CONFIDENTIAL

MC-060

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FOR COURT USE ONLY

FILED/ENDORSED
JUL 13 2012
By L. Gutierrez Deputy Clerk

SUPERIOR COURT OF CALIFORNIA, COUNTY OF Sacramento
STREET ADDRESS: 720 9th Street
MAILING ADDRESS:
CITY AND ZIP CODE: Sacramento, CA 95814
BRANCH NAME: Gordon D. Schaber Sacramento County Courthous

PLAINTIFF: **[UNDER SEAL]**

DEFENDANT: **[UNDER SEAL]**

CONFIDENTIAL COVER SHEET—FALSE CLAIMS ACTION

CASE NUMBER:
34-2012-00127426

INSTRUCTIONS: This civil action is brought under the False Claims Act, Government Code section 12650 et seq. The documents filed in this case are under seal and are confidential pursuant to Government Code section 12652(c).

This Confidential Cover Sheet must be affixed to the caption page of the complaint and to any other paper filed in this case until the seal is lifted.

You should check with the court to determine whether papers filed in False Claims Act cases must be filed at a particular location.

Seal to expire on *(date)*:

UNLESS:
(1) Motion to extend time is pending; or
(2) Extended by court order

1. The document to which this cover sheet is affixed is:
   a. [X] Complaint for damages for violation of the False Claims Act
   b. [ ] *Civil Case Cover Sheet* (form 982.2(b)(1))
   c. [ ] Motion for an extension of time to intervene
   d. [ ] Affidavit or other document in support of the motion for an extension of time
   e. [ ] Order extending time to intervene *(specify date order expires)*:
   f. [ ] Other order *(describe)*:

   g. [ ] Notice from the Attorney General of additional prosecuting authority that may have access to the file
   h. [ ] Other *(describe)*:

2. This *Confidential Cover Sheet* and the attached document must each be separately file-stamped by the clerk of the court.

Date: July 13, 2012

Form Adopted for Mandatory Use
Judicial Council of California
MC-060 [Rev. January 1, 2007]

CONFIDENTIAL COVER SHEET
FALSE CLAIMS ACTION

Legal Solutions Plus

Gov. Code, § 12652(c);
Cal. Rules of Court, rules 2.570-2.573

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Case Management 36
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IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF SACRAMENTO

STATE OF CALIFORNIA *ex rel.* **[FILED UNDER SEAL]**,

Plaintiff,

vs.

[FILED UNDER SEAL],

Defendants.

Case No. _____

COMPLAINT

(1) FOR VIOLATIONS OF THE CALIFORNIA INSURANCE FRAUDS PREVENTION ACT,

AND

(2) FOR VIOLATIONS OF THE CALIFORNIA FALSE CLAIMS ACT

(Cal. Gov. Code § 12652; Cal. Ins. Code § 1871.7)

DEMAND FOR JURY TRIAL

FILED IN CAMERA AND UNDER SEAL

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IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF SACRAMENTO

STATE OF CALIFORNIA *ex rel.* **ANNA MARIA CHRISTINA SILLS**

Plaintiff,

vs.

Bahar Gharib-Danesh, D.C.;
Anthony Danesh;
Mohammad Gharib;
Khosrow Gharib;
Joanna Munguia;
Nira Hariri;
John T. Terrence;
Charles Michael Boyer, D.C.
Na Young Eoh, D.C.;
Laura Lyn Hazen, D.C.;
Lana Elizabeth Montes, D.C.;
Jorge A. Rivas, D.C.;
Rodrigo T. Sanchez, D.C.;
Tushar Ramnik Doshi, M.D.;
Boniface Okwudili Onobah, M.D.;
William Bernard Simpson, M.D.;
Behnoush Zarrini, M.D.;

Case No.

COMPLAINT

(1) FOR VIOLATIONS OF THE CALIFORNIA INSURANCE FRAUDS PREVENTION ACT,

AND

(2) FOR VIOLATIONS OF THE CALIFORNIA FALSE CLAIMS ACT

(Cal. Ins. Code § 1871.7; Cal. Gov. Code § 12652)

DEMAND FOR JURY TRIAL

Bahar Gharib-Danesh Chiropractic, Inc.;
Pain Free Management Company LLC;
Pain Relief Health Center, LLC;
Pain Free Diagnostic;
CA Orthopedic and Pain Centres, Inc., a Medical Corporation;
Southern CA Pain Centre, Inc.;
Mindwaves Psychological Services, Inc.;
Sanchez Chiropractic, Inc.;
United Health Services;
Omnipysch, a Medical Corporation;
Southern California Industrial Clinic;
Encino Care Pharmacy, Inc.;
and DOES 1 through 60,

Defendants.

FILED IN CAMERA AND UNDER SEAL

TABLE OF CONTENTS

I. INTRODUCTION

1. This *Qui Tam* lawsuit is brought to stop the rampant insurance fraud perpetrated by **pain management health clinics** in California. This fraud is achieved through the unlawful employment of "runners, cappers and steerers," and a pattern and practice of overbilling, billing for services never rendered, ordering unnecessary treatments, tests, and evaluations, billing for medical services that are only superficially provided by untrained low-wage workers, and using unaffiliated physicians' credentials to unlawfully order prescription drugs in the area of chronic pain management. The Defendants named herein are running a "medical billing mill." By virtue of their unlawful scheme, Defendants, and their unnamed co-conspirators, have cheated the California Workers' Compensation System, including the State Compensation Insurance Fund ("SCIF"), Medi-Cal, and private insurers out of hundreds of millions of dollars.

2. At the center of the scheme are seven pain management clinics (the "Clinics") in Southern California, largely owned and controlled by Defendant Bahar Gharib-Danesh, D.C. Together, these Clinics see hundreds of patients per day under the guise of "pain management" diagnosis and treatment. The Clinics obtain these patients through unlawful referrals from attorneys in exchange for a guaranteed diagnosis.

3. The Clinics have instituted and engaged in a pattern and practice of ordering dozens of tests, treatments, and medications for **all** patients, regardless of injury or proper medical diagnosis. Many of these procedures are never performed, and patients often never receive the medications for which the insurers pay. This scheme subjects the Clinics' patients to dangerous medical treatments and medications that are unnecessary, unproven, and conducted solely for billing purposes. Each stage of the patients' care is designed to fraudulently maximize billing while providing no actual medical care or benefit. The following language

from a June 22, 2012 email from Defendant Gharib-Danesh to employees at the Clinics exemplifies this fraudulent pattern and practice:

> So managers from now on any MD clinic If 20 patients come in
> Central needs to get 20 RX /20 Referal needed /20 Eswt screening form /20 pr2 s emailed back to central.

Managerial employees at the Clinics would be terminated if they did not schedule each patient for a minimum number of treatments, tests, and medications.

4. The Clinics invariably order each patient to undergo a boilerplate battery of treatments, tests, and medications. The physicians, chiropractors, psychologists, and other personnel at the Clinics prescribe these treatments without regard for necessity, effectiveness, or patient safety. The Clinics do not tailor care to a patient's unique medical situation and do not base treatment on a review of the results of the medical tests. Employees would be demoted if they did not schedule patients. An excerpt from an email dated November 17, 2011 from Defendant Joanna Munguia, operations manager at one of Defendant Clinics, to Defendant Doctor Eoh, as well as several employees of the Clinics:

> **Joanna Mungula** jmunguiaprhc@gmail.com 11/17/11
>
> to Jessica, Mildred, Lizet, mayra, Maribel, me, bahardc, Eoh
>
> Managers and Med Rep,
> This is a verbal warning to all of you. We need to make make sure we are scheduling 60 patients for the MD clinics.
> The show up rate is very low anything below a 50% will result in a written notice or possible demotion.
> Also remember all the patients that come in for MD need to get UA and meds. The numbers are very off, you need to monitoring this, this is part of your job!!!!
> Let me know what the issues are
>
> **Joanna Mungula**

5. The majority of the treatments are useless and only used to bill for the alleged services. Physical therapy treatments, diagnostic tests, psychiatric evaluations, and therapeutic massages are performed by uncertified low-wage employees and provide no curative effect. Indeed, a number of the treatments

require the use of complex and dangerous medical equipment that stimulate nerves with electricity or use ultrasonic sound waves that can damage tissue. The technicians who operate these machines have no understanding of how to treat specific injuries using the different settings and functions of these machines. **Every patient receives treatment under the exact same setting regardless of that patient's specific injury, e.g., thumb or hip injury, or whether his or her pain is muscular, skeletal, or due to damaged nerves.** Despite the carousel of tests and treatments, most patients never see any improvement in their chronic pain.

6. The Clinics bill excessive numbers of treatments, tests, and prescriptions. The billing and collection personnel at the Clinics faced warnings, demotions, and even terminations if all treatments, tests, and prescriptions were **not** billed, whether or not there was a doctor's order or other evidence of medical necessity supporting the bill. Below is an excerpt from a December 13, 2011 email from Defendant Danesh to several employees demanding the employees performing billing and collections improve the billing numbers OR ELSE:

On Tue, Dec 13, 2011 at 7:46 AM, Bahar <bahardc@gmail.com> wrote:
Hi Everyone

-Unfortunately we have to make big changes since billing departments is failing and we are givin this one last chance , numbers needed dont get accomplished - department will be shut and billing outsourced...
Changes :
- Johana will manage the billing Department till we find a better management system
- numbers u see on the board are what needs to be done. If u are close to max required u will get a bonus. If u are below Min then unfortunately we can't keep u in that department. This is for both billing and mailing numbers.

-No personal phone calls.
-No more excused , info missing u can't bill - put it in the Box for central to fix. Otherwise Bill Bill Bill NO EXCUSE
Mail Mail Mail NO EXCUSE

7. Defendants have also unlawfully misappropriated the credentials of unaffiliated physicians in an attempt to legitimize their operations. The Clinics display the names of these physicians on their website to create the perception that they actually treat patients at the Clinics. Further, the Clinics prescribe controlled substances using the DEA Numbers of these physicians. In some instances, the Clinics establish superficial or short-lived relationships with physicians, then, after the relationship has ended, use the physician's name to order and bill for procedures the physicians did not authorize. Other physicians allow untrained workers to perform their duties, then sign off and bill insurers and the State at their full rates.

8. After the Clinics write prescriptions for all of their patients, they often dispense the medications directly from their office. The Clinics also have a relationship with pharmacies that fill prescriptions without question. Patients are never given the freedom to have written prescriptions filled at the pharmacy of their choice, as required under California law.

9. The affiliated pharmacies carefully monitor the number of medications each patient receives and stop filling prescriptions once the patient crosses a predetermined threshold that might draw the attention of insurers or regulators. Together, the Clinics and pharmacies ensure they are dispensing and billing insurers for the maximum number of prescriptions possible for each patient.

10. *Qui Tam* Plaintiff, through investigation and inside knowledge of Defendants' operations, has obtained vast non-public evidence from various sources supporting the allegations contained in this Complaint. Among other evidence, *Qui Tam* Plaintiff is in possession of email correspondence from Defendant Bahar Gharib-Danesh demanding her employees order medications and urinalysis for each and every patient that is seen at her clinics, **whether or not** the patient requires the medication or testing. *Qui Tam* Plaintiff also is in possession

of the Central Logs used to track treatments each patient allegedly receives. The Clinics use a Central Log System to ensure each patient receives the maximum number of billable medical services, and to direct patient care accordingly.

11. Additionally, *Qui Tam* Plaintiff has obtained bills and invoices charging thousands of dollars per patient for a battery of psychological tests for patients who sought care at the Clinics. The Clinics and their affiliated psychologist consistently bill insurers for many more examinations than is humanly possible, **sometimes for hundreds of hours of evaluations in a single day**. *Qui Tam* Plaintiff has also obtained detailed admissions and descriptions from individuals involved in this chronic pain management scheme.

12. California's employers, including its public employers, are required by law to carry workers' compensation insurance. In 2010, employers paid over **$7 billion** in insurance premiums to **private insurers** or **SCIF**, to cover their workers' compensation liability. In turn, these insurers have paid billions in medical claims related to injured workers. As a result of the unlawful scheme described herein, private workers' compensation insurers, other private insurers, SCIF, and Medi-Cal have paid for millions in medically unnecessary tests, treatments, and medications. This unlawful and fraudulent scheme by Defendants has increased the cost of mandatory workers' compensation coverage for California's employers and insurance premiums in the private market for every day working people.

13. The Legislature established the State Compensation Insurance Fund in 1914. It is now the largest provider of workers' compensation coverage in California. SCIF is a division of the California Department of Industrial Relations and is considered a California state agency. *Gilmore v. SCIF* (1937) 23 Cal.App.2d 325, 329 (SCIF "is an agency of the state."). SCIF's mission is to provide an available market for workers' compensation insurance at fair rates, and to serve as a model for all workers' compensation carriers. SCIF includes

approximately 150,000 policyholders, more than $1.2 billion in premiums, and nearly $20 billion in assets. In addition to covering private employers, SCIF also acts as the workers' compensation carrier for several California state agencies and political subdivisions. *See* Ins. Code § 11870. SCIF has been fraudulently billed for millions of dollars by Defendants.

14. Additionally, many of the Defendants' patients received treatments paid for by Medi-Cal – California's safety net for individuals unable to afford health insurance. Medi-Cal is intended to provide essential care for California's growing indigent population, but its funds are presently stretched to their limit. Medi-Cal has been defrauded and abused by unscrupulous providers and others involved in the healthcare system, including Defendants in this case, who put profits above the public welfare. These unlawful schemes diminish the quality of care, and substantially burden taxpayers.

