



IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Norfolk Division

UNITED STATES OF AMERICA)

v.)

JAVAID PERWAIZ,)

Defendant.)

CRIMINAL NO. 2:19cr 189

18 U.S.C. § 1347
Health Care Fraud
(Counts One through Five)

18 U.S.C. § 1035
False Statements Related to
Health Care Matters
(Counts Six through Nine)

18 U.S.C. § 1028A
Aggravated Identity Theft
(Counts Ten and Eleven)

18 U.S.C. § 982(a)(7)
Forfeiture

INDICTMENT

THE GRAND JURY CHARGES THAT:

GENERAL ALLEGATIONS

At all times relevant to this Indictment, unless otherwise stated:

The Health Care Benefit Programs

1. The term “health care benefit program,” is defined in 18 U.S.C. § 24(b) to mean any public and private plan and contract, affecting commerce, under which any medical benefit, item, and service is provided to any individual, and includes any individual and entity who is providing a medical benefit, item, and service for which payment may be made under the plan and contract.

2. Medicaid is a state-administered health insurance program funded predominately by the federal government and administered by the Commonwealth of Virginia. Medicaid helps pay for reasonable and necessary medical procedures and services provided to individuals who are deemed eligible under state low-income programs. The Virginia Department of Medical Assistance Services (DMAS) administers the Medicaid program in Virginia.

3. Medicare is a federal health insurance program administered by the Centers for Medicare and Medicaid Services (hereafter “CMS”), an agency of the U.S. Department of Health and Human Services. Medicare helps pay for reasonable and medically necessary medical services for people aged 65 and older, and some persons under 65 who are blind or disabled.

4. The TRICARE Program (TRICARE) is a health care benefit program of the United States Department of Defense Military Health System. TRICARE provides civilian health benefits for military personnel, military retirees, and their dependents.

5. Anthem Blue Cross Blue Shield, Cigna, Aetna, Humana, Sentara Optima, and Optum are private health care insurance companies doing business in the Eastern District of Virginia.

6. Medicare, Medicaid, TRICARE, Anthem Blue Cross Blue Shield, Cigna, Aetna, Humana, Sentara Optima, and Optum will be referred to as “health care benefit programs.”

7. The American Medical Association publishes an annual manual of Current Procedural Terminology (CPT) codes. The CPT Manual is a listing of descriptive terms and identifying codes for reporting the nature and complexity of medical services and procedures performed by physicians. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services. In 2000, to implement the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Department of Health and Human Services designated the CPT Code set as a national coding standard for physicians and other

health care professional services and procedures. As a result, for all financial and administrative health care transactions, CPT Codes must be used in describing health care services rendered. Health care benefit programs contractually require health care providers to use CPT Codes in submitting reimbursement claims.

8. Health care providers are given and provided with online access to health care benefit program manuals and services bulletins describing proper billing procedures and billing rules and regulations. Providers can only submit claims to health care benefit programs for medically necessary services they rendered, and providers are required to maintain patient records to verify that the services were provided as described on the claims.

9. To receive payment, a provider must submit a claim using a CMS 1500, a Health Insurance Claim Form (claim form). Claims can be submitted electronically and by mail.

10. The claim form requires information about: the date of service for the procedure, the service and supplies received, the name of the providing physician, the medical diagnosis, the place of service, and the service facility location.

11. By submitting a claim, the provider certifies under penalty of perjury that the services and equipment were medically “indicated” and necessary, and were actually performed by the provider. In the act of submitting the claim, the provider is also certifying to the health care benefit program that everything contained in it is true and in compliance with rules and laws. Health care benefit programs rely on the truth and accuracy of information on the claim form to determine whether to pay the provider for the equipment and services rendered.

12. At all times relevant to this investigation, health care benefit programs prohibited payment for items and services that were not “reasonable and necessary” for the diagnosis and treatment of an illness or injury. Medicare claim forms, for example, require the provider who

makes a claim for reimbursement to certify that the services were “medically indicated and necessary for the health of the patient.” The DMAS Manual for providers and practitioners states that the physician is responsible for certifying that the service is medically necessary any that the treatment prescribed is in accordance with the community standards of medical practice.

