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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA *et al*. *ex rel*. ALLISON LYNES and JEFFREY ZUCKERMAN,

Plaintiff and Relator,

-against-

THE RADIOLOGY GROUP LLC and ANAND LALAJI,

Defendants.

UNITED STATES OF AMERICA,

Plaintiff-Intervenor,

-against-

THE RADIOLOGY GROUP LLC and ANAND LALAJI,

Defendants.

19 Civ. 3542 (AT)

COMPLAINT-IN-INTERVENTION OF THE UNITED STATES

JURY TRIAL DEMANDED

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

PRELIMINARY STATEMENT

1. This is a civil fraud action brought by the United States against The Radiology Group LLC ("TRG") and its CEO and co-owner, Dr. Anand Lalaji (together with TRG, "Defendants"), to recover damages and civil penalties arising from Defendants' violations of the False Claims Act ("FCA"), 31 U.S.C. § 3729 *et seq.*, in connection with the provision of diagnostic radiology services to patients covered by Medicare, Medicaid, TRICARE, and Veterans Health Administration programs (the "Federal health care programs").

2. Diagnostic radiology involves the diagnosis of diseases and injuries using imaging techniques, such as Computed Tomography scans, Magnetic Resonance Imaging, and ultrasounds. Radiologists review the generated images and prepare written reports summarizing their findings (an "Interpretation Report"). Health care providers rely on these Interpretation Reports when diagnosing patient conditions and when making important decisions regarding patient medical care.

3. TRG is a teleradiology practice that provides diagnostic radiology services to hospitals, urgent care centers, and primary care physician offices (the "Referring Providers") located throughout the United States. The Referring Providers transmitted imaging to TRG so that TRG could review the images and prepare Interpretation Reports. Using online-based teleradiology platforms, TRG sent the images to contractors located outside the United States, who would conduct initial reviews of the imaging and prepare draft Interpretation Reports. After that process was complete, TRG's U.S.-based radiologists were supposed to conduct an independent and separate review of the imaging, and make all necessary changes to the Interpretation Reports before transmitting them to a Referring Provider.

4. During the period from April 1, 2013, to July 31, 2019 (the "Relevant Period"), TRG and Lalaji violated the FCA by knowingly submitting and/or causing the submission of

false claims for payment to Federal health care programs for radiology services that: (1) were not furnished by a U.S.-based credentialed radiologist because TRG's radiologist just "rubber stamped" radiology interpretations that were performed by persons located in India who were not U.S.-licensed physicians or providers enrolled in any Federal health care program; (2) were not rendered by the radiologist listed by TRG as the rendering provider in the claim for reimbursement; and/or (3) were furnished entirely by persons located outside of the United States and were thus ineligible for reimbursement from Medicare.

5. By engaging in the above-referenced conduct, Defendants submitted, or caused to be submitted, thousands of false claims to Federal health care programs in violation of the FCA.

JURISDICTION AND VENUE

6. This Court has subject matter jurisdiction over the Government's claims pursuant to 31 U.S.C. § 3730(a) and 28 U.S.C §§ 1331, 1345.

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

8. Further, because Defendants transacted business in this District, and provided radiology services to patients who reside in this District, venue is proper in this District pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. § 1391(b).

THE PARTIES

9. Plaintiff is the United States of America. Through its agencies, the Government administers and funds the Federal health care programs at issue in this action. More specifically, the Centers for Medicare & Medicaid Services ("CMS"), a component within the U.S. Department of Health and Human Services ("HHS"), administers the Medicare and Medicaid

programs; the Defense Health Agency ("DHA") administers the TRICARE program; and the U.S. Department of Veterans Affairs administers Veterans Health Administration programs.

10. Defendant The Radiology Group is a radiology services company headquartered in Atlanta, Georgia. TRG provides teleradiology services—radiology services that are provided remotely—for hospitals, urgent care centers, and primary care physician centers located throughout the United States. TRG has provided radiology services for thousands of Federal health care program beneficiaries.