II. JURISDICTION AND VENUE

15. This Court has jurisdiction over the claims in this Complaint pursuant to California Insurance Code § 1871.7 (the "California Insurance Frauds Prevention Act") and California Government Code § 12652 (the "California False Claims Act").

16. All of the entities named in this Complaint operate under the laws of California and conduct substantial business within the State of California, as well as maintain employees and offices within the State. The entities' unlawful, false, and/or fraudulent conduct took place within the State of California.

17. All individuals named in this Complaint reside in California. Their unlawful, false, and/or fraudulent conduct took place within California.

18. Venue in the County of Sacramento is appropriate pursuant to the California Insurance Frauds Prevent Act and the California False Claims Act. *Qui Tam* Plaintiff brings this action to recover unlawful, false, and/or fraudulent claims on behalf of the California Department of Insurance, the State Compensation

Insurance Fund, and Medi-Cal. These state agencies, as well as their special investigative units, are located in the County of Sacramento. Moreover, any recovery achieved under these statutes is returned to the State of California and the appropriate public agency.

III. PARTIES

A. *Qui Tam* Plaintiff

19. The Plaintiff in this action is the State of California, by and through *Qui Tam* Plaintiff **Anna Maria Christina Sills**, pursuant to Insurance Code § 1871.7(e)(1) and California Government Code § 12652.

20. *Qui Tam* Plaintiff **Anna Maria Christina Sills** is an individual and former employee of Defendant Pain Free Management Company LLC, an entity at the center of this conspiracy ("Pain Free Management"). Her employment with Pain Free Management provided her with the opportunity for understanding all of the related entities, also named as Defendants herein, owned and controlled by Defendant Gharib-Danesh and others. *Qui Tam* Plaintiff Anna Maria Christina Sills is an "original source" as that term is defined, and she has direct and independent knowledge of the information on which these allegations are based. The facts set forth herein are based entirely upon her personal observation, investigation, documents, and other tangible things in her possession.

21. In November 2011, *Qui Tam* Plaintiff was hired by Pain Free Management, in Reseda, California as the billing and collections manager. Her duties at Pain Free Management were to structure the internal billing and collections department, implement billing software, and perform billing and collections work for Pain Free Management and numerous other clinics under the control of Defendant Gharib-Danesh. Prior to *Qui Tam* Plaintiff's employment, Pain Free Management and the other clinics outsourced billing and collection services. *Qui Tam* Plaintiff was hired to develop internal billing and collection services for Pain Free Management and other related entities.

22. *Qui Tam* Plaintiff stayed at Pain Free Management through February 2012, during which time she had access to the books and records of Pain Free Management, and numerous other clinics and entities who participated in the schemes as hereinafter alleged.

23. During her employment at Pain Free Management, *Qui Tam* Plaintiff raised concerns several times concerning the billing practices of Pain Free Management and the other clinics. For example, as shown above, on December 13, 2011, Defendant Gharib-Danesh emailed *Qui Tam* Plaintiff and several other employees, stating "[u]nfortunately we have to make big changes since billing departments is failing and we are givin this one last chance, numbers needed don't get accomplished [*sic*]...." In response, *Qui Tam* Plaintiff wrote "[t]he problems are that we don't get information to bill correctly and efficiently...." *See* **Exhibit A**. *Qui Tam* Plaintiff was told directly and/or in substance or affect that her duties as a billing and collections managers included not only structuring the internal billing work as stated above but: a) she was to sign doctors' name to prescriptions; b) she was to use different coding; c) she was to make sure that each bill had the maximum amount of tests; d) she was to engage in various different activities which were illegal on their face; e) she was told to insert doctors' names where necessary; and, above all else, f) she was instructed to keep quiet about the operation.

24. *Qui Tam* Plaintiff was terminated because she repeatedly raised concerns and refused to participate in the fraud being perpetrated at Pain Free Management and the other Defendants, as more fully alleged herein.

25. Concurrently herewith, *Qui Tam* Plaintiff will provide the Attorney General's office, the Sacramento County District Attorney, and the Insurance Commissioner of California with a full disclosure of substantially all material facts, as required by Cal. Ins. Code § 1871.7(e)(2), and Government Code §12652.

B. **Individual Defendants**

26. **Defendant Bahar Gharib-Danesh, D.C.** ("Gharib-Danesh"), California Board of Chiropractic Examiners License Number 28361, is the owner and operator of many of the Defendant Clinics and entities named herein, and she is at the center of this medical billing fraud conspiracy. She is a chiropractor practicing in Southern California. The entities owned and controlled by Gharib-Danesh have instituted a pattern and practice of defrauding public and private insurers, and California's consumers. Gharib-Danesh is also active in the scheme as a chiropractor. **She schedules patients that she never sees, signs off on treatments and tests that she does not perform or supervise, and bills insurers for her time and services.**

27. Gharib-Danesh also pressures her office workers and medical assistants into performing medical duties far beyond the scope of their training and aptitude. She has instituted a number of policies requiring clerks and assistants to bill insurers, forge and stamp the signatures of physicians, and provide medication to patients. Gharib-Danesh is also responsible for the relationships with the pharmacies that fill her patients' prescriptions.

28. Gharib-Danesh has knowingly and unlawfully: (a) employed unlawful "runners, cappers, and steerers" to refer patients to her Clinics; (b) engaged in a pattern and practice of ordering unnecessary medical tests and treatments; (c) consistently allowing untrained workers to perform her licensed duties for her; (d) fraudulently billed insurers for these tests and treatments; (e) caused other physicians to order and perform unnecessary and medically insufficient medical treatments; and (f) caused others to prepare and present fraudulent documents for the purpose of billing insurers.

29. **Defendant Anthony Danesh** ("Tony Danesh") is the brother of Gharib-Danesh. Tony Danesh is the senior operations manager of the Clinics.

Tony Danesh has knowingly engaged in the schemes described herein as well as aided and abetted Gharib-Danesh in perpetuating this fraud.

30. **Defendant Mohammad Gharib** ("Mohammad Gharib") is the father of Gharib-Danesh. Mohammad Gharib owns some clinics as a straw person for Gharib-Danesh. Mohammad Gharib has knowingly engaged in the schemes described herein and aided and abetted Gharib-Danesh in perpetuating this fraud.

31. **Defendant Khosrow Gharib** ("Khosrow Gharib") is the mother of Gharib-Danesh. Khosrow Gharib owns some of the clinics as a straw person for Gharib-Danesh. Khosrow Gharib has knowingly engaged in the schemes described herein as well as aided and abetted Gharib-Danesh in perpetuating this fraud.

32. Defendants Mohammad Gharib and Khosrow Gharib were responsible for processing all mail and depositing all checks. They would arrive at the Clinics with suitcases filled with mail and checks from insurers, and then secretly process these payments through the various Defendant entities.

33. **Defendant Joanna Munguia** ("Munguia") is Operations Manager of Defendant Pain Free Management and acts as Gharib-Danesh's right-hand. Munguia has directed employees of the Clinics to engage in the schemes described herein as well as aided and abetted Gharib-Danesh in perpetuating this fraud.

34. **Defendant Nira Hariri** ("Hariri"), California Board of Pharmacy License Number 52003, owns and operates **Encino Care Pharmacy**, located at 16001 Ventura Blvd., Suite 135, Encino, CA 91436-4481. She is responsible for ensuring the fraudulently written prescriptions are filled without question and for providing the Clinics with the necessary documents needed to bill the insurers.

35. Defendant Hariri knowingly and unlawfully: (a) filled fraudulent prescriptions for dangerous medications; (b) prepared fraudulent documents in support of a false claim presented to insurers for payment; and (c) submitted false claims to insurers for payment of fraudulently prescribed medications and medications that Hariri never provided to patients.

C. **Defendant Doctors of Chiropractic Medicine**

36. Each of the Defendant Chiropractors listed herein has participated in the unlawful scheme to defraud insurers. Each Defendant Chiropractor has: (a) ordered, or allowed others to order in their name, unnecessary medical tests; treatments, prescriptions, and durable medical equipment; (b) allowed untrained workers to perform their licensed duties for them; (c) fraudulently billed insurers for these medical products and services; (d) caused other physicians to order unnecessary and medically insufficient medical products and perform unnecessary procedures; and (e) caused others to prepare and present fraudulent documents for the purpose of billing insurers.

37. **Defendant Charles Michael Boyer, D.C.** ("Boyer") California Board of Chiropractic Examiners License Number 12366, is a chiropractor practicing in Southern California. His principal place of business is 1421 A Redondo Avenue, Long Beach, California 90804. Boyer is currently employed by Defendant Gharib-Danesh and practices at the Clinics.

38. **Defendant Na Young Eoh, D.C.** ("Eoh") California Board of Chiropractic Examiners License Number 28688, is a chiropractor practicing in Southern California. Eoh's principal place of business is 2920 F Street, #C-5, Bakersfield, California 93301. Eoh is currently employed by Defendant Gharib-Danesh and practices at the Clinics.

39. **Defendant Laura Lyn Hazen, D.C.** ("Hazen") California Board of Chiropractic Examiners License Number 30826, is a chiropractor practicing in Southern California. Her principal place of business is 7677 Center Avenue, Suite 402, Huntington Beach, California 92647. As of December 16, 2011, Hazen was employed by Defendant Gharib-Danesh and practiced at the Clinics.

40. **Defendant Lana Elizabeth Montes, D.C.** ("Montes") California Board of Chiropractic Examiners License Number 30740, is a chiropractor practicing in Southern California. Her principal place of business is 2211 Corinth

Avenue, #301, Los Angeles, California 90064. Montes is currently employed by Defendant Gharib-Danesh and practices at the Clinics.

41. **Defendant Jorge A. Rivas, D.C.** ("Rivas") California Board of Chiropractic Examiners License Number 30558, is a chiropractor practicing in Southern California. His principal place of business is 6944 Reseda Blvd., Reseda, California 91335, which is the same address as Defendants Pain Free Management Company LLC, Pain Relief Health Center, LLC, CA Orthopedic and Pain Centres, Inc., and Southern CA Pain Centre, Inc. As of December 16, 2011, Rivas was employed by Defendant Gharib-Danesh and practiced at the Clinics.

42. **Defendant Rodrigo T. Sanchez, D.C.** ("Sanchez") California Board of Chiropractic Examiners License Number 26487, is a chiropractor practicing in Southern California, and is the owner of Defendant Sanchez Chiropractic, Inc. His principal place of business is 42544 10th Street West, Suite G, Lancaster, California 93534. As of December 16, 2011, Sanchez was employed by Defendant Gharib-Danesh and practiced at the Clinics.

D. Defendant Doctors of Medicine

43. Each of the Defendant Medical Doctors listed herein has participated in the unlawful scheme to defraud insurers. The Defendant Medical Doctors have each: (a) ordered, or allowed others to order in their name, unnecessary medical tests, treatments, prescriptions, and durable medical equipment; (b) allowed untrained workers to perform their licensed duties for them; (c) fraudulently billed insurers for these medical products and services; (d) caused other physicians to order and perform unnecessary and medically insufficient medical products and services; (e) prepared and presented, or caused others to prepare and present, fraudulent documents for the purpose of billing insurers; and (f) failed to provide their patients with the statutorily mandated freedom to choose who fills their prescriptions.

44. **Defendant Tushar Ramnik Doshi, M.D.** ("Doshi") Medical Board of California License Number A53572, is a medical doctor practicing orthopedic surgery in Southern California. Dr. Doshi's principal place of business is P.O. Box 7547, Newport Beach, California 92658. Dr. Doshi attended medical school in India at the University of Bombay, Seth G.S. Medical College. Dr. Doshi is currently employed by Defendant Gharib-Danesh.

45. **Defendant Boniface Okwudili Onobah, M.D.** ("Onobah") Medical Board of California License Number A52415, is a medical doctor practicing neurology in Southern California. Dr. Onobah's principal place of business is 13428 Maxella Avenue, #909, Marina Del Ray, California 90292. Dr. Onobah attended medical school in Nigeria, at the University of Ilorin Faculty of Health Sciences. Dr. Onobah is currently employed by Defendant Gharib-Danesh.

46. **Defendant William Bernard Simpson, M.D.** ("Simpson") Medical Board of California License Number G43101, is a medical doctor practicing orthopedic surgery in Southern California. Dr. Simpson's principal place of business is 34740 Carnaghi, Wildomar, California 92595. Dr. Simpson is responsible for the shockwave therapy treatments at the Clinics, but does not actually perform the treatments himself. Instead, he relies on low-wage workers to perform the tests for him. Those workers then bring him the reports to sign. He also instructs those workers to forge his name on reports when he is not seeing patients at the Clinics. Dr. Simpson ordered shockwave therapy for over twenty patients a day — even though he did not examine the patients beforehand — and ordered four rounds of therapy for every patient. **These treatments, given by low-wage workers, were ineffective, lasting from two to five minutes.** The purpose of these treatments was to maximize the amount billed to insurers, not cure the patients.

