WellCare Health Plans, Inc. ("WellCare"), and CVS Health

Corporation ("CVS Health"), along with their related subsidiaries and affiliates, contracted with CMS to provide managed care to Medicare Advantage beneficiaries through various plans.

16. UnitedHealth, Humana, WellCare, and CVS Health were "health care benefit programs," as defined by Title 18, United States Code, Section 24(b).

17. These companies, through their respective Medicare Advantage plans, often made payments directly to providers, rather than to the Medicare beneficiary that received the health care benefits, items, and services. This occurred when the provider accepted assignment of the right to payment from the beneficiary.

18. To obtain payment for services or treatment provided to a beneficiary enrolled in a Medicare Advantage plan, providers had to submit itemized claim forms to the beneficiary's Medicare Advantage plan. The claim forms were typically submitted electronically via interstate wire. The claim form required certain important information, including the information described above in paragraph 5 of this Superseding Indictment

19. When a provider submitted a claim form to a Medicare Advantage plan, the provider certified that the contents of the form were true, correct, complete, and that the form was prepared in compliance with the laws and regulations governing Medicare. The provider also certified that the services being billed were medically necessary and were in fact provided as billed.

20. The private health insurance companies offering Medicare Advantage plans were paid a fixed rate per beneficiary per month by CMS, regardless of the actual number or type of services the beneficiary received. These payments by Medicare to the insurance companies were known as "capitation" payments. Thus, every month, CMS paid the health insurance companies a pre-determined amount for each beneficiary who was enrolled in a Medicare Advantage plan,

regardless of whether the beneficiary utilized the plan's services that month. CMS determined the per-patient capitation amount using actuarial tables, based on a variety of factors, including the beneficiary's age, sex, severity of illness, and county of residence. CMS adjusted the capitation rates annually, taking into account each beneficiary's previous diagnoses and treatments. Beneficiaries with more illnesses or more serious conditions would rate a higher capitation payment than healthier beneficiaries.

GENETIC TESTS

21. Various forms of genetic testing existed using DNA sequencing to detect mutations in genes that could indicate a higher risk of developing certain diseases or health conditions in the future. For example, cancer genomic ("CGx") testing used DNA sequencing to detect mutations in genes that could indicate a higher risk of developing certain types of cancers in the future. CGx testing was not a method of diagnosing whether an individual presently had cancer. Pharmacogenetic ("PGx") testing used DNA sequencing to assess how the body's genetic makeup would affect the response to certain medications.

22. Medicare did not cover laboratory testing that was "not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." 42 U.S.C. § 1395y(a)(1)(A). Except for certain statutory exceptions, Medicare did not cover "examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint or injury." 42 C.F.R. § 411.15(a)(1). Among the statutory exceptions Medicare covered were cancer screening tests such as "screening mammography, colorectal cancer screening tests, screening pelvic exams, [and] prostate cancer screening tests." *Id.*

23. If laboratory testing was necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, Medicare imposed additional requirements before covering the testing. Title 42, Code of Federal Regulations, Section 410.32(a) provided, "All diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem." "Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary." *Id.*

TELEMEDICINE

24. Telemedicine provided a means of connecting patients to doctors by using telecommunications technology, such as the internet or telephone, to interact with a patient.

25. Telemedicine companies provided telemedicine services to individuals by hiring doctors and other health care providers. Telemedicine companies typically paid doctors a fee to conduct consultations with patients. In order to generate revenue, telemedicine companies typically either billed insurance or received payment from patients who utilized the services of the telemedicine company.

26. Medicare Part B and Medicare Advantage covered expenses for specified telehealth services if certain requirements were met. These requirements included that: (a) the beneficiary was located in a rural or health professional shortage area; (b) services were delivered via an interactive audio and video telecommunications system; and (c) the beneficiary was at a practitioner's office or at a specified medical facility—not at a beneficiary's home—during the telehealth consultation with a remote practitioner.

THE DEFENDANT AND RELATED ENTITIES

27. LabSolutions, LLC ("LabSolutions"), a company formed under the laws of Georgia, was a laboratory that purportedly provided CGx, PGx, and other forms of laboratory testing to Medicare and Medicare Advantage beneficiaries.