The Defendant

13. Defendant JAVAID PERWAIZ, a resident of Chesapeake, Virginia, was a licensed physician, board certified to practice obstetrics and gynecology. He was first licensed by the Virginia Board of Medicine in April 1980.

14. JAVAID PERWAIZ was a solo practitioner and owned and operated Javaid A. Perwaiz, M.D., P.C. He had two different locations for his obstetrics and gynecology (OB/GYN) practice in Chesapeake, Virginia.

15. In addition to treating obstetric patients, JAVAID PERWAIZ performed gynecological services, which included performing surgeries, operations, and procedures at various hospitals and outpatient surgical centers within the Eastern District of Virginia.

16. PERWAIZ was enrolled as a participating provider with Medicare, Medicaid, TRICARE, Anthem Blue Cross Blue Shield, Humana, Sentara Optima, and others. As such, he entered into contract with each provider and was aware of their policies and procedures.

17. PERWAIZ recorded the services he alleged to have performed on patient encounter sheets and surgical summary forms, which he then provided to his office staff responsible for submitting claims for reimbursement to health care benefit programs.

Medical Terms Defined

18. “Hysteroscopy” is used to diagnose or treat problems of the uterus. A hysteroscope is a thin, lighted telescope-like device. It is inserted through a woman’s vagina into her uterus.

19. “Colposcopy” is a way of looking at the cervix through a special magnifying device called a colposcope. It shines a light into the vagina and onto the cervix. A colposcope can greatly enlarge the normal view. This exam allows the health care provider to find problems that cannot be seen by the eye alone.

20. “Cone biopsy” is a type of excisional treatment in which a cone-shaped piece of the cervix that contains the abnormal cells is removed.

21. “Dilation & curettage” (D&C) is a surgical procedure in which the cervix is opened (dilated) and a thin instrument is inserted into the uterus. This instrument is used to remove tissue from the inside of the uterus (curettage).

22. “Hysterectomy” is the removal of the uterus. A “bilateral salpingo-oophorectomy,” which is the removal of both ovaries and both fallopian tubes, may also be performed during a hysterectomy as well. A woman is no longer able to have children after having a hysterectomy. A total hysterectomy removes the entire uterus, including the cervix. A supracervical (also called subtotal or partial) hysterectomy removes the upper part of the uterus, but the cervix is left in place. This type of hysterectomy can only be performed laparoscopically or abdominally. A radical hysterectomy is a total hysterectomy that also includes removal of structures around the uterus. It may be recommended if cancer is diagnosed or suspected.

23. “Laparoscopy” is a surgical procedure in which a fiber-optic instrument is inserted through the abdominal wall to view the organs in the abdomen or to permit a surgical procedure.

24. “Lysis of adhesions” is a surgery to cut bands of tissue that form between organs. They are often caused by scar tissue that formed after an earlier surgery.

25. “Myomectomy” is the surgical removal of fibroids while leaving the uterus in place. Fibroids do not regrow after surgery, but new fibroids may develop.

COUNTS ONE THROUGH FIVE
(18 U.S.C. § 1347 - Health Care Fraud)

26. Paragraphs 1 through 25 of the General Allegations section of this Indictment are realleged and incorporated by reference as though fully set forth herein.

27. Beginning at least as early as January 2010 and continuing until November 8, 2019, in the Eastern District of Virginia, the defendant JAVAID PERWAIZ, 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 18 U.S.C. § 24(b), that is Medicare, Medicaid, TRICARE, Anthem Blue Cross Blue Shield, Humana, Sentara Optima, and others, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by and under the custody of Medicare, Medicaid, TRICARE, Anthem Blue Cross Blue Shield, Humana, Sentara Optima, and others, in connection with the delivery of and payment for health care benefits, items, and services.

Purpose of the Scheme and Artifice

28. It was the purpose of the scheme and artifice for JAVAID PERWAIZ to unlawfully enrich himself through the submission of false and fraudulent claims for services that were: (a) not medically necessary, (b) performed without the informed consent of the patient, (c) based upon fraudulent and falsified purported patient complaints and diagnostic procedures, and/or (d) not, in fact, performed.