47. **Defendant Behnoush Zarrini M.D.** ("Zarrini") Medical Board of California License Number A80739, is a medical doctor practicing pain medicine in Southern California. Dr. Zarrini's principal place of business is 9808 Venice Blvd., #707, Culver City, California 90232. Defendant Zarrini attended medical school in Iran at Tehran University of Medical Sciences and Health Services. Defendant Zarrini is primarily responsible for the prescription drug prong of the scheme operating out of the Clinics. **Under the scheme, Defendant Zarrini writes prescriptions for patients he has not examined and allows office clerks to use his signature and credentials to prescribe medications in his absence.** Under the scheme, Defendant Zarrini also orders medical tests and treatments for patients without regard to their individual medical needs and allows untrained office workers and medical assistants to perform these tests and treatments without supervision.

E. Defendant Doctor of Psychology

48. **Defendant John T. Terrence PsyD, PhD** ("Terrence") is a psychologist with California Board of Psychology License number PSY17840. Terrence's principal place of business is 13900 Panay Way, # DS-35, Marina Del Ray, CA 90292. Terrence purportedly performs psychiatric evaluations on patients in the Clinics. Terrence operates the psychological evaluation arm of the fraudulent billing scheme, performing sham psychiatric evaluations on as many patients as possible and billing insurers for up to **20 hours** in a day for services per patient. Terrence also bills insurers for patients he does not actually evaluate.

49. When submitting bills to insurers, Terrence bills as if he sees up to a dozen patients per day. For each of these patients, Terrence submits he provided **each patient** with over twenty hours of psychological evaluations. In a period of two weeks, Terrence billed in excess of **1,000 hours for services**. *See* **Exhibit B.**

50. Terrence knowingly and unlawfully: (a) ordered unnecessary psychiatric evaluations; (b) fraudulently billed insurers in excess of the services actually rendered; and (c) fraudulently billed for evaluations he did not perform.

F. Defendant Clinics and Other Billing Entities

51. The Defendant Clinics and related Billing Entities herein each participate in the unlawful scheme to defraud insurers. Some of these entities are clinics owned and operated by Defendant Gharib-Danesh. Others merely serve as fictitious entities used to bill insurers. These Clinics and Billing Entities have no purpose other than to divert some of Defendants' fraudulent bills through diverse channels to avoid drawing attention to the immense volume of bills generated by Defendants. **Each entity listed knowingly submits false bills to insurers.**

52. The addresses of the Clinics which Gharib-Danesh operates under the entity names listed below include the following:

a. 6944 Reseda Blvd., Reseda, California 91335 ("Reseda Office");

b. 3580 Wilshire Blvd., Suite 100, Los Angeles, California 90010 ("Los Angeles Office");

c. 1555 W. 5th Street, Suite 270, Oxnard, California 93030 ("Oxnard Office");

d. 2920 F Street, Suite C-5, Bakersfield, California 93301 ("Bakersfield Office");

e. 4201 Long Beach Blvd., Suite 430, Long Beach, California 90807 ("Long Beach Office");

f. 2323 W. Caldwell Avenue, Visalia, California 93277 ("Visalia Office");

g. 1801 E. Edinger Avenue, Suite 125, Santa Ana, California 92705 ("Santa Ana Office"); and

h. 5339 N. Fresno Street, Suite 105, Fresno, California 93710 ("Fresno Office").

53. **Defendant Bahar Gharib-Danesh Chiropractic, Inc.** ("Danesh Chiropractic") is located at 132 Vermont Avenue, Suite 204, Los Angeles, California 90004. Danesh Chiropractic is owned and controlled by Defendant Gharib-Danesh. Danesh Chiropractic is a suspended California corporation.

54. **Defendant Pain Free Management Company LLC** ("Pain Free Management") is a California LLC located at 6944 Reseda Blvd., Reseda, California 91335. Pain Free Management is owned and controlled by Defendants Gharib-Danesh and Tony Danesh.

55. **Defendant Pain Relief Health Center, LLC** ("PRHC") is a California LLC located at 6944 Reseda Blvd., Reseda, California 91335. PRHC is owned and controlled by Defendant Gharib-Danesh.

56. **Defendant Pain Free Diagnostic** ("PFD") is a California corporation located at 4335 Van Nuys Blvd., Suite 422, Sherman Oaks, California 91364. The agent for service of process is Bardia Danesh.

57. **Defendant CA Orthopedic and Pain Centres, Inc., a Medical Corporation** ("CA Orthopedic") is a California medical corporation located at 9644 Reseda Blvd., Reseda, California 91335. CA Orthopedic is owned and controlled by Defendant Tushar Doshi, M.D.

58. **Defendant Southern CA Pain Centre, Inc.** ("Southern CA Pain") is a California medical corporation located at 6944 Reseda Blvd., Reseda, California 91355. Southern CA Pain is owned and controlled by Defendant Behnoush Zarrini, M.D.

59. **Defendant Mindwaves Psychological Services, Inc.** ("Mindwaves") is a California professional corporation located at 4712 Admiralty Way, Suite 476, Marina Del Rey, California 90292. Mindwaves is owned and controlled by Defendant John Terrence, PsyD.

60. **Defendant Sanchez Chiropractic, Inc.**("Sanchez Chiropractic") is a California corporation located at 42544 10th Street West, Suite G, Lancaster,

California 93534. Sanchez Chiropractic, Inc. is owned and controlled by Defendant Rodrigo Sanchez, D.C.

61. **Defendant United Health Services** ("United Health") is a California corporation located at 20929 Ventura Blvd., Suite 47385, Woodland Hills, California 91364. United Health Services is owned and controlled by Bardia Danesh.

62. **Defendant Omnipysch, a Medical Corporation** ("Omnipysch") is a California medical corporation located at 2312 W. Victory Blvd., Burbank, California 91506.

63. **Defendant Southern California Industrial Clinic** ("SoCal Industrial") is a suspended California corporation located at 2717 Angelo Drive, Los Angeles, California 90077. SoCal Industrial is owned and controlled by Khosrow Gharib, the mother of Defendant Gharib-Danesh.

64. **Defendant Encino Care Pharmacy, Inc.** ("Encino Care Pharmacy") is a California corporation located at 16025 Ventura Blvd., Suite 100, Encino, California 91436. Encino Care Pharmacy is owned and controlled by Defendant Nira Hariri.

G. Defendant Does

65. The Defendants set forth above are just a few of the individuals and entities *Qui Tam* Plaintiff knows are involved in the schemes alleged herein. *Qui Tam* Plaintiff is ignorant of the names and capacities of additional individuals and entities sued herein as DOES 1 through 60, inclusive, and therefore sues such Defendants by fictitious names pursuant to California Code of Civil Procedure § 474. *Qui Tam* Plaintiff will amend this Complaint to allege the true names and capacities of the fictitiously named Defendants once they are ascertained.

H. Agents, Co-Conspirators, and Aiders and Abettors

66. *Qui Tam* Plaintiff is informed and believes, and on that basis alleges, that at all times herein mentioned, Defendants, and each of them, were acting as

each other's agents and within the course and scope of their agency with the full knowledge, consent, permission, authorization, and ratification, either express or implied, of each of the other Defendants in performing the acts alleged herein.

67. As members of the conspiracy alleged below, each of the Defendants participated and acted with or in furtherance of said conspiracy, or aided or assisted in carrying out the purposes of the conspiracy, and have performed acts and made statements in furtherance of the conspiracy and other violations of law. Each of the Defendants acted both individually and in alignment with other Defendants with full knowledge of their respective wrongful conduct. As such, the Defendants conspired together, building upon each other's wrongdoing, in order to accomplish the acts outlined in this complaint.

68. Defendants are individually sued as principals, participants, and aiders and abettors in the wrongful conduct complained of and the liability of each arises from the fact that each has engaged in all or part of the improper acts, plans, conspiracies, or transactions complained of herein. Defendants, and each of them, have participated in or in furtherance of the conspiracy and other violations of California law, or aided or assisted in carrying out its purposes as alleged in this Complaint. The conspiracy "may be inferred from the nature of the acts done, the relations of the parties, the interests of the alleged conspirators, and other circumstances." *Sales Corp. v. Olsen* (1978) 80 Cal.App.3d 645, 649.

I. <u>Un-Named Co-Conspirators</u>

69. Various other persons, firms, and corporations, not named herein as Defendants have participated as co-conspirators with Defendants, and each of them, and have performed acts and made statements in furtherance of the conspiracy. In the course of participating in the conspiracy and in furtherance of the objective of the conspiracy, these co-conspirators made statements prior to or during the time these co-conspirators were participating in the conspiracy that fall within the provisions of California Evidence Code Section 1223.

70. Some of these persons, firms, and corporations are as yet unidentified because their identities are unknown to *Qui Tam* Plaintiff at this time. Once the identities of these unknown co-conspirators are ascertained, *Qui Tam* Plaintiff will seek leave of court to add them as Defendants herein. Others that have been identified are set forth herein. *Qui Tam* Plaintiff reserves the right to bring claims against these other persons, firms, and corporations at a later date. The following persons, firms, and corporations have been identified as having knowledge of some of the allegations in this Complaint.

71. **Roger S. Rahn, D.C.** ("Rahn"), California Board of Chiropractic Examiners License Number 19253, is a chiropractor practicing in Southern California. His principal place of business is 5339 N. Fresno Street, Suite 105-E, Fresno, California 93710. Rahn is employed by Defendant Gharib-Danesh and practices at the Clinics. **Dr. Rahn is not named as a defendant in this action.**

72. **Tram Tran Sotelo, D.C.** ("Sotelo") California Board of Chiropractic Examiners License Number 30533, is a chiropractor practicing in Southern California. Sotelo's principal place of business is 1555 W. 5th Street, #210, Oxnard, California 93030. Sotelo is employed by Defendant Gharib-Danesh and practices at the Clinics. **Dr. Sotelo is not named as a defendant in this action.**

73. **Catalino Dominic Dureza, M.D.** ("Dureza") Medical Board of California License Number A66607, is a medical doctor practicing neurological surgery in Southern California. Dr. Dureza's principal place of business is 79935 De Sol A Sol, La Quinta, California 92253. Dr. Dureza is employed by Defendant Gharib-Danesh. **Dr. Dureza is not named as a defendant in this action.**

74. **Raquel Christine Dureza-Muneses, M.D.** ("Dureza-Muneses") Medical Board of California License Number G84893, is a medical doctor practicing neurological surgery in Southern California. On the State of California Medical Board website, Dr. Dureza-Muneses' principal place of business is P.O. Box 94, White Marsh, Maryland 21162. Dr. Dureza-Muneses is currently

employed by Defendant Gharib-Danesh. **Dr. Dureza-Muneses is not named as a defendant in this action.**

75. **Edwin Haronian, M.D.** ("Haronian") Medical Board of California License Number A71385, is a medical doctor practicing orthopedic surgery in Southern California. Dr. Haronian's principal place of business is 16542 Ventura Blvd., Suite 402, Encino, California 91436. As of April 11, 2011, Dr. Haronian was employed by Defendant Gharib-Danesh. **Dr. Haronian is not named as a defendant in this action.**

76. **Sanjiv Kumar Jain, M.D.** ("Jain") Medical Board of California License Number A47841, is a medical doctor practicing anesthesiology in Southern California. Dr. Jain's principal place of business is 19716 Trammell Lane, Chatsworth, California 91311. Dr. Jain is employed by Defendant Gharib-Danesh. **Dr. Jain is not named as a defendant in this action.**

77. **Stepan Ozcan Kasimian, M.D.** ("Kasimian") Medical Board of California License Number A77961, is a medical doctor practicing orthopedic surgery in Southern California. Dr. Kasimian's principal place of business is 1505 Wilson Terrace, Suite 300, Glendale, California 91206. As of April 11, 2011, Dr. Kasimian was employed by Defendant Gharib-Danesh. **Dr. Kasimian is not named as a defendant in this action.**

78. **Abel R. Quesada, M.D.** ("Quesada") Medical Board of California License Number A100315, is a medical doctor practicing in Southern California. Dr. Quesada's principal place of business is 1125 E. Broadway, #251, Glendale, California 91205. Dr. Quesada attended medical school at the Autonomous University of Guadalajara Faculty of Medicine. Dr. Quesada is employed by Defendant Gharib-Danesh. **Dr. Quesada is not named as a defendant in this action.**

79. **Parviz Salehi, M.D.** ("Salehi") Medical Board of California License Number A39866, is a medical doctor practicing surgery in Southern California. On

the State of California Medical Board website, Dr. Salehi's principal place of business is listed as P.O. Box 1026, Woodland Hills, California 91365. Dr. Salehi attended medical school in Iran at Shiraz University Faculty of Medicine, also known as Pahlavi University. As of April 11, 2011, Dr. Salehi was employed by Defendant Gharib-Danesh. **Dr. Salehi is not named as a defendant in this action.**

80. **Aflatoon Kamran, D.O.** ("Kamran"), Osteopathic Medical Board of California License Number 20A8503, practices osteopathic medicine in Southern California. Dr. Kamran's principal place of business is 520 Superior Avenue, #245, Newport Beach, California 92663. As of April 11, 2011, Dr. Kamran was employed by Defendant Gharib-Danesh. **Dr. Kamran is not named as a defendant in this action.**

81. **Edward Nana Opoku, Jr., D.O.** ("Opoku"), Osteopathic Medical Board of California License Number 20A11418, practices osteopathic medicine in Southern California. Dr. Opoku's principal place of business is 2222 Foothill Blvd., #E122, La Canada Flintridge, California, 91011. Dr. Opoku is employed by Defendant Gharib-Danesh. **Dr. Opoku is not named as a defendant in this action.**