11. Defendant Anand Lalaji, M.D. is TRG's Chief Executive Officer and a co-owner of the practice. Lalaji is a Board-certified radiologist, and oversaw all aspects of TRG's operations during the Relevant Period, including with respect to its provision of radiology services and billing Federal health care programs for these services.

12. Relator Allison Lynes was employed by TRG as its Director of Operations from approximately 2014 to 2018. Relator Jeffrey Zuckerman, M.D., is a Board-certified radiologist, and was formerly an independent contractor for TRG. On or about April 22, 2019, the relators filed a complaint under the *qui tam* provisions of the FCA and comparable state false claims laws alleging, among other things, that Defendants misrepresented the identities of radiologists who performed services billed to Federal health care programs and sought reimbursement from Federal health care programs for radiology interpretations that had not been reviewed by U.S.-based radiologists.

RELEVANT BACKGROUND

I. THE FALSE CLAIMS ACT

13. The FCA establishes treble damages liability to the United States for an individual who, or entity that, "knowingly presents, or causes to be presented, a false or fraudulent claim for

payment or approval," 31 U.S.C. § 3729(a)(1)(A); or "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim," 31 U.S.C. § 3729(a)(1)(B).

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

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

II. THE FEDERAL HEALTH CARE PROGRAMS AT ISSUE

16. ***Medicare***. In 1965, Congress enacted Title XVIII of the Social Security Act, commonly known as "Medicare," to pay for health-care services and items for the elderly and disabled. 42 U.S.C. § 1395 *et seq.* HHS is responsible for the administration and supervision of the Medicare program. CMS is an agency of HHS and is directly responsible for the administration of the Medicare program.

17. Medicare has several parts, including Part B, which provides coverage for outpatient medical services, including radiology services. *See generally* 42 U.S.C. §§ 1395j–1395w-6.

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

19. ***Medicaid***. Pursuant to the provisions of Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, the Medicaid program was established in 1965 as a joint federal and state program created to provide financial assistance to qualified individuals with low income to

enable them to receive medical care. Under Medicaid, each state establishes its own eligibility standards, benefit packages, payment rates, and program administration rules in accordance with certain federal statutory and regulatory requirements. The states directly pay the health care providers for services rendered to Medicaid recipients, with the states obtaining the federal share of the Medicaid payment from accounts which draw on the United States Treasury. *See* 42 C.F.R. § 430.0 *et seq*. The federal portion of each state's Medicaid payments, known as the Federal Medical Assistance Percentage ("FMAP"), is based on the state's per capita income compared to the national average. 42 U.S.C. § 1396d(b).

20. The majority of states award contracts to private companies to evaluate and process claims for payment on behalf of Medicaid recipients. Typically, after processing the claims, these private companies then generate funding requests to the state Medicaid programs. Before the beginning of each calendar quarter, each state submits to CMS an estimate of its Medicaid federal funding needs for the quarter. CMS reviews and adjusts the quarterly estimate as necessary and determines the amount of federal funding each state will be permitted to draw down as it incurs expenditures during the quarter. The state then draws down federal funding as actual provider claims are presented for payment. After the end of each quarter, the state then submits to CMS a final expenditure report, which provides the basis for adjustment to the quarterly federal funding amount (to reconcile the estimated expenditures to actual expenditures). *See* 42 C.F.R. § 430.30.

21. Providers who participate in the Medicaid program must sign enrollment agreements with the state that certify compliance with state and federal Medicaid requirements. The agreements require, in substance, that the Medicaid providers agree to comply with all state

and federal laws and Medicaid rules and regulations in connection with providing services and care to patients and billing the state Medicaid program for services or supplies furnished.

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

23. ***Medicare and Medicaid Managed Care.*** Private insurers and managed care organizations may offer Medicare coverage to beneficiaries through Medicare Part C as Medicare Advantage Organizations ("MAOs") and may offer Medicaid benefits as Medicaid Managed Care Organizations ("MCOs"). MAOs enter into contracts with CMS under which they agree to provide Medicare benefits to beneficiaries, and MCOs contract with states to provide Medicaid benefits to beneficiaries. Pursuant to those contracts, the MAOs or MCOs are paid a capitated rate based on the number of Medicare and Medicaid beneficiaries they service and the level of sickness of those beneficiaries. Radiology services provided to beneficiaries who receive Medicare or Medicaid benefits through an MAO or MCO are paid for by the MAO or MCO if covered.[1] The MAO or MCO makes the initial determination, subject to appeal, as to whether the services are covered by Medicare or Medicaid.