28. Defendant **MINAL PATEL, a/k/a "Minalkumar Patel,"** a resident of Georgia, was the owner of LabSolutions and a signatory on LabSolutions's bank account ending in 5953 at Bank 1 ("LabSolutions Account").

29. XGEN Marketing, LLC ("XGEN") was a company formed under the laws of Florida, with its listed place of business in Palm Beach County, Florida.

30. Christian McKeon, a resident of Palm Beach County, Florida, was a manager and member of XGEN and a signatory on XGEN's bank account ending in 3990 at Bank 2 ("XGEN Account").

31. Alite Medical Solutions, LLC ("Alite Medical") was a company formed under the laws of Florida, with its listed place of business in Nassau County, New York.

32. Brett Hirsch, a resident of Palm Beach County, Florida, was one of two managers and members of Alite Medical and a signatory on bank accounts ending in 7575 and 6891 at Bank 2 ("Hirsch Account 1" and "Hirsch Account 2," respectively).

COUNT 1
Conspiracy to Commit Health Care Fraud and Wire Fraud
(18 U.S.C. § 1349)

1. The General Allegations section of this Superseding Indictment is re-alleged and incorporated by reference as though fully set forth herein.

2. From in or around July 2016, and continuing through in or around August 2019, in Palm Beach County, in the Southern District of Florida, and elsewhere, the defendant,

MINAL PATEL, a/k/a "Minalkumar Patel,"

did willfully, that is, with the intent to further the objects of the conspiracy, and knowingly combine, conspire, confederate, and agree with Christian McKeon, Brett Hirsch, and others known and unknown to the Grand Jury, to commit offenses against the United States, that is:

a. to knowingly and willfully execute a scheme and artifice to defraud a health care benefit program affecting commerce, as defined in Title 18, United States Code, Section 24(b), that is, Medicare and Medicare Advantage plans, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of, said health care benefit programs, in connection with the delivery of and payment for health care benefits, items, and services, in violation of Title 18, United States Code, Section 1347; and

b. to knowingly and with the intent to defraud, devise and intend to devise a scheme and artifice to defraud, and for obtaining money and property by means of materially false and fraudulent pretenses, representations, and promises, knowing the pretenses, representations, and promises were false and fraudulent when made, and for the purpose of executing the scheme and artifice, did knowingly transmit and cause to be transmitted by means of wire communication in interstate and foreign commerce, certain writings, signs, signals, pictures, and sounds, in violation of Title 18, United States Code, Section 1343.

PURPOSE OF THE CONSPIRACY

3. It was a purpose of the conspiracy for the defendant and his co-conspirators to unlawfully enrich themselves by, among other things: (a) paying and receiving kickbacks in exchange for the referral of Medicare beneficiaries, so that LabSolutions could bill Medicare for genetic tests, without regard to whether the beneficiaries needed the test; (b) paying kickbacks to

telemedicine companies in exchange for ordering and arranging for the ordering of genetic tests for Medicare beneficiaries, without regard for the medical necessity of the prescribed genetic tests; (c) submitting and causing the submission, via interstate wire communication, of false and fraudulent claims to Medicare and Medicare Advantage plans through LabSolutions for genetic tests that were not medically necessary and not eligible for reimbursement; (d) concealing the submission of false and fraudulent claims to Medicare and Medicare Advantage plans; and (e) diverting fraud proceeds for their personal use and benefit, the use and benefit of others and to further the fraud.

MANNER AND MEANS

The manner and means by which the defendant and his co-conspirators sought to accomplish the objects and purpose of the conspiracy included, among other things:

4. **MINAL PATEL** falsely certified to Medicare that he, as well as LabSolutions, would comply with all Medicare rules and regulations, and federal laws, including that they would not knowingly present or cause to be presented a false and fraudulent claim for payment by Medicare and that they would comply with the Federal Anti-Kickback Statute.

5. **MINAL PATEL** and his co-conspirators, through LabSolutions, paid kickbacks and bribes to co-conspirators, including Christian McKeon, Brett Hirsch, and others, in exchange for genetic test samples from Medicare beneficiaries and Medicare-required documents (collectively referred to as "doctors' orders") that were used to submit claims, via interstate wire communication, to Medicare and Medicare Advantage plans for those tests from LabSolutions.