82. **Rehab Acupuncture, Inc.** ("Rehab Acupuncture") is a California corporation located at 430 32nd Street, Suite 100, Newport Beach, California 92663. Rehab Acupuncture is owned and controlled by Nam Suk Lee, Lic. Ac., California Acupuncture Board License Number 8662. Nam Suk Lee is among the acupuncturists employed by Defendant Gharib-Danesh. **Rehab Acupuncture is not named as a defendant in this action.**

83. **Advanced Management Group, LLC** ("Advanced Management") is a California corporation located at 523 W. 6th Street, Suite 626, Los Angeles, California 90014. **Advanced Management is not named as a defendant in this action.**

84. **Caring Health Services, LLC** ("Caring Health") is a California LLC located at 4335 Van Nuys Blvd #422, Sherman Oaks, California 91403. **Caring Health is not named as a defendant in this action.**

85. **USS Orthopedic Physical Therapy, PC** ("USS Orthopedic") is a California professional corporation located at 16835 Algonquin Street, Suite 499, Huntington Beach, California 92649. **USS Othopedic is not named as a defendant in this action.**

86. **San Fernando Diagnostic & Imaging, Inc.** ("San Fernando") is a California corporation located at 16060 Ventura Blvd., Suite 105-338, Encino, California 91436. **San Fernando is not named as a defendant in this action.**

87. **Pacific RX, LLC** ("Pacific RX") is a California corporation located at 1700 N. Chrisman Road, Tracy, California 95304. **Pacific RX is not named as a defendant in this action.**

IV. HOW THE SCHEME WORKS

A. Billing for Compound Medications Off a Log

88. Every day billing clerks working at the Clinics are given a Medications Log by one or more of the following Defendants: Gharib-Danesh, Anthony Danesh, or Joanna Munguia. These billing clerks then consult the Medications Log and bill insurers for the compound medications as listed. These Medications Logs are spreadsheets shared through the Google Docs internet application, listing what medications to bill insurers for each of the patients. Although the Medications Logs purport to reflect the prescriptions of physicians, in reality, the Medication Logs serve as a mechanism by which the Clinics ensure billing for the **maximum number of prescriptions for each patient**.

89. *Qui Tam* Plaintiff, in her responsibilities structuring the Clinics' internal billing department, initially sought to obtain the underlying prescriptions that were necessary to construct the Medications Log and bill insurers. She found that many of the drug entries on the Medications Log had **no accompanying**

prescription, and others had unsigned prescriptions. *Qui Tam* Plaintiff also witnessed Defendant Munguia and other employees forge the signatures of physicians and chiropractors, and was initially asked to do the same.

90. Attached as **Exhibit C** is an example of a Medications Log used at the Clinics for the purpose of billing insurers. According to this log, Dr. Pratley allegedly examined 41 patients on April 1, 2011. **Dr. Pratley never saw any of these patients on April 1, 2011.**

91. **Exhibit C** also shows that of the 41 patients allegedly seen by Dr. Pratley on April 1, 2011, 39 patients received exactly the same drugs; Capsacin .069%, and 40 patients received Amitriptyline 2% and Flubiprofen-D. This pattern demonstrates the fraudulent nature of the Clinics' practice, as every patient is receiving the same medications irrespective of his or her actual condition. Every claim submitted to insurers for prescriptions written without a legitimate medical purpose is a **false claim**.

92. Additionally, the Medications Log is not supported by actual legitimate prescriptions written by physicians. Many of the prescriptions that the Medications Log is allegedly based upon are either forged or unsigned, and some have no accompanying prescription.

93. Further, Dr. Pratley, the physician listed as the attending and prescribing practitioner, *did not practice at these Clinics.* His credentials were used without his consent to bill insurers for services and medications. Each and every bill based off of the Medications Log showing Dr. Pratley as the treating and prescribing physician constitutes a **false claim**.

94. **Exhibit D** is a printout of an email chain dated February 16, 2012, including replies by Defendant Gharib-Danesh and Defendant Munguia. In the email chain, Munguia reports to Gharib-Danesh that they have found all the prescriptions that exist. In response, Gharib-Danesh states Munguia should "have [the billers] stop looking and just bill by pharm report" (*sic*). She further states

"billers shouldn't waste time looking for RX." This email shows Defendants billing insurers for medications that did not have prescriptions and using the Medications Log to maximize billing.

95. **Exhibit E** is a printout of an email dated June 22, 2012 by Defendant Gharib-Danesh, chastising her employees for failing to comply with the Clinics' prescription policy. In the email, Gharib-Danesh states "[i]f 20 patients come in Central needs to get 20 RX/20 Referal needed /20 eswt screening form /20pr2" (*sic*). Gharib-Danesh is reminding her employees that ***every single patient* seen must receive a prescription, a referral to other Clinic services, a shockwave therapy screening, and a progress report follow-up appointment**.

96. Every claim submitted to insurers for prescriptions that do not have a signed prescription written by a physician is a **false claim**. Further, every prescription and procedure billed to insurers that was ordered pursuant to the Clinics' policy of uniform patient care, instead of independent medical judgment, is a **false claim**.

B. Enforcement of Daily Patient Quotas

97. A central element of the Clinics' fraudulent scheme is to ensure that as many patients as possible are processed through Defendants' sham medical mill, irrespective of whether they actually need treatment. All managers and schedulers are warned that they will be *terminated* if they fail to schedule 50 patients every day at each of the Clinics.

98. The managers and scheduling staff at each Clinic — not medical professionals — are responsible for determining whether patients require additional treatment and medical care. These managers and scheduling staff receive care instructions for all of their patients from Defendant Gharib-Danesh, even though Gharib-Danesh does not treat these patients.

99. **Exhibit F** is a printout of an email chain dated November 17, 2011 written by Defendants Gharib-Danesh and Munguia, warning Doctor Eoh, as well

as the managers and medical representatives at the Clinics, that they will be disciplined if they fail to schedule 50 patients a day for each Clinic. This email chain demonstrates patient throughput was the primary objective of the Clinics, and also shows that treating physicians were not the individuals responsible for ordering appointments and treatments for patients. *See* excerpt below:

Joanna Mungula jmunguiaprhc@gmail.com 11/17/11

to Jessica, Mildred, Lizet, mayra, Maribel, me, bahardc, Eoh

Managers and Med Rep,
This is a verbal warning to all of you. We need to make make sure we are scheduling 50 patients for the MD clinics. The show up rate is very low anything below a 50% will result in a written notice or possible demotion.
Also remember all the patients that come in for MD need to get UA and meds. The numbers are very off, you need to monitoring this, this is part of your job!!!!
Let me know what the issues are

Joanna Mungula

100. **Exhibit F** also includes emails by Defendant Gharib-Danesh to the managers instructing them to ensure that every patient receives signed prescriptions and urinalysis testing. This email chain also demonstrates prescriptions and medical tests are uniformly prescribed to patients by office clerks, not physicians. Every bill submitted to insurers for prescription medications and treatments pursuant to this blanket policy of having office personnel order urinalysis and prescriptions for each patient is a **false claim**.

101. **Exhibit G** is a printout of an email dated May 4, 2011 from Defendant Danesh stating all schedulers should schedule 20 patients for Functional Capacity Evaluations ("FCE") in 15 minute intervals. This email shows the pattern and practice of maximizing the number of patients seen at the Clinics every day with no regard for independent medical judgment. All bills submitted to insurers for patients scheduled and treated pursuant to the quota system articulated in **Exhibits F and G** are **false claims**.

102. **Exhibit H** is a printout of two emails dated April 16, 2011 between Defendant Gharib-Danesh and Defendant Munguia discussing the need to increase the number of patients receiving tests at their appointments. Defendant Gharib-Danesh complains that Defendant Zarrini orders an unacceptably low number of tests, and that across the board the Clinic managers "need to double the #s" (*sic*). This email demonstrates that the objective of the Clinics is to order as many tests as possible without regard for medical necessity or patient needs. Every bill submitted to insurers for tests and treatments ordered under the Clinics' quota policy is a **false claim**.

C. Patients Are Required to Receive Repeated Tests, Treatments and Mandatory Return Appointments

103. Once patients are in the care of the Clinics, they are required to undergo repeated rounds of tests and treatments. Clinic staff are instructed to ensure that every patient has a return appointment scheduled before the patient leaves, no matter what their individual circumstances are.

104. **Exhibit I** is a printout of two emails dated March 4, 2011 between Defendant Gharib-Danesh and Defendant Munguia discussing the scheduling of return appointments for patients. In the email, Gharib-Danesh notes Attorney Wachtel was upset because a patient never received a return appointment. Gharib-Danesh also warns she does not want any patients to leave the office without a return appointment, and schedulers who fail to comply will be terminated.

105. This email demonstrates the Clinics' emphasis on maximizing patient treatment for billing purposes. Defendant Gharib-Danesh's comments illustrate medical judgment plays no role in determining what treatment each patient receives. Every bill submitted to insurers for appointments, tests, and treatments pursuant to the policy of artificially increasing the number of appointments is a **false claim**.

D. Master Logs Are Used to Direct Patient Care

106. As further evidence that patient care at the Clinics was implemented by unlicensed workers following boilerplate instructions, and not by licensed physicians exercising independent medical judgment, each Clinic kept a Master Log of patients showing the treatment that each received. The Master Log was updated daily to ensure each patient received the maximum amount of services they could force upon a patient. In fact, the Clinics had to keep several Master Logs due to the sheer volume of patients seen.

107. **Exhibit J** is a Master Log for Dr. Pratley at the Los Angeles Clinic for mid-2011. The log has columns indicating the types of treatments each patient received. For example, the first column shows the patient's date of referral under the heading "DOR." The third column indicates the primary treating physician and whether the patient's appointment was a follow-up.

108. The remaining columns indicate what treatment and prescriptions the patient received. Column 4 shows what MRI tests the patient received. Column 5 lists the Durable Medical Equipment ordered under the heading "DME." Additional Columns show whether the patient received medications ("MEDS"), acupuncture ("ACCU"), chiropractic treatment ("CHIRO"), shockwave therapy ("SHOCKWAVE"), nerve conduction tests ("VSNCT"), and psychological evaluations ("PSYCH").

109. **This Master Log shows almost every patient received the identical treatment in an attempt to maximize billing to insurers.** For example, nearly every patient is ordered to receive acupuncture and chiropractic treatment twice a week for six weeks. Most patients received psychological evaluation referrals. 21 of 24 patients seen on May 26, 2011, received shockwave therapy. The Master Log contains unjustified uniformity of treatment and patterns of care inconsistent with proper independent medical judgment. All bills submitted to insurers for medical services, prescriptions, and durable medical

equipment directed by the use of a Master Log, rather than sound medical judgment, are **false claims**.

110. This Master Log also shows that the Clinics claim Dr. Pratley saw hundreds of patients and prescribed thousands of MRIs, acupuncture treatments, shockwave therapy treatments, psychological evaluations, and durable medical equipment. Because Dr. Pratley did not practice at these Clinics, the bills based on the Master Logs constitute **false claims**.

E. Fraudulent Billing by Listing False Treatments on a Daily Basis

111. The Clinics also falsified hundreds of bills to insurers by billing for treatments that never occurred. The Clinics billed insurers for acupuncture treatments of up to 82 patients *per day*, far more than could actually be treated by a certified acupuncturist at the Clinics.

112. **Exhibit K** is a Central Report generated by Defendant Gharib-Danesh's central office to track patient care for the purpose of billing. This Central Report details the number of treatments given at the Los Angeles Clinic during early 2011. The Central Report shows that on Friday, February 11, 2011, 71 patients purportedly received acupuncture treatments. It also shows 73 patients received acupuncture on February 14, and 71 patients received acupuncture on February 28. Similarly, the Central Report also shows over 75 patients per day were treated with physical therapy on certain days, and dozens of patients received Nerve Conduction Studies ("VSNCT"), shockwave therapy, and Electromyography ("Ncv-emg").

113. This Central Report demonstrates that Defendants were engaged in fraudulent billing for services that never occurred because the clinics did not have sufficient staff or resources to perform all of the procedures. The Central Report further demonstrates the Clinics' blanket approach to developing care plans for their patients. Each bill submitted to insurers for services not actually administered, or for unnecessary services, is a **false claim**.

F. The Fraudulent Designation of Primary Treating Physicians

114. The Clinics also instituted a policy to fraudulently designate a patient's Primary Treating Physician ("PTP") based on whether that physician or chiropractor is in the patients' Medical Provider Network ("MPN"), instead of listing which practitioner — if any — actually treats the patient. In many cases, Defendant Rivas was the preferred PTP because he covered most MPNs.

115. If the Clinics encountered an issue with a patient's MPN not covering a particular practitioner, they simply adjusted the paperwork to list another covered practitioner, or simply listed the Clinic itself. Similarly, if the referring attorneys wanted a physician to treat a particular patient, Defendant Gharib-Danesh instructed her employees to use the Clinic chiropractors as co-treating practitioners or secondary consults to preserve their ability to maximize billing to insurers.

116. **Exhibit L** is a printout of an email dated January 17, 2011 by Defendant Gharib-Danesh instructing her employees that, "if there's MPN issue with one provider, the patient can be switched to another provider within the MPN in our group" (*sic*). She further instructs her employees that, "if you are not sure which provider application is final just have them designate 'Pain Relief Health Centre' as PTP and if any problems we'll switch within our group" (*sic*).