24. ***TRICARE***. TRICARE (formerly known as CHAMPUS) is part of the United States military's health care system, designed to maintain the health of active-duty service personnel, provide health care during military operations, and offer health care to non-active duty beneficiaries, including dependents of active duty personnel and military retirees and their dependents. The military health system, which is administered by DHA, is composed of the

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

direct care system, consisting of military hospitals and military clinics, and the benefit program, known as TRICARE. TRICARE is a triple-option benefit program designed to give beneficiaries a choice between health maintenance organizations, preferred provider organizations, and fee-for-service benefits.

25. ***Veterans Health Administration Programs***. The Department of Veterans Affairs, through the Veterans Health Administration, administers health care programs that cover the costs of health services for eligible veterans and beneficiaries. *See* 38 U.S.C. § 1701 *et seq*.

III. THE RELEVANT FEDERAL HEALTH CARE PROGRAM REQUIREMENTS

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

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

28. Claims for Medicare Part B services are submitted on CMS form 1500 or its electronic equivalent. The CMS 1500 form requires the provider who signs the form to represent

that: "[i]n submitting this claim for payment from federal funds, I certify that: . . . the services on this form were . . . personally furnished by me." Under the line, "Signature of Physician (or Supplier)," the individual is also directed to represent: "I certify that the services listed above were personally furnished by me."

29. In addition, with limited exceptions not relevant here, health care providers are prohibited from seeking reimbursement from Medicare for any services furnished outside the United States. *See* 42 U.S.C. § 1395y(a)(4); 42 C.F.R. § 411.9(a).

30. CMS has published manuals that provide guidance to health care providers. In the Medicare Program Integrity Manual, for example, CMS identifies the following examples of fraudulent practices: billing for services not furnished and misrepresenting the identity of the individual who furnished the services. *See* Medicare Program Integrity Manual, Pub. 100-08, Ch. 4.2.1.

31. Further, in CMS's Medicare Benefit Policy Manual, CMS has noted that "[p]ayment may not be made for a medical service (or a portion of it) that was subcontracted to another provider or supplier located outside the United States. For example, if a radiologist who practices in India analyzes imaging tests that were performed on a beneficiary in the United States, Medicare would not pay the radiologist or the U.S. facility that performed the imaging test for any of the services that were performed by the radiologist in India." *See* Medicare Benefit Policy Manual, Pub. 100-02, Ch. 16 § 60 (Feb. 23, 2007).

32. Other Federal health care programs include similar requirements. For example, providers of services to TRICARE beneficiaries are required to comply with TRICARE's program requirements, including its anti-abuse provisions. *See* 32 C.F.R. §199.9(a)(4). Examples

of TRICARE program fraud include billing for services not rendered and misrepresentations of the identity of the person who rendered the services. *Id.* at §§ 199.9(c)(1) and 199.9(c)(6).

33. Similarly, the State of Georgia's Department of Community Health's Division of Medicaid has published Policies and Procedures for Physician Procedures, which observe that "[i]ndiscriminate billing under one physician's name or provider number without regard to the specific circumstances of rendition of the services is prohibited and is grounds for disallowing reimbursement or for recoupment of reimbursement." Georgia, Department of Community Health, Division of Medicaid, *Policies and Procedures for Physician Services (Part II)*, Ch. 601.1. (Jan. 1, 2024). The publication further notes that "[a] physician may not bill for services rendered by a person not approved to provide that service by Medicaid Policy, or by applicable licensure, certification, or other State or Federal Regulation." *Id.*

FACTUAL ALLEGATIONS

I. Professional Diagnostic Radiology

34. A diagnostic radiologist reviews and interprets imaging scans to diagnose a patient. Examples include Computed Tomography scans ("CT scans"), Magnetic Resonance Imaging ("MRI"), and ultrasounds.