6. **MINAL PATEL**, Christian McKeon, Brett Hirsch, and other co-conspirators created sham contracts and documentation that disguised the kickbacks and bribes as payments from LabSolutions for marketing services. In the contracts, **PATEL**, through LabSolutions,

agreed to pay co-conspirators, including McKeon, Hirsch, and others, a percentage—as much as 50%—of the gross revenues paid by Medicare in exchange for their recruitment and referral of Medicare beneficiaries, genetic tests, and doctors' orders to LabSolutions, regardless of whether the genetic tests were medically necessary.

7. **MINAL PATEL**, Christian McKeon, Brett Hirsch, and other co-conspirators obtained access to thousands of Medicare beneficiaries by targeting them with telemarketing campaigns and health fairs and inducing them to accept genetic tests regardless of medical necessity.

8. **MINAL PATEL**, Christian McKeon, Brett Hirsch, and other co-conspirators obtained doctors' orders for the genetic tests by paying telemedicine companies for doctors' orders written by doctors contracted with the telemedicine companies, even though those doctors were not treating the beneficiaries for cancer or symptoms of cancer or other diseases, did not use the test results in the treatment of the beneficiaries, and did not conduct a proper telemedicine visit.

9. **MINAL PATEL**, Christian McKeon, Brett Hirsch, and other co-conspirators caused LabSolutions to submit false and fraudulent claims to Medicare and Medicare Advantage plans in at least the approximate amount of $463,889,078, via interstate wire communication, including approximately $269,480,736 for CGx testing.

10. As the result of these false and fraudulent claims, Medicare and Medicare Advantage plans made payments to LabSolutions in at least the approximate amount of $187,369,693, including approximately $128,163,945 for CGx testing.

11. **MINAL PATEL**, Christian McKeon, Brett Hirsch, and other co-conspirators used the fraud proceeds to benefit themselves and others, and to further the fraud.

All in violation of Title 18, United States Code, Section 1349.

COUNTS 2-4
Health Care Fraud
(18 U.S.C. § 1347)

1. The General Allegations section of this Superseding Indictment is re-alleged and incorporated by reference as though fully set forth herein.

2. From in or around July 2016, and continuing through in or around August 2019, in Palm Beach County, in the Southern District of Florida, and elsewhere, the defendant,

MINAL PATEL, a/k/a "Minalkumar Patel,"

in connection with the delivery of and payment for health care benefits, items, and services, did knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud a health care benefit program affecting commerce, as defined in Title 18, United States Code, Section 24(b), that is Medicare, and to obtain by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of, said healthcare benefit programs.

PURPOSE OF THE SCHEME AND ARTIFICE

3. It was a purpose of the scheme and artifice for the defendant and his accomplices to unlawfully enrich themselves by, among other things: (a) paying and receiving kickbacks in exchange for the referral of Medicare beneficiaries, so that LabSolutions could bill Medicare for genetic tests, without regard to whether the beneficiaries needed the test; (b) paying kickbacks to telemedicine companies in exchange for ordering and arranging for the ordering of genetic tests for Medicare beneficiaries, without regard for medical necessity for the prescribed genetic tests; (c) submitting and causing the submission of false and fraudulent claims to Medicare through LabSolutions for genetic tests that were not medically necessary and not eligible for reimbursement; (d) concealing the submission of false and fraudulent claims to Medicare; and (e)

diverting fraud proceeds for their personal use and benefit, the use and benefit of others and to further the fraud.

THE SCHEME AND ARTIFICE

4. The Manner and Means section of Count 1 of this Superseding Indictment is re-alleged and incorporated by reference as though fully set forth herein as a description of the scheme and artifice.