117. **Exhibit M** is a printout of an email dated January 24, 2011 by Defendant Gharib-Danesh to her employees. The email directs that Dr. Rivas and other chiropractors are to be listed as the PTP because they are in most MPNs. It also explains how to resist the referring attorney's request to use a medical doctor as a PTP, and how to ensure the chiropractors are involved in care so Gharib-Danesh can track treatments.

118. **Exhibits L and M** demonstrate the Clinics' practice of fraudulently listing medical providers as the PTP in order to ensure the Clinics could bill the patient's insurer. Gharib-Danesh never considers listing which physician, if any,

treated the patient. **Exhibit L** also shows Gharib-Danesh instructing her billing associates to reverse the paperwork long after the patient has been seen. These documents show the Clinics did not contemporaneously align the patients with providers in their networks before the start of treatment, but altered medical records in order to increase costs to insurers. The use of fraudulently drafted documents misrepresenting the PTP constitutes a false claim.

G. Using the Credentials of Unaffiliated Physicians

119. The Clinics also misappropriated the credentials of unaffiliated physicians in violation of California Business and Professions Code § 2289. The Clinics advertise the names of these physicians creating the perception that physicians actually treat patients at the Clinics. The Clinics also use the names of these physicians to order treatments and write prescriptions with the purpose of billing insurers.

120. During *Qui Tam* Plaintiff's tenure at the Clinics, she never saw or met Dr. Pratley. Moreover, she has spoken to many of her former co-workers, none of whom have ever seen or met Dr. Pratley. *Qui Tam* Plaintiff has personal knowledge that Dr. Pratley will say:

A. He has never practiced at the Clinics;

B. He has never performed *or* prescribed extra corporeal Shock Wave Therapy to any patient;

C. He has never given permission to anyone to use his medical license to evaluate patients;

D. He has never sent patients to Defendant Harriri to fill their prescriptions;

E. He would never prescribe six different compound medications to a single patient;

F. He would never prescribe the exact same medications to all patients he sees; and

G. He has never given permission to Pain Relief Health Center or any of Defendant Clinics to use his name on their web page.

121. **Exhibits C and J** are documents containing references to Dr. Pratley, including references to compound prescription drugs and shockwave therapy treatments he allegedly ordered. The Clinics have also promoted Dr. Pratley as a treating physician on their website.

122. **Exhibit N** is a printout of an email dated April 29, 2011 from Defendant Gharib-Danesh to her employees. It states Dr. Pratley has ordered Vital Wrap DME for all of his patients at all of the Clinics. This email demonstrates the fraudulent use of another physician's credentials to order treatment and prescribe medical equipment. Every bill submitted to insurers which lists Dr. Pratley as the physician who treated, prescribed, or ordered a reimbursable service is a **false claim**.

H. Obtaining Referrals from Attorneys for a Guaranteed Diagnosis

123. The Clinics obtain all of their patients from referral sources. The majority of these sources are attorneys who specialize in workers' compensation law. **The Clinics and these attorneys have entered into an unlawful kickback arrangement. The attorneys bring scores of "patients" to the Clinics. In return, the Clinics guarantee that all of the patients will be seen 24 times over six months for pain treatment.** Under the American College of Occupational and Environmental Medicine's guidelines ("ACOEM"), once a patient has undergone six months of treatment, that is the clinical predicate for being diagnosed as in "chronic pain." Once a patient is deemed in "chronic pain," the patient is clinically eligible for additional benefits, and more treatments for the clinics to bill insurers. The ACOEM's guidelines are expressly incorporated into the California workers' compensation system through Lab. Code §§ 4600(b), 4604.5(c), 4610, 4616.

124.

125. **Exhibit I** highlights the unlawful referral and kickback scheme engaged in by Defendant Clinics and attorneys. This March 4, 2011 email shows attorney Wachtel is upset because the patients he referred to the Clinics did not receive the guaranteed number of visits to allow them to be diagnosed with "chronic pain" in order to maximize the damages in his clients' workers' compensation claims. Each patient procured by unlawful runners, cappers, and steerers violates California Insurance Code § 1871.7(a) and all procedures billed to insurers for these patients constitute **false claims**. Additionally, each treatment, test, and appointment billed to insurers that was ordered pursuant to the Clinics' unlawful guaranteed diagnosis kickback is a **false claim**.

I. Ensuring Chronic Condition Diagnoses for Every Patient to Inflate False Billing

126. A primary objective of the Clinics' fraudulent scheduling and treatment scheme was to classify every patient as having a "chronic" condition under the ACOEM's guidelines and Lab. Code §§ 4600(b), 4604.5(c), 4610, 4616. Once a patient is treated at the clinic 24 times over a period of six months, the patient's condition is diagnosed as "chronic" and eligible for additional treatment and benefits.

127. **Exhibit O** is a printout of an email dated January 21,2011 from Defendant Gharib-Danesh to her employees. Through this email, Gharib-Danesh instructed her employees to focus their efforts on contacting patients that began treatment within the last 4 months but stopped treatment at the Clinics before they visited 24 times, or before they met the six-month threshold under ACOEM's guidelines and Lab. Code §§ 4600(b), 4604.5(c), 4610, 4616. This email demonstrates the Clinics' primary objective to continue patient treatments to six months in order to obtain a diagnosis of a chronic condition, thereby allowing the clinics to increase billing to insurers.

128. In the January 21 email (**Exhibit O**), Defendant Gharib-Danesh also instructed her employees to contact **the patient's attorney** if the patient stopped attending their scheduled appointments at the Clinics. She noted that patients may have stopped attending treatments if they changed attorneys or settled their case. This email illustrates the relationship between the Clinics and the referring attorneys as patients only receive treatment so long as their attorney has not settled their case. Also, a patient may stop treatment at the clinic if they changed attorneys and changed clinics. This further illustrates how invested referring attorneys are in obtaining a diagnosis of a chronic condition for their clients while they are patients of the clinics.

J. Fraudulent Billing for Psychological Evaluations

129. The Clinics worked closely with Defendant Terrence, a California licensed psychologist, to fraudulently bill insurers for psychological evaluations. **Defendant Terrence performed sham evaluations on his patients and grossly inflated the amount of time he allegedly spent with each patient.** Many of the evaluations for which he billed insurers never occurred.

130. **Exhibit B** is a spreadsheet summarizing Defendant Terrence's billing to insurers for patient evaluations during late 2011. Pattern analysis of this data shows that these evaluations are fraudulent. Defendant Terrence billed insurers the exact same amount for a boilerplate bundle of psychiatric evaluations for multiple different patients. Each patient received exactly 20.8 hours of evaluations. Defendant Terrence billed for the exact same amount of time for each component of the evaluations for each patient. The medical history prepared by Defendant Terrence for each patient never changed no matter how disparate their medical histories may have been. This type of "care" is fraudulent and any submission of claims arising from it constitute **false claims**.

131. **Exhibit B** also shows Defendant Terrence billing insurers for an impossible amount of time treating patients. For example, on September 30, 2011,

he billed a total of **166.4 hours** for treating eight patients. Just seven days later he billed insurers for treating fourteen patients on October 7, 2011, for a total of **291.2 hours** of evaluations that day. Between October 12 and 14, 2011 he billed for 32 patients and **665.6 hours**. In a period of two weeks, Defendant Terrence submitted bills to insurers claiming he spent **1,123.2 hours** treating patients and writing reports. **This amount of hours is over three times the total available hours on planet earth for that time-period.** Every bill to insurers for psychological evaluations that inflated the duration or existence of services is a **false claim**.

132. **Exhibit P** and **Exhibit Q** are two psychological evaluation reports prepared by Defendant Terrence summarizing his findings. The reports generated by Terrence contain identical sections that appear to be replicated in every report. **Exhibits P & Q** show both patients presented with anxiety, daily depression, irritability, and anger. Both patients experienced memory loss, social isolation, headaches, and a loss of self-esteem. *Qui Tam* Plaintiff has examined a number of other psychological evaluation reports generated by Defendant Terrence, and they all contain identical language. **While there are many common threads among patients experiencing chronic pain, Defendant Terrence's psychological reports are all virtually identical, both substantively and stylistically. The litany of symptoms is presented in the same order, using the same sentence structure, and the same diction.** *Qui Tam* Plaintiff is in possession of many more patient reports also containing the same language. Every bill to insurers that contains boilerplate information that was not obtained through a legitimate psychological evaluation is a **false claim**.

K. Untrained and Uncertified Workers Employed to Perform Medical Services at the Clinics

133. Defendant Gharib-Danesh hires young workers in their early twenties to perform physical therapy, massage, treatments, and tests on Clinic patients.

Many of these workers have little or no training. For example, the workers receive approximately four hours of training on the equipment used in shockwave therapy. These machines allow the user to calibrate the pressure and frequency of the ultrasonic waves. The different settings allow the user to adjust the machine based on the condition of the patient and the location of the injury. However, at higher settings the sound waves can cause tissue damage. The workers do not understand the settings or how to adjust them to effectively treat patients. **They are therefore instructed to never adjust the settings on the shockwave therapy machine under any circumstances and give every patient the exact same treatment regardless of injury.**

134. The treatment itself is short and cursory. The Clinics' employees are instructed to limit all treatments to 15 minutes or less, and so many patients are scheduled that workers are forced to adhere to the strict time limit. Some workers who perform shockwave therapy are instructed to spend only 5 minutes giving treatment to patients, and often spend less time because the patients were visibly in pain. Every medical service billed to insurers performed by untrained workers is a **false claim**.

L. The Clinics Dispense Compound Medications Directly or Through Pharmacies in Violation of the Patients' Rights

135. The Clinics have taken an active role in drug distribution by dispensing compound drugs directly to their patients during their visits. This step bypasses the use of a pharmacy entirely and allows the Clinics to bill insurers directly.

136. In addition, the Clinics conspire with pharmacies, also named as Defendants herein, to dispense expensive medications to each and every patient. **These pharmacies rubber stamp any prescription submitted by the Clinics and mail the medications directly to the patient without any accompanying instructions or consultation.** Irrespective of whether the Clinics provide

medications through direct dispensing or through arrangements with Defendant Pharmacies, the Clinics disregard the patients' right to choose where they want their prescriptions filled. This conduct violates California Business and Professions Code § 4170. Every bill submitted to insurers for prescription medications dispensed in violation of Section 4170 is a **false claim**.

V. EACH DEFENDANT'S PARTICIPATION IN THE CONSPIRACY

A. The Individual Defendants

137. **Defendant GHARIB-DANESH** is at the center of this medical billing fraud conspiracy. She owns and operates many of the Defendant Clinics and entities herein. The entities owned and controlled by Gharib-Danesh have engaged in a pattern and practice of defrauding public and private insurers and California's consumers. Gharib-Danesh is also active in the scheme as a chiropractor. **She schedules patients that she never sees, signs off on treatments and tests that she does not perform or supervise, bills insurers for her time and services, and causes others to do the same.**

138. Gharib-Danesh also pressures all office workers and medical assistants into performing medical duties far beyond the scope of their training and aptitude. She has instituted a number of policies requiring clerks and assistants to bill insurers, forge and stamp the signatures of physicians, and provide medication to patients. Gharib-Danesh is also responsible for the relationships with the pharmacies that fill her patients' prescriptions.

139. Gharib-Danesh has knowingly and unlawfully: (a) employed unlawful "runners, cappers and steerers" to refer patients to her Clinics; (b) engaged in a pattern and practice of ordering unnecessary medical tests and treatments; (c) consistently allowing untrained workers to perform her licensed duties for her; (d) fraudulently billed insurers for these tests and treatments; (e) caused other physicians to order and perform unnecessary and medically

insufficient medical treatments; and (f) caused others to prepare and present fraudulent documents for the purpose of billing insurers.

140. **Defendant TONY DANESH**, the brother of Gharib-Danesh, is also fundamental to this medical billing fraud conspiracy. Tony Danesh serves as the overall operations manager of the Clinics. Tony Danesh has knowingly engaged in the schemes described herein as well as aided and abetted Gharib-Danesh in perpetuating this vast fraud.

141. **Defendant MOHAMMAD GHARIB**, the father of Gharib-Danesh, provides substantial aid to this medical billing fraud conspiracy. Mohammad Gharib serves as supposed "owner" of some Clinics, but is in reality a mere straw person for Gharib-Danesh. Mohammad Gharib has knowingly engaged in the schemes and aided and abetted Gharib-Danesh in perpetuating this fraud.

142. **Defendant KHOSROW GHARIB**, the mother of Gharib-Danesh, provides substantial aid to this medical billing fraud conspiracy. Khosrow Gharib serves as supposed "owner" of some of the Clinics, but is in reality a mere straw person for Gharib-Danesh. Khosrow Gharib has knowingly engaged in the schemes described herein as well as aided and abetted Gharib-Danesh in perpetuating this vast fraud.

143. Defendants Mohammad Gharib and Khosrow Gharib were responsible for processing all mail and depositing all checks. They would arrive at the Clinics with suitcases filled with mail and checks from insurers, and then secretly process these payments through the various Defendant entities.

144. **Defendant JOANNA MUNGUIA**, as Operations Manager of Defendant Pain Free Management, acts as Gharib-Danesh's right-hand person. Munguia has directed employees of the Clinics to engage in the schemes described herein and aided and abetted Gharib-Danesh in perpetuating this fraud.

145. **Defendant NIRA HARIRI** owns and operates Defendant Encino Care Pharmacy. She is responsible for ensuring the fraudulently written

prescriptions are filled without question and for providing the Clinics with the necessary documents needed to bill the insurers. She receives kickbacks as well.