The Scheme and Artifice

29. JAVAID PERWAIZ submitted and caused the submission of false fraudulent claims to Medicare, Medicaid, TRICARE, Anthem Blue Cross Blue Shield, Humana, Sentara Optima, and other health care benefit programs for procedures and services, including hysteroscopies,

colposcopies, vaginal and abdominal hysterectomies, D&Cs, lysis of adhesions, salpingo-oophorectomies, myomectomies, cystectomies, and others.

30. In perpetrating his scheme, PERWAIZ employed several types of false and fraudulent claims. For example, PERWAIZ falsely claimed that a patient sought out, and authorized, a particular gynecological procedure.

31. Additionally, he recorded in a patient's medical record that a patient reported symptoms and complaints from which she did not actually suffer, and which she did not relay to PERWAIZ. PERWAIZ used these purported patient complaints to justify gynecological procedures to the health care benefit programs.

32. Further, PERWAIZ aggressively encouraged patients to consent to irreversible gynecological surgeries by reporting that they would develop cancer if they did not undergo the surgery.

33. PERWAIZ claimed to perform diagnostic procedures, including hysteroscopies and colposcopies, in his medical offices, and used the results of those examinations to justify that a patient undergo surgery very quickly – at times as little as three days later. In truth, PERWAIZ often did not perform the diagnostic procedure and did not always have appropriately functioning tools to perform the procedure.

34. As a result of this scheme and artifice to defraud, patients unknowingly underwent unnecessary procedures. Some of these patients incurred permanent physical damage and injury.

35. From in or about January 2010 through in or November 8, 2019, JAVAID PERWAIZ submitted and caused to be submitted tens of thousands of claims to health care benefit programs for diagnostic procedures and gynecological surgeries.

Acts in Furtherance of the Scheme and Artifice

36. On the dates set forth below, JAVAID PERWAIZ submitted and caused to be submitted, and attempted to do so, claims for reimbursement to health care benefit programs that were false and fraudulent as outlined:

<u>Count</u>	<u>On or About Service Date</u>	<u>Health Care Benefit Program</u>	<u>Patient</u>	<u>Description of the Item Billed</u>	<u>Approximate Amount Billed</u>	<u>False/Fraudulent Representation</u>
ONE	December 29, 2012	Virginia Medicaid	D.A.	Total abdominal hysterectomy, anteroposterior colporrhaphy	\$2,100 \$1,500	Fraudulent patient authorization.
TWO	March 18, 2016	Virginia Medicaid	A.N.	D&C, chromotubation of oviduct, surgical laparoscopy with lysis of adhesions, surgical laparoscopy with lesions of ovary	\$500 \$300 \$1,000 \$1,500	Fraudulent diagnosis and representation of patient complaint.
THREE	February 16, 2019	Optima Health	L.G.	Surgical hysteroscopy with D&C, cautery of the cervix	\$700 \$300	Fraudulent representation of patient complaints.
FOUR	August 10, 2019	Humana Medicare	A.F.	Vaginal hysterectomy, combined anteroposterior colporrhaphy	\$1,500 \$1,500	Fraudulent diagnosis.

FIVE	October 19, 2019	Blue Cross Blue Shield Federal Employee Program	D.B.	Supracervical abdominal hysterectomy, salpingo- oophorectomy, lysis of adhesions	\$1,800 \$1,200 \$600	Fraudulent representation of patient complaint.
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(In violation of Title 18, United States Code, Sections 1347 and 1349.)

COUNTS SIX THROUGH NINE
(18 U.S.C. § 1035- False Statement Related to Health Care Matters)

On or about the dates set forth below, in the Eastern District of Virginia, JAVAID PERWAIZ, the defendant, in a matter involving a health care benefit program as defined in Title 18, United States Code, Section 24(b), knowingly and willfully did make a materially false, fictitious, and fraudulent statement and representation, and make and use a materially false writing and document knowing the same to contain a materially false, fictitious, and fraudulent statement and entry, in connection with the delivery of and payment for health care benefits, items, and services, in that the defendant submitted and caused to be submitted to the indicated health care benefit program, the following claims for health care benefit payments, each of which falsely and fraudulently represented that the defendant had provided medically necessary care and services, as indicated, to a recipient, when in truth and fact, as the defendant well knew, the recipient did not receive and require such care and service. Each claim is a separate count of this indictment as indicated:

<u>Count</u>	<u>On or About Service Date</u>	<u>Health Care Benefit Program</u>	<u>Patient</u>	<u>Description of the Item Billed</u>	<u>Approximate Amount Billed</u>	<u>False, Fictitious, and Fraudulent Statement</u>
SIX	March 18, 2016	Virginia Medicaid	A.N.	D&C, chromotubation of oviduct, surgical laparoscopy with lysis of adhesions, surgical laparoscopy with lesions of ovary	\$500 \$300 \$1,000 \$1,500	Fraudulent diagnosis and representation of patient complaint.
SEVEN	February 16, 2019	Optima Health	L.G.	Surgical hysteroscopy with D&C,	\$700 \$300	Fraudulent representation of patient complaints.

				cautery of the cervix		
EIGHT	August 10, 2019	Humana Medicare	A.F.	Vaginal hysterectomy, anteroposterior colporrhaphy	\$1,500 \$1,500	Fraudulent diagnosis.
NINE	October 19, 2019	Blue Cross Blue Shield Federal Employee Program	D.B.	Supracervical abdominal hysterectomy, salpingo-oophorectomy, lysis of adhesions	\$1,800 \$1,200 \$600	Fraudulent representation of patient complaint.

(In violation of Title 18, United States Code, Section 1035.)

COUNT TEN
(18 U.S.C. § 1028A- Aggravated Identity Theft)

On or about March 18, 2016, in the Eastern District of Virginia, JAVAID PERWAIZ, the defendant, did knowingly transfer, possess and use, without lawful authority, a means of identification of another person, that is, the Medicaid identification number of A.N., during and in relation to a felony enumerated in 18 U.S.C. § 1028A(c), namely, health care fraud in violation of 18 U.S.C. § 1347, as charged in Count Two of this indictment.

(In violation of Title 18, United States Code, Section 1028A(a)(1).)

COUNT ELEVEN
(18 U.S.C. § 1028A- Aggravated Identity Theft)

On or about October 19, 2019, in the Eastern District of Virginia, JAVAID PERWAIZ, the defendant, did knowingly transfer, possess and use, without lawful authority, a means of identification of another person, that is, Social Security Account Number of D.B., during and in relation to a felony enumerated in 18 U.S.C. § 1028A(c), namely, health care fraud in violation of 18 U.S.C. § 1347, as charged in Count Five of this indictment.

(In violation of Title 18, United States Code, Section 1028A(a)(1).)

FORFEITURE

THE GRAND JURY FURTHER FINDS PROBABLE CAUSE THAT:

1. Defendant JAVAID PERWAIZ, if convicted of the violations alleged in Counts One through Nine, shall forfeit to the United States, as part of the sentencing pursuant to Federal Rule of Criminal Procedure 32.2, any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the violation.

2. If any property that is subject to forfeiture above is not available, it is the intention of the United States to seek an order forfeiting substitute assets pursuant to Title 21, United States Code, Section 853(p) and Federal Rule of Criminal Procedure 32.2(e).

3. The property subject to forfeiture includes, but is not limited to, the following property:

a. A sum of money in the amount of the proceeds JAVAID PERWAIZ obtained from the health care fraud scheme charged in Counts One through Five;

b. Real property and improvements located at 340 Mill Stone Road, Chesapeake, Virginia 23322;

c. Real property and improvements located at 109 Wimbledon Square, Unit F, Chesapeake, Virginia 23320; and

d. Real property and improvements located at 3003 Churchland Boulevard, Chesapeake, Virginia 23321.

(All in accordance with Title 18, United States Code, Section 982(a)(7); and Title 21, United States Code, Section 853(p).)

United States v. Javaid Perwaiz
Criminal No. 2:19cr 189

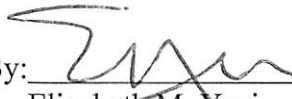
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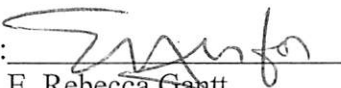
A TRUE BILL:

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