ACTS IN EXECUTION OR ATTEMPTED EXECUTION OF THE SCHEME AND ARTIFICE

5. On or about the dates specified below as to each count, in Palm Beach County, in the Southern District of Florida, and elsewhere, the defendant,

MINAL PATEL, a/k/a "Minalkumar Patel,"

in connection with the delivery of and payment for health care benefits, items, and services, did knowingly and willfully execute, and attempt to execute, the above-described scheme and artifice to defraud a health care benefit program affecting commerce, as defined by Title 18, United States Code, Section 24(b), that is, Medicare, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of, said health care benefit program, in that the defendant submitted and caused the submission of false and fraudulent claims, which sought the identified dollar amounts, representing that such services were medically necessary, eligible for Medicare reimbursement, and provided to Medicare beneficiaries as claimed:

Count	Medicare Beneficiary	Approx. Date of Submission of Claim	Claim No.	Most Expensive Genetic Test Claimed; Total Approx. Amount Billed
2	V.H.	9/24/2018	161118267915670	Gene analysis (breast cancer 1); $6,470

Count	Medicare Beneficiary	Approx. Date of Submission of Claim	Claim No.	Most Expensive Genetic Test Claimed; Total Approx. Amount Billed
3	E.G.	9/24/2018	161818267031920	Gene analysis (breast cancer 1); $5,820
4	H.K.	9/24/2018	161818267031710	Gene analysis (breast cancer 1); $5,820

In violation of Title 18, United States Code, Sections 1347 and 2.

COUNT 5
Conspiracy to Defraud the United States and to Pay and Receive Health Care Kickbacks
(18 U.S.C. § 371)

1. The General Allegations section of this Superseding Indictment is re-alleged and incorporated by reference as though fully set forth herein.

2. From in or around July 2016, and continuing through in or around August 2019, in Palm Beach County, in the Southern District of Florida, and elsewhere, the defendant,

MINAL PATEL, a/k/a "Minalkumar Patel,"

did willfully, that is, with the intent to further the objects of the conspiracy, and knowingly combine, conspire, confederate, and agree with Christian McKeon, Brett Hirsch, and others known and unknown to the Grand Jury,

a. to defraud the United States by impairing, impeding, obstructing, and defeating through deceitful and dishonest means, the lawful government functions of the HHS in its administration and oversight of Medicare and Medicare Advantage; and

b. to commit an offense against the United States, that is, to violate Title 42, United States Code, Section 1320a-7b(b)(2)(A), by knowingly and willfully offering and paying any remuneration, including kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind, including by wire transfer, to a person to induce such person to refer an individual to

a person for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole and in part by a Federal health care program, that is, Medicare and Medicare Advantage plans.

PURPOSE OF THE CONSPIRACY

3. It was a purpose of the conspiracy for the defendant and his co-conspirators to unlawfully enrich themselves by: (a) soliciting, receiving, offering, and paying kickbacks and bribes in return for recruiting and referring Medicare and Medicare Advantage beneficiaries to LabSolutions; (b) submitting and causing the submission of claims to Medicare and Medicare Advantage plans for genetic tests that LabSolutions purported to provide to those beneficiaries; (d) concealing the kickback and bribes, among other things; and (e) diverting fraud proceeds for their personal use and benefit, the use and benefit of others and to further the fraud.

MANNER AND MEANS

The manner and means by which the defendant and his co-conspirators sought to accomplish the objects and purpose of the conspiracy included, among other things, the following:

4. Co-conspirators, including Christian McKeon, Brett Hirsch, and others, recruited and referred Medicare and Medicare Advantage beneficiaries to LabSolutions, knowing that LabSolutions would bill Medicare and Medicare Advantage for genetic tests purportedly provided to the recruited beneficiaries.

5. **MINAL PATEL**, through LabSolutions, offered and paid kickbacks to co-conspirators, including Christian McKeon, Brett Hirsch, and others, in exchange for the recruitment and referral of Medicare and Medicare Advantage beneficiaries to LabSolutions.

6. **MINAL PATEL**, Christian McKeon, Brett Hirsch, and other co-conspirators created sham contracts and documentation that disguised the kickbacks and bribes as payments

from LabSolutions for marketing services. In the contracts, **PATEL**, through LabSolutions, agreed to pay co-conspirators, including McKeon, Hirsch, and others, a percentage—as much as 50%—of the gross revenues paid by Medicare and Medicare Advantage in exchange for their recruitment and referral of Medicare and Medicare Advantage beneficiaries, genetic tests and doctors' orders to LabSolutions, regardless of whether the genetic tests were medically necessary.