146. Defendant Hariri knowingly and unlawfully: (a) filled fraudulent prescriptions for dangerous medications; (b) prepared fraudulent documents in support of a false claim presented to insurers for payment; and (c) submitted false claims to insurers for payment of fraudulently prescribed medications and medications that Hariri never provided to patients.

B. Defendant Chiropractors and Medical Doctors

147. **Exhibits R, S, and T** are printouts from Defendant Pain Relief Health Center's website, dated April 11, 2011, December 16, 2011, and July 6, 2012, respectively. These documents identify many of Defendant Chiropractors, Defendant Medical Doctors, and Defendant Doctor of Psychology who have been or are active participants in the unlawful scheme to defraud insurers.

148. **Defendant CHARLES MICHAEL BOYER**, a chiropractor, is currently employed by Defendant Gharib-Danesh and practices at the Clinics. *See* **Exhibit T**. Defendant Boyer engaged in a pattern and practice of ordering dozens of tests, treatments, and medications for **all** patients, regardless of injury or proper medical diagnosis. Many of these procedures are never performed, and patients often never receive the medications for which the insurers pay. Each stage of the patients' care is designed to fraudulently maximize billing while providing no actual medical care or benefit.

149. Each stage of a patient's care is designed to fraudulently maximize billing while providing no actual medical care or benefit. For example, on October 13, 2011, from 9:00 a.m. to 11:35 a.m., Defendant Boyer billed for 61 patient visits. A cursory review of the schedule for Defendant Boyer demonstrates the audacity that characterizes this insurance fraud. From 9:00 a.m. to 11:35 a.m., Defendant Boyer billed for seeing four separate patients every five minutes.

150. Defendant Boyer prescribes these treatments without regard for necessity or effectiveness. As an example, on December 14, 2010, Defendant Boyer caused to be billed *four* separate Beck Depression Inventories, *three* Sentence Completion Tests, and *two* Assessments of Aphasia, all supposedly performed on the same patient on the same day. *See* **Exhibit U**.

151. Defendant Boyer does not tailor care to a patient's unique medical situation and does not base the care on a review of the results of the medical tests. Instead, Defendant Boyer uses boilerplate diagnoses, such as "stress, anxiety, insomnia." By using such a diagnosis, Defendants are able to cause all patients to be seen by Defendant Terrence, further unnecessarily inflating bills to insurers. Physical therapy treatments, diagnostic tests, psychiatric evaluations, and therapeutic massages are performed by uncertified low-wage employees and provide no curative effect. The technicians who operate these machines have no understanding of how to treat specific injuries using the different settings and functions of these machines. Every patient receives treatment under the exact same setting with no regard for their specific injury, e.g., thumb or hip injury, or whether his or her pain is muscular, skeletal, or due to damaged nerves. Despite the carousel of tests and treatments, most patients never see any improvement in their chronic pain. Defendant Boyer allows untrained workers to perform his professional duties, then signs off and bills insurers and the State at his full rates. Defendant Boyer is part of the scheme whereby the Central Logs are used to ensure each patient receives the maximum number of billable medical services, and to direct patient care accordingly.

152. **Defendant NA YOUNG EOH**, a chiropractor, is currently employed by Defendant Gharib-Danesh and practices at the Clinics. *See* **Exhibit T**. Defendant Eoh engaged in a pattern and practice of, like those above, ordering dozens of tests, treatments, and medications for **all** patients, regardless of injury or proper medical diagnosis. Many of these procedures are never performed, and

patients often never receive the medications for which the insurers pay. Each stage of the patients' care is designed to fraudulently maximize billing while providing no actual medical care or benefit. Defendant Eoh invariably causes each patient to undergo a boilerplate battery of treatments, tests, and medications. Defendant Eoh prescribes these treatments without regard for necessity, effectiveness, or patient safety. Defendant Eoh does not tailor care to a patient's unique medical situation and does not base the care on a review of the results of the medical tests. Instead, Defendant Eoh also uses boilerplate diagnoses, such as "stress, anxiety, insomnia." By using such a diagnosis, Defendants are able to cause all patients to be seen by Defendant Terrence, further unnecessarily inflating bills to insurers.

153. Defendant Eoh was involved in Defendants' practice of "doctor swapping" for purposes of obtaining insurance coverage for a patient's treatment. "Doctor swapping" occurs when a doctor is treating a patient and that doctor is "out of network." The Clinics would bill an insurer, using the name of a second doctor, one who is within the insurer's network, as the doctor treating the patient.

154. Physical therapy treatments, diagnostic tests, psychiatric evaluations, and therapeutic massages are performed by uncertified, low-wage employees, and provide no curative effect. The technicians who operate these machines have no understanding of how to treat specific injuries using the different settings and functions of these machines. Every patient receives treatment under the exact same setting with no regard for their specific injury, e.g., thumb or hip injury, or whether his or her pain is muscular, skeletal, or due to damaged nerves. Despite the carousel of tests and treatments, most patients never see any improvement in their chronic pain. Defendant Eoh allows untrained workers to perform his professional duties, then signs off and bills insurers and the State at Defendant Eoh's full rates. Defendant Eoh is part of the scheme whereby the Central Logs are used to ensure each patient receives the maximum number of billable medical

services, and to direct patient care accordingly. Defendant Eoh was one of several employees who received an email dated March 4, 2011 from Defendant Gharib-Danesh, warning that she does not want any patients to leave the office without a return appointment, and schedulers who fail to comply will be terminated. *See* **Exhibit I.** Defendant Eoh was also one of several employees who received an email dated November 17, 2011, written by Defendants Gharib-Danesh and Munguia, warning the managers and medical representatives at the Clinics that they would be disciplined if they failed to schedule 50 patients a day for each Clinic. *See* **Exhibit F**.

155. **Defendant LAURA LYN HAZEN**, a chiropractor, was employed by Defendant Gharib-Danesh and practiced at the Clinics as of December 16, 2011. *See* **Exhibit S**. Defendant Hazen engaged in a pattern and practice of, like those above, ordering dozens of tests, treatments, and medications for **all** patients, regardless of injury or proper medical diagnosis. Many of these procedures are never performed, and patients often never receive the medications for which the insurers pay. Each stage of a patient's care is designed to fraudulently maximize billing while providing no actual medical care or benefit.

156. For example, on December 6, 2011, from 9:00 a.m. to 11:05 a.m., Defendant Hazen billed for 66 patient visits. *See* **Exhibit V**. A cursory review of **Exhibit V** demonstrates the degree and audacity that characterizes this insurance fraud. For the five minute time period, from 9:00 a.m. to 9:05 a.m., Defendant Hazen billed for seeing seven separate patients.

157. Furthermore, Defendant Hazen invariably causes each patient to undergo a boilerplate battery of treatments, tests, and medications. Defendant Hazen prescribes these treatments without regard for necessity or effectiveness. Defendant Hazen does not tailor care to a patient's unique medical situation and does not base the care on a review of the results of the medical tests. The majority of the treatments are useless. Physical therapy treatments, diagnostic tests,

psychiatric evaluations, and therapeutic massages are performed by uncertified low-wage employees and provide no curative effect. The technicians who operate these machines have no understanding of how to treat specific injuries using the different settings and functions of these machines. Every patient receives treatment under the exact same setting with no regard for their specific injury, e.g., thumb or hip injury, or whether his or her pain is muscular, skeletal, or due to damaged nerves. Despite the carousel of tests and treatments, most patients never see any improvement in their chronic pain. Defendant Hazen allows untrained workers to perform her professional duties, then signs off and bills insurers and the State at her full rates. Defendant Hazen is part of the scheme whereby the Central Logs are used to ensure each patient receives the maximum number of billable medical services, and to direct patient care accordingly.

158. **Defendant LANA ELIZABETH MONTES**, a chiropractor, is currently employed by Defendant Gharib-Danesh and practices at the Clinics. *See* **Exhibit T**. Defendant Montes engaged in a pattern and practice of, like those above, ordering dozens of tests, treatments, and medications for **all** patients, regardless of injury or proper medical diagnosis. Many of these procedures are never performed, and patients often never receive the medications for which the insurers pay. Each stage of the patients' care is designed to fraudulently maximize billing while providing no actual medical care or benefit. For example, on November 10, 2011, from 9:00 a.m. to 12:15 p.m., Defendant Montes billed for 79 patient visits. During that three hour time frame, Defendant Montes billed for seeing four separate patients every ten minutes.

159. Defendant Montes does not tailor care to a patient's unique medical situation and does not base the care on a review of the results of the medical tests. Instead, Defendant Montes uses boilerplate diagnoses, such as "stress, anxiety, insomnia." By using such a diagnosis, Defendants cause all patients to be seen by Defendant Terrence, further unnecessarily inflating bills to insurers.

160. Defendant Montes invariably causes each patient to undergo a boilerplate battery of treatments, tests, and medications. Defendant Montes prescribes these treatments without regard for necessity or effectiveness.

161. Defendant Montes was involved in Defendants' practice of "doctor swapping" for purposes of obtaining insurance coverage for a patient's treatment. "Doctor swapping" occurs when a doctor is treating a patient and that doctor is "out of network." The Clinics would bill an insurer, using the name of a second doctor, one who is within the insurer's network, as the doctor treating the patient.

162. Defendant Montes does not tailor care to a patient's unique medical situation and does not base the care on a review of the results of the medical tests. The majority of the treatments are useless. Physical therapy treatments, diagnostic tests, psychiatric evaluations, and therapeutic massages are performed by uncertified low-wage employees and provide no curative effect. The technicians who operate these machines have no understanding of how to treat specific injuries using the different settings and functions of these machines. Every patient receives treatment under the exact same setting with no regard for their specific injury, e.g., thumb or hip injury, or whether his or her pain is muscular, skeletal, or due to damaged nerves. Despite the carousel of tests and treatments, most patients never see any improvement in their chronic pain. Defendant Montes allows untrained workers to perform her professional duties, then signs off and bills insurers and the State at her full rates. Defendant Montes is part of the scheme whereby the Central Logs are used to ensure each patient receives the maximum number of billable medical services, and to direct patient care accordingly. Defendant Montes was one of several employees who received an email dated March 4, 2011 from Defendant Gharib-Danesh, warning that she does not want any patients to leave the office without a return appointment, and schedulers who fail to comply will be terminated. *See* **Exhibit I.**

163. **Defendant JORGE A. RIVAS**, a chiropractor, was employed by Defendant Gharib-Danesh and practiced at the Clinics as of December 16, 2011. *See* **Exhibit S**. Defendant Rivas engaged in a pattern and practice of, like those above, ordering dozens of tests, treatments, and medications for **all** patients, regardless of injury or proper medical diagnosis. Many of these procedures are never performed, and patients often never receive the medications for which the insurers pay. Each stage of the patients' care is designed to fraudulently maximize billing while providing no actual medical care or benefit. Defendant Rivas invariably causes each patient to undergo a boilerplate battery of treatments, tests, and medications. Defendant Rivas prescribes these treatments without regard for necessity or effectiveness. Defendant Rivas does not tailor care to a patient's unique medical situation and does not base the care on a review of the results of the medical tests. The majority of the treatments are useless. Physical therapy treatments, diagnostic tests, psychiatric evaluations, and therapeutic massages are performed by uncertified low-wage employees and provide no curative effect. The technicians who operate these machines have no understanding of how to treat specific injuries using the different settings and functions of these machines. Every patient receives treatment under the exact same setting with no regard for their specific injury, e.g., thumb or hip injury, or whether his or her pain is muscular, skeletal, or due to damaged nerves. Despite the carousel of tests and treatments, most patients never see any improvement in their chronic pain. Defendant Rivas allows untrained workers to perform his professional duties, then signs off and bills insurers and the State at his full rates. Defendant Rivas is part of the scheme whereby the Central Logs are used to ensure each patient receives the maximum number of billable medical services, and to direct patient care accordingly. Defendant Rivas allowed Defendant Gharib-Danesh to alter medical records in order to claim that Defendant Rivas, who was on more MPNs than other chiropractors and doctors working for the Clinics, was actually the Primary

Treating Physician, in order to ensure the Clinics could bill the patient's insurer. *See* **Exhibit M**.

164. **Defendant RODRIGO T. SANCHEZ**, a chiropractor, was employed by Defendant Gharib-Danesh and practiced at the Clinics as of December 16, 2011. *See* **Exhibit S**. Defendant Sanchez engaged in a pattern and practice of, like those above, ordering dozens of tests, treatments, and medications for **all** patients, regardless of injury or proper medical diagnosis. Many of these procedures are never performed, and patients often never receive the medications for which the insurers pay.

165. Each stage of a patient's care is designed to fraudulently maximize billing while providing no actual medical care or benefit. For example, on November 17, 2011, from 9:00 a.m. to 6:00 p.m., Defendant Sanchez billed for 89 patient visits.