35. The time it takes to review the imaging can vary depending on the type of test performed. CT and MRI images are arranged in a "stack" that permit a radiologist to scroll through and review them. A CT scan may have anywhere from fifty to over a thousand images in a stack, while an MRI may have hundreds of such images. In order to prepare the Interpretation Report and diagnose any conditions, a radiologist must review the relevant images.

36. Professional diagnostic radiology services are reimbursed by Federal health care programs under specific billing codes that correspond to the services provided, such as CPT Code 71046 (chest x-ray, two views) and CPT Code 73721 (MRI, any joint of lower extremity,

without contrast material). TRG, through a billing company that it hired, submitted tens of thousands of claims for reimbursement to Federal health care programs for professional diagnostic radiology services furnished by its employees and contractors.

II. TRG "Rubber Stamped" Interpretation Reports Prepared By Individuals Located Outside the United States Who Were Not Permitted to Practice Medicine in the United States or Bill Federal Healthcare Programs

37. TRG contracted with companies based in India to conduct initial reviews of the imaging transmitted by Healthcare Providers and to prepare Interpretation Reports. TRG also separately employed and contracted with U.S.-based and licensed radiologists. The U.S.-based radiologists were supposed to review the Interpretation Reports prepared by the individuals in India, conduct an independent and separate review of the images, and make any necessary changes to the report before it was transmitted to a Referring Provider. The final Interpretation Reports were signed by the U.S.-based radiologist, who was responsible for the Interpretation Report's content.

38. Defendants knew that the TRG-contracted individuals located in India who prepared draft Interpretation Reports were not permitted to practice medicine in the United States or bill Federal health care programs. Nevertheless, certain TRG radiologists merely "rubber stamped" the draft reports, and transmitted them to the Health Care Providers without conducting a meaningful and adequate review of the findings contained in the draft Interpretation Reports prepared by persons in India.

39. Defendants did not implement sufficient procedures or controls to ensure that TRG radiologists actually performed the radiology services reflected in the final Interpretation Reports that TRG radiologists signed. During the Relevant Period, Defendants' own internal reporting showed that certain TRG radiologists had approved and signed over ten thousand Interpretation Reports in a single month. Despite these findings, Defendants failed to take necessary steps to

ensure that these radiologists had appropriately reviewed all of the relevant images associated with the radiology scans and had verified the accuracy of the Interpretation Reports before approving and signing them.

40. For instance, Radiologist A[2] approved, signed, and transmitted to Healthcare Providers over 100,000 Interpretation Reports during the Relevant Period. He frequently approved, in less than thirty seconds, Interpretation Reports of CT scans prepared by persons in India.

41. As an example, in December 2017, a hospital emergency room requested that TRG interpret a CT scan of a patient's abdomen. A TRG contactor in India prepared a draft Interpretation Report for this CT scan, and Radiologist A approved the draft report in less than 16 seconds. It was not possible for Radiologist A to have reviewed all of the images associated with the CT scan and properly considered whether any changes should have been made to the Interpretation Report in fewer than 16 seconds. TRG, through its billing company, subsequently submitted a claim for payment to Medicare for the professional diagnostic radiology services provided to this patient, and Medicare paid the claim.

42. Beginning in 2017, Defendants began to internally track the amount of time radiologists spent reviewing the draft Interpretation Reports prepared by the India-based contractors. Defendants' review identified Radiologist A's turn-around times as "notably short," particularly with respect to MRI and CT studies. In October 2017, TRG advised Radiologist A to achieve "more realistic [turn-around times.]" However, Radiologist A continued to approve and sign Interpretations Reports prepared by individuals in India without engaging in any meaningful review, and Defendants failed to take further appropriate action.

[2] Upon information and belief, Radiologist A no longer resides in the United States.

43. TRG was also supposed to document critical findings for Referring Providers by "tagging" the accompanying report as critical on the online-based platform. TRG's India-based contractors did not have the capacity to apply the "critical" tag, which was the responsibility of the U.S.-based reviewing radiologist. Healthcare Providers repeatedly complained to TRG that Radiologist A had not applied the critical tag when necessary, but Defendants still continued to rely on Radiologist A to interpret scans.