7. Co-conspirators, including Christian McKeon, Brett Hirsch, and others, offered and paid kickbacks to telemedicine companies and others in exchange for the ordering and arranging for ordering genetic tests for Medicare and Medicare Advantage beneficiaries, who were paid, at least in part, to authorize the genetic tests.

8 **MINAL PATEL**, Christian McKeon, Brett Hirsch, and other co-conspirators caused LabSolutions to submit claims, including claims for CGx testing, to Medicare and Medicare Advantage plans in at least the approximate amount of $463,889,078.

9. As the result of these claims, Medicare and Medicare Advantage plans made payments to LabSolutions in at least the approximate amount of $187,369,693.

10. **MINAL PATEL** paid his co-conspirators, including Christian McKeon, Brett Hirsch, and others, at least approximately $14,200,685, and used the fraud proceeds received from LabSolutions to benefit himself and others, and to further the fraud.

<u>OVERT ACTS</u>

In furtherance of the conspiracy, and to accomplish its objects and purpose, at least one co-conspirator committed and caused to be committed, in the Southern District of Florida, at least one of the following overt acts, among others:

1. On or about July 5, 2016, **MINAL PATEL**, through LabSolutions, entered into a contract with Brett Hirsch, through Alite Medical, providing that LabSolutions would pay Alite

Medical 50% of the monthly revenue LabSolutions received from Medicare and Medicare Advantage for genetic tests referred by Hirsch or Alite Medical, minus certain costs, and that Hirsch would receive a 5% "over-ride" commission of any reimbursements LabSolutions received from Medicare and Medicare Advantage for genetic tests referred by other marketers Hirsch recruited to LabSolutions, also known as "downlines" of Hirsch.

2. On or about January 1, 2017, **MINAL PATEL** caused an employee of LabSolutions to execute a contract with XGEN pursuant to which LabSolutions agreed to pay XGEN 45% of the monthly revenue LabSolutions received from Medicare and Medicare Advantage for genetic tests referred by XGEN, minus certain costs.

3. On or about February 14, 2017, **MINAL PATEL** transferred approximately $35,738 from the LabSolutions Account to the Hirsch Account 2 in exchange for Hirsch's referral of Medicare and Medicare Advantage beneficiaries to LabSolutions.

4. On or about January 14, 2019, **MINAL PATEL** transferred approximately $365,043 from the LabSolutions Account to the XGEN Account in exchange for XGEN's referral of Medicare and Medicare Advantage beneficiaries to LabSolutions.

5. On or about February 14, 2019, **MINAL PATEL** transferred approximately $800,000 from the LabSolutions Account to the XGEN Account in exchange for XGEN's referral of Medicare and Medicare Advantage beneficiaries to LabSolutions.

6. On or about February 14, 2019, **MINAL PATEL** transferred approximately $150,000 from the LabSolutions Account to the Hirsch Account 1 in exchange for Hirsch's referral of Medicare and Medicare Advantage beneficiaries to LabSolutions.

7. On or about April 30, 2019, **MINAL PATEL** transferred approximately $600,000 from the LabSolutions Account to the XGEN Account in exchange for XGEN's referral of Medicare and Medicare Advantage beneficiaries to LabSolutions.

All in violation of Title 18, United States Code, Section 371.

COUNTS 6-9
Payment of Kickbacks in Connection with a Federal Health Care Program (42 U.S.C. § 1320a-7b(b)(2)(A))

1. The General Allegations section of this Superseding Indictment is re-alleged and incorporated by reference as though fully set forth herein.