166. Defendant Sanchez invariably causes each patient to undergo a boilerplate battery of treatments, tests, and medications. Defendant Sanchez prescribes these treatments without regard for necessity or effectiveness. Defendant Sanchez does not tailor care to a patient's unique medical situation and does not base the care on a review of the results of the medical tests. The majority of the treatments are useless. Physical therapy treatments, diagnostic tests, psychiatric evaluations, and therapeutic massages are performed by uncertified, low-wage employees, and provide no curative effect. The technicians who operate these machines have no understanding of how to treat specific injuries using the different settings and functions of these machines. Every patient receives treatment under the exact same setting with no regard for their specific injury, e.g., thumb or hip injury, or whether his or her pain is muscular, skeletal, or due to damaged nerves. Despite the carousel of tests and treatments, most patients never see any improvement in their chronic pain. Defendant Sanchez allows untrained workers to perform his professional duties, then signs off and bills insurers and the

State at his full rates. Defendant Sanchez is part of the scheme whereby the Central Logs are used to ensure each patient receives the maximum number of billable medical services, and to direct patient care accordingly.

167. **Defendant TUSHAR RAMNIK DOSHI**, a medical doctor, is currently employed by Defendant Gharib-Danesh and practices at the Clinics. *See* **Exhibit T**. Defendant Doshi engaged in a pattern and practice of, like those above, ordering dozens of tests, treatments, and medications for **all** patients, regardless of injury or proper medical diagnosis. Many of these procedures are never performed, and patients often never receive the medications for which the insurers pay. Each stage of a patient's care is designed to fraudulently maximize billing while providing no actual medical care or benefit.

168. Defendant Doshi invariably causes each patient to undergo a boilerplate battery of treatments, tests, and medications. In fact, Defendant Doshi is a prime example of what happens at many of the Clinics. It is the date the patient is seen, not the patient's individual symptoms, that dictates what drugs the patient is prescribed. For example, at the Reseda Office, on March 29, 2010, all fifteen patients received prescriptions for two Capsnicin, Flurbiprofen-D2. *See* **Exhibit W**. Defendant Doshi prescribes these treatments without regard for necessity or effectiveness. Defendant Doshi does not tailor care to a patient's unique medical situation and does not base the care on a review of the results of the medical tests. The majority of the treatments are useless. Physical therapy treatments, diagnostic tests, psychiatric evaluations, and therapeutic massages are performed by uncertified, low-wage employees, and provide no curative effect. The technicians who operate these machines have no understanding of how to treat specific injuries using the different settings and functions of these machines. Every patient receives treatment under the exact same setting with no regard for their specific injury, e.g., thumb or hip injury, or whether his or her pain is muscular, skeletal, or due to damaged nerves. Despite the carousel of tests and

treatments, most patients never see any improvement in their chronic pain. Defendant Doshi allows untrained workers to perform his professional duties, then signs off and bills insurers and the State at his full rates. Defendant Doshi is part of the scheme whereby the Central Logs are used to ensure each patient receives the maximum number of billable medical services, and to direct patient care accordingly.

169. **Defendant BONIFACE OKWUDILI ONOBAH**, a medical doctor, is currently employed by Defendant Gharib-Danesh and practices at the Clinics. *See* **Exhibit T**. Defendant Onobah engaged in a pattern and practice of, like those above, ordering dozens of tests, treatments, and medications for **all** patients, regardless of injury or proper medical diagnosis, particularly shock wave and nerve test services. Many of these procedures are never performed, and patients often never receive the medications for which the insurers pay.

170. Each stage of the patients' care is designed to fraudulently maximize billing while providing no actual medical care or benefit. On September 23, 2011, Defendant Onobah saw nine patients in the Oxnard Office. All nine patients received prescriptions for Capsaicin, Cyc/Keto/Lido LDS, and DEXTRO. In addition, on the same date, Defendant Onobah saw thirteen patients in the Reseda Office. All thirteen patients received prescriptions for the same drugs: Capsaicin, Cyc/Keto/Lido LDS, and DEXTRO.

171. On September 29, 2011, Defendant Onobah saw twenty-three patients in the Bakersfield Office. All twenty-three patients received prescriptions for Capsaicin, Amitriptyline, and Flurbiprofen.

172. Defendant Onobah invariably causes each patient to undergo a boilerplate battery of treatments, tests, and medications, particularly shock wave and nerve test services. Defendant Onobah prescribes these treatments without regard for necessity or effectiveness. Defendant Onobah does not tailor care to a patient's unique medical situation and does not base the care on a review of the

results of the medical tests. Physical therapy treatments, diagnostic tests, psychiatric evaluations, and therapeutic massages are performed by uncertified, low-wage employees, and provide no curative effect. The technicians who operate these machines have no understanding of how to treat specific injuries using the different settings and functions of these machines. Every patient receives treatment under the exact same setting with no regard for their specific injury, e.g., thumb or hip injury, or whether his or her pain is muscular, skeletal, or due to damaged nerves. Despite the carousel of tests and treatments, most patients never see any improvement in their chronic pain. Defendant Onobah allows untrained workers to perform his professional duties, then signs off and bills insurers and the State at his full rates. Defendant Onobah is part of the scheme whereby the Central Logs are used to ensure each patient receives the maximum number of billable medical services, and to direct patient care accordingly. *Qui Tam* Plaintiff witnessed Defendant Onobah visit to the Reseda Clinic on multiple occasions to pick up a check from Defendant Gharib-Danesh and then leave immediately. *Qui Tam* Plaintiff never witnessed Defendant Onobah visit the Reseda Clinic for long enough to see or treat any patients.

173. **Defendant WILLIAM BERNARD SIMPSON**, a medical doctor, is currently employed by Defendant Gharib-Danesh and practices at the Clinics. *See* **Exhibit T**. Defendant Simpson engaged in a pattern and practice of, like those above, ordering dozens of tests, treatments, and medications for **all** patients, regardless of injury or proper medical diagnosis. Many of these procedures are never performed, and patients often never receive the medications for which the insurers pay. Each stage of the patients' care is designed to fraudulently maximize billing while providing no actual medical care or benefit. Defendant Simpson invariably causes each patient to undergo a boilerplate battery of treatments, tests, and medications. Defendant Simpson prescribes these treatments without regard for necessity or effectiveness., often without ever having seen the patient. For

example, on October 7, 2011, Defendant Simpson signed at least four prescription forms *in blank*, allowing unlicensed workers to later enter the specific medication and dosage. *See* **Exhibit X**.

174. Defendant Simpson does not tailor care to a patient's unique medical situation and does not base the care on a review of the results of the medical tests. The majority of the treatments are useless. Physical therapy treatments, diagnostic tests, psychiatric evaluations, and therapeutic massages are performed by uncertified, low-wage employees, and provide no curative effect. The technicians who operate these machines have no understanding of how to treat specific injuries using the different settings and functions of these machines. Every patient receives treatment under the exact same setting with no regard for their specific injury, e.g., thumb or hip injury, or whether his or her pain is muscular, skeletal, or due to damaged nerves. Despite the carousel of tests and treatments, most patients never see any improvement in their chronic pain. Defendant Simpson allows untrained workers to perform his professional duties, then signs off and bills insurers and the State at his full rates. Defendant Simpson is part of the scheme whereby the Central Logs are used to ensure each patient receives the maximum number of billable medical services, and to direct patient care accordingly. Dr. Simpson is responsible for the shockwave therapy treatments at the Clinics, but does not actually perform the treatments himself. Instead, he relies on low-wage workers to perform the tests for him. Those workers then bring him the reports to sign. He also instructs those workers to forge his name on reports when he is not seeing patients at the Clinics. Dr. Simpson ordered shockwave therapy for over twenty patients a day — even though he did not examine the patients beforehand — and ordered four rounds of therapy for every patient. **These treatments, given by low-wage workers, were ineffective, lasting from two to five minutes.** The purpose of these treatments was to maximize the amount billed to insurers, not cure the patients.

175. **Defendant BEHNOUSH ZARRINI**, a medical doctor, was employed by Defendant Gharib-Danesh and practiced at the Clinics, as of December 16, 2011. *See* **Exhibit S**. Defendant Zarrini engaged in a pattern and practice of, like those above, ordering dozens of tests, treatments, and medications for **all** patients, regardless of injury or proper medical diagnosis. Many of these procedures are never performed, and patients often never receive the medications for which the insurers pay. Each stage of the patients' care is designed to fraudulently maximize billing while providing no actual medical care or benefit.

176. Defendant Zarrini invariably causes each patient to undergo a boilerplate battery of treatments, tests, and medications. Defendant Zarrini prescribes these treatments without regard for necessity or effectiveness. Defendant Zarrini does not tailor care to a patient's unique medical situation and does not base the care on a review of the results of the medical tests. All patients receive identical prescription refills, irrespective of the individual symptoms, based on the day the patient was seen. For example, on December 1, 2010, all patients who visited Defendant Zarrini at the Long Beach Office received 3 refills for all drugs prescribed that day. *See* **Exhibit Y**. On December 2, 2010, all patients who visited Defendant Zarrini at the Oxnard Office received 3 refills for all drugs prescribed that day and all patients who visited Defendant Zarrini at the Los Angeles Office received 1 refill1 for all drugs prescribed that day.

177. Physical therapy treatments, diagnostic tests, psychiatric evaluations, and therapeutic massages are performed by uncertified, low-wage employees, and provide no curative effect. The technicians who operate these machines have no understanding of how to treat specific injuries using the different settings and functions of these machines. Every patient receives treatment under the exact same setting with no regard for their specific injury, e.g., thumb or hip injury, or whether his or her pain is muscular, skeletal, or due to damaged nerves. Despite the carousel of tests and treatments, most patients never see any improvement in

their chronic pain. Defendant Zarrini allows untrained workers to perform his professional duties, then signs off and bills insurers and the State at his full rates. Defendant Zarrini is part of the scheme whereby the Central Logs are used to ensure each patient receives the maximum number of billable medical services, and to direct patient care accordingly. Defendant Zarrini is primarily responsible for the prescription drug prong of the scheme operating out of the Clinics. **Under the scheme, Defendant Zarrini writes prescriptions for patients he has not examined and allows office clerks to use his signature and credentials to prescribe medications in his absence.** Under the scheme, Defendant Zarrini also orders medical tests and treatments for patients without regard to their individual medical needs and allows untrained office workers and medical assistants to perform these tests and treatments without supervision.

178. Defendant **John T. Terrence PsyD, PhD** operates the psychological evaluation arm of the fraudulent billing scheme. Terrence performs sham psychiatric evaluations on as many patients as possible, and bills insurers for as many as **20 hours** in a day for services per patient, without exception. Terrence also bills insurers for patients he does not actually evaluate. When submitting bills to insurers, Terrence bills as if he sees up to a dozen patients per day. For each of these patients, Terrence submits that he has provided **each patient** with over twenty hours of psychological evaluations. In a period of two weeks, Terrence has billed in excess of **1,000 hours for services**. *See* **Exhibit B.** Defendant Terrence knowingly and unlawfully: (a) ordered unnecessary psychiatric evaluations; (b) fraudulently billed insurers in excess of the services actually rendered; and (c) fraudulently billed insurers for evaluations that he did not perform.

C. **Defendant Clinics and Other Billing Entities**

179. **Defendant Danesh Chiropractic** participated in the unlawful scheme to defraud insurers by billing dozens of tests, treatments, and medications for **all** patients, regardless of injury or proper medical diagnosis. Many of these procedures were never performed, and patients often never received the medications for which the insurers pay. Defendant Danesh Chiropractic has no purpose other than to divert some of Defendants' fraudulent bills through more diverse channels to avoid drawing attention to the immense volume of bills generated by Defendants. **This entity knowingly submits false bills to insurers.**

180. **Defendant Pain Free Management** participated in the unlawful scheme to defraud insurers by billing dozens of tests, treatments, and medications for **all** patients, regardless of injury or proper medical diagnosis. Many of these procedures were never performed, and patients often never received the medications for which the insurers pay. As an example, on December 14, 2010, Defendant Pain Free Management billed for four separate Beck Depression Inventories, three Sentence Completion Tests, and two Assessments of Aphasia, all supposedly performed on the same patient on the same day. *See* **Exhibit U**. Defendant Pain Free Management has no purpose other than to divert some of Defendants' fraudulent bills through more diverse channels to avoid drawing attention to the immense volume of bills generated by Defendants. **This entity knowingly submits false bills to insurers.**

181. **Defendant PRHC** participated in the unlawful scheme to defraud insurers by billing dozens of tests, treatments, and medications for **all** patients, regardless of injury or proper medical diagnosis. Many of these procedures were never performed, and patients often never received the medications for which the insurers pay. Defendant PRHC has no purpose other than to divert some of Defendants' fraudulent bills through more diverse channels to avoid drawing

attention to the immense volume of bills generated by Defendants. **This entity knowingly submits false bills to insurers.**

182. **Defendant PFD** participated in the scheme to defraud insurers by billing dozens of tests, treatments, and medications for **all** patients, regardless of injury or proper medical diagnosis. Many of these procedures were not performed, and patients did not receive the medications for which the insurers pay. Defendant PFD has no purpose other than to divert some of Defendants' fraudulent bills through more diverse channels to avoid drawing attention to the immense volume of bills generated by Defendants. **This entity knowingly submits false bills to insurers.**

183. **Defendant CA Orthopedic** participated in the unlawful scheme to defraud insurers by billing dozens of tests, treatments, and medications for **all** patients, regardless of injury or proper medical diagnosis. Many of these procedures were never performed, and patients often never received the medications for which the insurers pay. Defendant CA Orthopedic has no purpose other than to divert some of Defendants' fraudulent bills through more diverse channels to avoid drawing attention to the immense volume of bills generated by Defendants. **This entity knowingly submits false bills to insurers.**

184. **Defendant Southern CA Pain** participated in the unlawful scheme to defraud insurers by billing dozens of tests, treatments, and medications for **all** patients, regardless of injury or proper medical diagnosis. Many of these procedures were never performed, and patients often never received the medications for which the insurers pay. Defendant Southern CA Pain has no purpose other than to divert some of Defendants' fraudulent bills through more diverse channels to avoid drawing attention to the immense volume of bills generated by Defendants. **This entity knowingly submits false bills to insurers.**

185. **Defendant Mindwaves** participated in the unlawful scheme to defraud insurers by billing dozens of tests, treatments, and medications for **all**

patients, regardless of injury or proper medical diagnosis. Many of these procedures were never performed, and patients often never received the medications for which the insurers pay. Defendant Mindwaves has no purpose other than to divert some of Defendants' fraudulent bills through more diverse channels to avoid drawing attention to the immense volume of bills generated by Defendants. **This entity knowingly submits false bills to insurers.** Defendant Mindwaves is owned and controlled by Defendant John Terrence, PsyD.