44. In sum, Defendants failed to ensure that their U.S.-based credentialed radiologists had, in fact, furnished the radiology services for which Defendants, through their billing company, submitted claims for payment to Federal health care programs. As a result, the claims falsely misrepresented that the services were rendered by U.S.-based radiologists who were enrolled in the Federal health care programs.

III. Defendants Routinely Misrepresented That The Rendering Provider Was Lalaji And The Other TRG Owner In Federal Health Care Program Claims

45. Defendants also understood that they were prohibited by Federal health care program rules from submitting claims for reimbursement for radiology services if the radiologist listed as the rendering provider on the claim for reimbursement had not actually rendered the services.

46. Defendants, however, consistently submitted, or caused to be submitted, claims for payment to Federal health care programs that identified either Lalaji or the other owner of TRG as the rendering provider, even though they had not in fact rendered the radiology services for which reimbursement was sought.

47. Lalaji was well aware of this improper billing practice. For example, on January 18, 2016, TRG's billing company emailed a chart to Lalaji and others that listed twelve TRG

radiologists as the actual rendering providers, but showed that the services would all be billed to Medicare and Medicaid under the names and NPIs of Lalaji and the other owner of the practice.

48. Although TRG internal reports showed that Lalaji and the other owner of the practice rendered less than 10% of the total diagnostic radiology services billed by TRG, Defendants listed them as the rendering provider on over 80% of the claims submitted to Medicare Part B during the Relevant Period.

49. For example, TRG, through its billing company, submitted a claim for payment to Medicare for an interpretation, prepared in September 2018, of a CT scan of the brain without contrast. In that claim, TRG falsely identified Lalaji as the rendering provider. Lalaji, however, did not prepare the Interpretation Report associated with this CT scan, which was signed by a different TRG radiologist.

IV. Defendants Improperly Billed Medicare for Services Performed Outside the United States

50. Defendants also knowingly submitted, or caused to be submitted, claims for payment for radiology services that were furnished outside the United States.

51. As set forth above, Defendants billed Medicare in instances for where a U.S.-based radiologist rubber stamped the Interpretation Report prepared by contractors in India. In these instances, the professional radiology services were in all practical respects performed in India.

52. Further, on numerous occasions, Defendants submitted claims for payment for diagnostic radiology services provided by a TRG radiologist who resided and worked in the United Kingdom ("Radiologist B"). Many of these claims for payment falsely listed Lalaji as the rendering provider.

53. Lalaji knew that Radiologist B lived in the United Kingdom. In June 2017, for example, Lalaji received an email noting that Radiologist B had only been in the United States

for a total of two weeks in the past seven years and had little desire to ever go back to the United States.

* * *

54. As result of the above-referenced improper practices, Defendants submitted, or caused to be submitted, thousands of false claims to Federal health care programs in violation of the FCA.

FIRST CLAIM

Violations of the False Claims Act: Presenting False Claims for Payment

31 U.S.C. § 3729(a)(1)(A)

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

56. The Government asserts claims against Defendants under 31 U.S.C. § 3729(a)(1)(A).

57. As a result of the improper practices set forth above in connection with the provision and billing of professional radiology services to Federal health care programs, Defendants knowingly presented, or caused to be presented, false or fraudulent claims for payment or approval in violation of 31 U.S.C. § 3729(a)(1)(A).

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

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

60. By reason of these false or fraudulent claims, the Government has been damaged in a substantial amount to be determined at trial, and is entitled to recover treble damages plus a civil monetary penalty for each false claim.

SECOND CLAIM

Violations of the False Claims Act: Use of False Statements

31 U.S.C. § 3729(a)(1)(B)

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

62. The Government asserts claims against Defendants under 31 U.S.C. § 3729(a)(1)(B).

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

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

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

PRAYER FOR RELIEF

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

(a) A sum equal to treble damages and civil penalties to the maximum amount allowed by law; and

(b) Granting the Government costs and such further relief as the Court may deem proper.

Dated: New York, New York
March 26, 2024

DAMIAN WILLIAMS
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Southern District of New York

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