2. On or about the dates enumerated below, in Palm Beach County, in the Southern District of Florida, and elsewhere, the defendant, **MINAL PATEL, a/k/a "Minalkumar Patel,"** did knowingly and willfully offer and pay remuneration, that is, kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind, including by wire transfer, as set forth below, to a person, to induce such person to refer an individual to a person for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole and in part under a Federal health care program, that is, Medicare and Medicare Advantage plans:

Count	Approx. Date of Kickback Payment	Approx. Amount of Kickback Payment	Description of Payment
6	2/14/2017	$35,738	Wire transfer from the LabSolutions Account to Hirsch Account 2.
7	11/14/2018	$150,251	Wire transfer from the LabSolutions Account to Hirsch Account 1.
8	12/13/2018	$728,972	Wire transfer from the LabSolutions Account to the XGEN Account.
9	4/30/2019	$600,000	Wire transfer from the LabSolutions Account to the XGEN Account.

In violation of Title 42, United States Code, Section 1320a-7b(b)(2)(A) and Title 18, United States Code, Section 2.

COUNT 10
Conspiracy to Commit Money Laundering
(18 U.S.C. § 1956(h))

From in or around January 2017, and continuing through in or around August 2019, in Palm Beach County, in the Southern District of Florida, and elsewhere, the defendant,

MINAL PATEL, a/k/a "Minalkumar Patel,"

did knowingly and voluntarily combine, conspire, and agree with others, known and unknown to the Grand Jury, to commit offenses under Title 18, United States Code, Sections 1956 and 1957, that is,

a. to knowingly conduct a financial transaction affecting interstate and foreign commerce, which transaction involved the proceeds of specified unlawful activity, knowing that the property involved in the financial transaction represented the proceeds of some form of unlawful activity, and knowing that the transaction was designed in whole and in part to conceal and disguise the nature, location, source, ownership, and control of the proceeds of specified unlawful activity, in violation of Title 18, United States Code, Section 1956(a)(1)(B)(i); and

b. to knowingly engage in a monetary transaction by, through, and to a financial institution, affecting interstate and foreign commerce, in criminally derived property of a value greater than $10,000, such property having been derived from specified unlawful activity, in violation of Title 18, United States Code, Section 1957.

It is further alleged that the specified unlawful activity is conspiracy to commit health care fraud, in violation of Title 18, United States Code, Section 1349; health care fraud, in violation of Title 18, United States Code, Section 1347; and wire fraud, in violation of Title 18, United States Code, Section 1343.

All in violation of Title 18, United States Code, Section 1956(h).

FORFEITURE ALLEGATIONS

1. The allegations of this Superseding Indictment are hereby re-alleged and by this reference fully incorporated herein for the purpose of alleging forfeiture to the United States of certain property in which the defendant, **MINAL PATEL, a/k/a "Minalkumar Patel,"** has an interest.

2. Upon conviction of a violation of Title 18, United States Code, Sections 371, 1347, or 1349, or a violation of, or criminal conspiracy to commit a violation of, Title 42, United States Code, Section 1320a-7b, as alleged in this Superseding Indictment, the defendant shall forfeit to the United States any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense, pursuant to Title 18, United States Code, Section 982(a)(7).

3. Upon conviction of a violation of Title 18, United States Code, Section 1956, as alleged in this Superseding Indictment, the defendant shall forfeit to the United States any property, real or personal, involved in such offense, and any property traceable to such property, pursuant to Title 18, United States Code, Section 982(a)(1).

4. The property subject to forfeiture as a result of the alleged offenses includes, but is not limited to, the following:

a. Approximately $13,896,134.78 seized, on or about August 16, 2019, from account number 0005245165945, held in the name of LabSolutions LLC at Bank 1;

b. Approximately $440,730.20 seized, on or about August 16, 2019, from account number 0005245166011, held in the name of LabSolutions LLC at Bank 1;

c. Approximately $534,093.52 seized, on or about August 16, 2019, from account number 0005245165953, held in the name of LabSolutions LLC at Bank 1;

d. Approximately $5,842,046.79 seized, on or about August 20, 2019, from account number 1374000767, held in the name of LabSolutions LLC at Bank 1;

e. Approximately $1,129,562.62 seized, on or about August 16, 2019, from account number 0005244918788, in the name of **MINALKUMAR PATEL** at Bank 1;

f. Approximately $4,000,000.00 seized, on or about August 16, 2019, from account number 0005248710219, in the name of **MINALKUMAR PATEL** at Bank 1;

g. Approximately $4,000,000.00 seized, on or about August 16, 2019, from account number 0005248710065, in the name of **MINALKUMAR PATEL** at Bank 1;

h. One 2019 black Land Rover Range Rover, VIN # SALGW5SE2KA545805, seized on or about August 16, 2019;

i. One 2018 red Ferrari 488 Spider, VIN # ZFF80AMA6J0236067, seized on or about August 16, 2019;

j. Real property located at 548 and 552 Ponce De Leon Avenue, NE, Atlanta, GA; and

k. Real property located at 1118 Blackshear Drive, Decatur, GA.

5. If any of the property subject to forfeiture, as a result of any act or omission of the defendant:

a. cannot be located upon the exercise of due diligence;

b. has been transferred or sold to, or deposited with, a third party;

c. has been placed beyond the jurisdiction of the court;

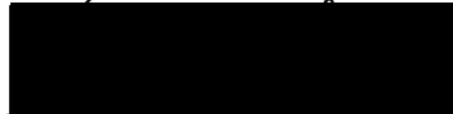
d. has been substantially diminished in value; or

e. has been commingled with other property which cannot be divided without difficulty,

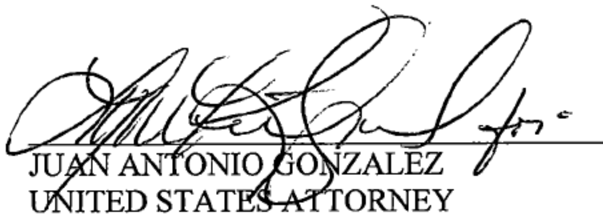
the United States shall be entitled to forfeiture of substitute property under the provisions of Title 21, United States Code, Section 853(p), and such property includes, but is not limited to, the real property located 2881 Peachtree Road, NE, #1903, Atlanta, GA.

All pursuant to Title 18, United States Code, Sections 982(a)(1) and (a)(7), and the procedures set forth in Title 21, United States Code, Section 853, as incorporated by Title 18, United States Code, Section 982(b)(1).

A TRUE BILL

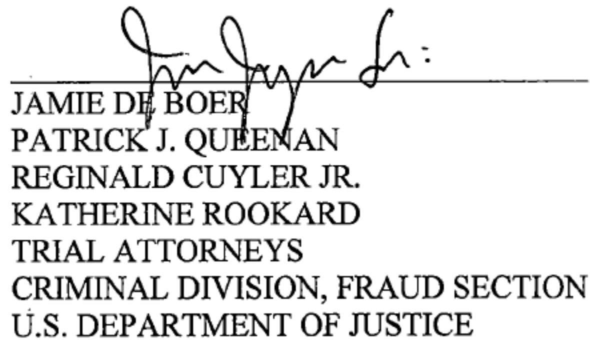


GRAND JURY FOREPERSON



JUAN ANTONIO GONZALEZ
UNITED STATES ATTORNEY

LORINDA I. LARYEA, ACTING CHIEF
CRIMINAL DIVISION, FRAUD SECTION
U.S. DEPARTMENT OF JUSTICE



JAMIE DE BOER
PATRICK J. QUEENAN
REGINALD CUYLER JR.
KATHERINE ROOKARD
TRIAL ATTORNEYS
CRIMINAL DIVISION, FRAUD SECTION
U.S. DEPARTMENT OF JUSTICE

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

UNITED STATES OF AMERICA

v.

MINAL PATEL,
a/k/a "Minalkumar Patel," /

Defendant.

CASE NO.: 19-80181-CR-RUIZ/REINHART(s)

CERTIFICATE OF TRIAL ATTORNEY*

Superseding Case Information:

New Defendant(s) (Yes or No) **No**
Number of New Defendants **0**
Total number of New Counts **6**

Court Division (select one)
☐ Miami ☐ Key West ☐ FTP
☐ FTL ☑ WPB

I do hereby certify that:

1. I have carefully considered the allegations of the indictment, the number of defendants, the number of probable witnesses and the legal complexities of the Indictment/Information attached hereto.

2. I am aware that the information supplied on this statement will be relied upon by the Judges of this Court in setting their calendars and scheduling criminal trials under the mandate of the Speedy Trial Act, Title 28 U.S.C. §3161.

3. Interpreter: (Yes or No) **No**
List language and/or dialect: ____________

4. This case will take **15** days for the parties to try.

5. Please check appropriate category and type of offense listed below:

(Check only one)		(Check only one)
I	☐ 0 to 5 days	☐ Petty
II	☐ 6 to 10 days	☐ Minor
III	☑ 11 to 20 days	☐ Misdemeanor
IV	☐ 21 to 60 days	☑ Felony
V	☐ 61 days and over	

6. Has this case been previously filed in this District Court? (Yes or No) **Yes**
If yes, Judge **Ruiz** Case No. **19-CR-80181**
7. Has a complaint been filed in this matter? (Yes or No) **No**
If yes, Magistrate Case No. ____________
8. Does this case relate to a previously filed matter in this District Court? (Yes or No) **No**
If yes, Judge ____________ Case No. ____________
9. Defendant(s) in federal custody as of ____________
10. Defendant(s) in state custody as of ____________
11. Rule 20 from the ____________ District of ____________
12. Is this a potential death penalty case? (Yes or No) **No**
13. Does this case originate from a matter pending in the Northern Region of the U.S. Attorney's Office prior to August 8, 2014 (Mag. Judge Shaniek Maynard? (Yes or No) **No**
14. Does this case originate from a matter pending in the Central Region of the U.S. Attorney's Office prior to October 3, 2019 (Mag. Judge Jared Strauss? (Yes or No) **No**

By: ____________
JAMIE DE BOER
DOJ Trial Attorney
Court ID No. A5502601

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

PENALTY SHEET

Defendant's Name MINAL PATEL, a/k/a "Minalkumar Patel"

Case No: 19-80181-CR-RUIZ/REINHART(s)

Count #: 1

Conspiracy to Commit Health Care Fraud and Wire Fraud

Title 18, United States Code, Section 1349

*** Max. Term of Imprisonment: 20 years**
*** Mandatory Min. Term of Imprisonment (if applicable): N/A**
*** Max. Supervised Release: 3 years**
*** Max. Fine: $250,000 or twice the gross gain or loss from the offense**

Counts #: 2 – 4

Health Care Fraud

Title 18, United States Code, Section 1347

*** Max. Term of Imprisonment: 10 years per count**
*** Mandatory Min. Term of Imprisonment (if applicable): N/A**
*** Max. Supervised Release: 3 years**
*** Max. Fine: $250,000 or twice the gross gain or loss from the offense**

Count #: 5

Conspiracy to Defraud the United States and to Pay and Receive Health Care Kickbacks

Title 18, United States Code, Section 371

*** Max. Term of Imprisonment: 5 years**
*** Mandatory Min. Term of Imprisonment (if applicable): N/A**
*** Max. Supervised Release: 3 years**
*** Max. Fine: $250,000 or twice the gross gain or loss from the offense**

***Refers only to possible term of incarceration, supervised release and fines. It does not include restitution, special assessments, parole terms, or forfeitures that may be applicable.**

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

PENALTY SHEET

Defendant's Name MINAL PATEL, a/k/a "Minalkumar Patel"

Case No: 19-80181-CR-RUIZ/REINHART(s)

Counts #: 6 – 9

Payment of Kickbacks in Connection with a Federal Health Care Program

Title 42, United States Code, Section 1320a-7b(b)(2)(A)

*** Max. Term of Imprisonment: 10 years per count**
*** Mandatory Min. Term of Imprisonment (if applicable): N/A**
*** Max. Supervised Release: 3 years**
*** Max. Fine: $250,000 or twice the gross gain or loss from the offense**

Count #: 10

Conspiracy to Commit Money Laundering

Title 18, United States Code, Section 1956(h)

*** Max. Term of Imprisonment: 20 years**
*** Mandatory Min. Term of Imprisonment (if applicable): N/A**
*** Max. Supervised Release: 3 years**
*** Max. Fine: $500,000 or twice the value of the property involved in the offense**

***Refers only to possible term of incarceration, supervised release and fines. It does not include restitution, special assessments, parole terms, or forfeitures that may be applicable.**