186. **Defendant Sanchez Chiropractic** participated in the unlawful scheme to defraud insurers by billing dozens of tests, treatments, and medications for **all** patients, regardless of injury or proper medical diagnosis. Many of these procedures were never performed, and patients often never received the medications for which the insurers pay. Defendant Sanchez Chiropractic has no purpose other than to divert some of Defendants' fraudulent bills through more diverse channels to avoid drawing attention to the immense volume of bills generated by Defendants. **This entity knowingly submits false bills to insurers.**

187. **Defendant United Health** participated in the unlawful scheme to defraud insurers by billing dozens of tests, treatments, and medications for **all** patients, regardless of injury or proper medical diagnosis. Many of these procedures were never performed, and patients often never received the medications for which the insurers pay. Defendant United Health has no purpose other than to divert some of Defendants' fraudulent bills through more diverse channels to avoid drawing attention to the immense volume of bills generated by Defendants. **This entity knowingly submits false bills to insurers.**

188. **Defendant Omnipysch** participated in the unlawful scheme to defraud insurers by billing dozens of tests, treatments, and medications for **all** patients, regardless of injury or proper medical diagnosis. Many of these procedures were never performed, and patients often never received the medications for which the insurers pay. Defendant Omnipysch has no purpose

other than to divert some of Defendants' fraudulent bills through more diverse channels to avoid drawing attention to the immense volume of bills generated by Defendants. **This entity knowingly submits false bills to insurers.**

189. **Defendant SoCal Industrial** participated in the unlawful scheme to defraud insurers by billing dozens of tests, treatments, and medications for **all** patients, regardless of injury or proper medical diagnosis. Many of these procedures were never performed, and patients often never received the medications for which the insurers pay. Defendant SoCal Industrial has no purpose other than to divert some of Defendants' fraudulent bills through more diverse channels to avoid drawing attention to the immense volume of bills generated by Defendants. **This entity knowingly submits false bills to insurers.**

190. **Defendant Encino Care Pharmacy** participated in the unlawful scheme to defraud insurers by billing dozens of tests, treatments, and medications for **all** patients, regardless of injury or proper medical diagnosis. Many of these procedures were never performed, and patients often never received the medications for which the insurers pay. Defendant Encino Care Pharmacy has no purpose other than to divert some of Defendants' fraudulent bills through more diverse channels to avoid drawing attention to the immense volume of bills generated by Defendants. **This entity knowingly submits false bills to insurers.**

VI. THE STATUTORY SCHEMES BEHIND DEFENDANTS' CONSPIRACY

A. Repeated Acts of Excessive Medical Treatments, Diagnostic Tests, and Drug Prescriptions

191. California law prohibits medical professionals from "[r]epeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities." Bus. & Prof. Code § 725.

192. California law also prohibits the prescription of dangerous medical drugs "without an appropriate prior examination and a medical indication." Bus. & Prof. Code § 2242.

193. The AMA Code of Medical Ethics further states "[t]reatments which have no medical indication and offer no possible benefit to the patient should not be used." *See* AMA Code of Medical Ethics, Opinion 8.20.

B. The Use of Runners, Cappers, Steerers, or Other Persons to Procure Patients

194. The Clinics' means of procuring patients are specifically prohibited by law. Under California Insurance Code § 1871.7(a), it is "unlawful to knowingly employ runners, cappers, steerers or other persons to procure clients or patients to perform or obtain services or benefits pursuant to [the California Workers Compensation System] or to procure clients or patients to perform or obtain services or benefits under a contract of insurance or that will be the basis of a claim against an insured individual or his or her insurer."

195. Any person or entity that violates § 1871.7(a) is subject to a civil penalty of up to $10,000 for each claim submitted to an insurer for payment. The person or entity is also subject to treble damages for the amount of the claim for compensation billed to the insurer. The Court may also grant equitable relief to protect the public. *See* Ins. Code § 1871.7(b).

C. Payment of Kickbacks to Attorneys for Referring Patients

196. The Clinics' payments to attorneys for referring patients is specifically prohibited by law. California Business & Professions Code §§ 650, 1003, and 2273 prohibits doctors and chiropractors from paying kickbacks for the referral of patients to their clinics.

197. California Labor Code § 3215 similarly prohibits persons from receiving kickbacks for referring patients or engaging in other acts, such as performing surgeries at particular hospitals or choosing particular medical implant

hardware in the workers' compensation context. *See also* Lab. Code § 3820. Ins. Code § 754 makes the same conduct generally unlawful when billed to any private insurer.

198. The Code of Medical Ethics of the American Medical Association ("AMA") strictly prohibits doctors from paying for referrals, making it clear that, "[p]ayment by or to a physician solely for the referral of a patient is fee splitting and is unethical." *See* AMA Code of Medical Ethics, Opinion 6.02.

D. Dishonest and Incompetent Practice

199. It is unlawful for medical personnel to engage in dishonest or incompetent practice. Bus. & Prof. Code § 2234(d-e).

E. Repeated Acts of Falsifying and Altering Medical Records

200. The clinics engaged in a pattern and practice of falsifying and offering medical records to inflate false billing to insurers. "Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct." Bus. & Prof. Code § 2262.

201. Additionally, under California law, "[k]nowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct." Bus. & Prof. Code § 2261.

F. Employment of Unlicensed Employees to Perform Medical Procedures

202. The Clinics regularly employed unlicensed and inexperienced personnel to operate medical equipment and treat patients in order to generate false claims for as many patients as possible. However, the law is clear: "The employing, directly or indirectly, the aiding, or the abetting of any unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which

requires a license to practice constitutes unprofessional conduct." Bus. & Prof. Code § 2264.

G. Dispensing Unnecessary Prescription Drugs by a Non-Physician

203. Contrary to the conduct of the Clinics whose non-physician employees dispensed dangerous drugs directly to patients, California law strictly limits the practice of bypassing a pharmacy and dispensing prescription medication from a medical office. Bus. & Prof. Code § 4170. First, the medication must be "necessary in the treatment of the condition for which the prescriber is attending the patient." Bus. & Prof. Code § 4170(a)(2). Second, the medication must be "dispensed to the prescriber's own patient," and cannot be dispensed by a nurse or physician attendant. Bus. & Prof. Code § 4170(a)(1).

204. The AMA Code of Ethics states physicians may only prescribe medication based "solely upon medical considerations and patient need and reasonable expectations of the effectiveness of the drug, device or other treatment for the particular patient." *See* AMA Code of Medical Ethics, Opinion 8.06.

205. Further, California law prohibits physicians from forcing their patients to accept medications dispensed from the physician or the pharmacy of the physician's choice; they must allow their patients the freedom to fill their prescriptions wherever the patient chooses. Bus. & Prof. Code § 4170(a)(6-7). The AMA Code of Ethics similarly states "physicians should respect the patient's freedom of choice in selecting who will fill their prescriptions." *See* AMA Code of Medical Ethics, Opinion 8.06.

H. Operating under the Imprimatur of or Impersonating a Licensed Medical Doctor

206. The Clinics openly and deliberately promote, report, and bill their services under the imprimatur and in the name of licensed medical doctors. However, licensed medical doctors are legitimately affiliated with only some of the Clinics. California law prohibits the impersonation of a licensed practitioner.

Bus. & Prof. Code § 2289. Additionally, it is unlawful to purchase the medical degree or medical certification of another practitioner. Bus. & Prof. Code § 2287

I. Submitting Fraudulent Claims and Preparing Fraudulent Documents to Support Claims to Insurers

207. At the heart of the Clinics' conduct is that Defendants, and each of them, participated in a conspiracy to defraud the insurance system by submitting false and fraudulent claims. California Penal Code § 550 makes it unlawful to "[k]nowingly make or cause to be made any false or fraudulent claim for payment of a health care benefit." California further proscribes the preparation of a false claim, or any other document used in support of a false claim. Pen. Code § 550(a)(5). It is also unlawful to submit a claim for a health care benefit that was not used by, or on behalf of, the claimant. Pen. Code § 550(a)(7).

208. California Business & Professions Code § 810 further prohibits health care professionals from presenting a fraudulent claim to an insurer, or from preparing documents that will be submitted in support of a fraudulent claim.

209. The AMA Code of Ethics states physicians "should make no intentional misrepresentations to increase the level of payment they receive." *See* AMA Code of Medical Ethics, Opinion 9.132.

J. Upcoding, Bill Inflation and Manipulating the California Workers' Compensation System's Official Medical Fee Schedule

210. In general, the reimbursement rates for procedures performed in the California Workers' Compensation System are governed by the Official Medical Fee Schedule ("OMFS"). *See,* Lab. Code § 5307.1; *see also,* 8 CCR §§ 9790 *et seq.*

211. The OMFS was promulgated by the Administrative Director of the Division of Workers' Compensation in an attempt to rein-in spiraling medical costs. The OMFS ties provider reimbursement to a multiplier of Medicare's rates for the same service.

212. Defendants have unlawfully "upcoded," inflated bills, and engaged in other acts described herein, such as billing for services never provided, that have had the purpose and effect of manipulating and circumventing the OMFS. Consequently, Defendants have submitted claims in violation of the OMFS.

VII. DELAYED DISCOVERY, FRAUDULENT CONCEALMENT, AND CONTINUING COURSE OF CONDUCT

A. Delayed Discovery Suspended Accrual of the Action

213. *Qui Tam* Plaintiff had no knowledge of the claims alleged herein, or of facts sufficient to place her on inquiry notice of the claims set forth herein, until December, 2011. *Qui Tam* Plaintiff did not discover, and could not have discovered through the exercise of reasonable diligence, the existence of this scheme until that time – December of 2011.

214. Because of the lack of transparency in the healthcare industry and medical billing generally, and due to the conduct of Defendants, and each of them, information was not available to *Qui Tam* Plaintiff prior to her employment with many of the Defendants. For these reasons, the statute of limitations did not begin to accrue with respect to the claims *Qui Tam* Plaintiff has alleged in this Complaint until just months before the filing of the Complaint.

B. Fraudulent Concealment Tolled the Statute of Limitations

215. In the alternative, application of the doctrine of fraudulent concealment tolled the statute of limitations on the claims asserted herein.

216. *Qui Tam* Plaintiff did not know and could not have known of the existence of the claims asserted herein until December of 2011.

217. Before that time, *Qui Tam* Plaintiff was unaware of Defendants' unlawful conduct. Defendants employed tactics to keep the schemes alleged herein secret. For example, in order to hide the pain management scheme, Defendants unlawfully employed "runners, cappers and steerers," and engaged in a pattern and practice of overbilling, billing for services never rendered, ordering

unnecessary treatments, tests, and evaluations, billing for medical services that are only superficially provided by untrained, low-wage workers, and using unaffiliated physicians' credentials to unlawfully order prescription drugs in the area of chronic pain management. This conduct concealed the true nature of the pain management scheme and deceived persons into believing they were engaged in appropriate practices. Moreover, federal and state medical privacy laws make it difficult for the public or whistleblowers to review medical billing in depth.

218. Additionally, Defendants utilized the lack of transparency in the healthcare industry and medical billing generally to carry out their unlawful and fraudulent schemes. For example, the SCIF's publication, *A Treating Physician's Guide to Patient Care in the Workers' Compensation System*, states that "[t]he nature of the workers' compensation system combined with minimal accountability demanded of service providers to allow documenting fraud and establishing potential criminal responsibility make fraud **exceptionally difficult to detect and prosecute.**"

219. Defendants hid their unlawful conduct through the use of sham corporations, LLCs, and other complex financial arrangements. Additionally, chiropractors and doctors were sometimes paid unlawful kickbacks in cash to conceal the payments. Consequently, the doctrine of fraudulent concealment has tolled *Qui Tam* Plaintiff's claims.

C. Defendants' Continuing Course of Conduct Constitutes a Continuing Violation of the Insurance Frauds Prevent Act and the California False Claims Act

220. *Qui Tam* Plaintiff is informed and believes with respect to each individual and entity named in this Complaint, their conduct constituted a continuing pattern and course of conduct beginning as early as 2008 and continues up until the present.

221. This pattern and course of conduct constitutes a continuing violation of the statutes at issue in this case.

VIII. CAUSES OF ACTION

FIRST CAUSE OF ACTION

(Against All Defendants)

California Insurance Frauds Prevention Act, Employment of Runners, Cappers, and Steerers or Other Persons to Procure Patients

(Cal. Ins. Code § 1871.7(a))

222. *Qui Tam* Plaintiff incorporates herein by reference and realleges all of the allegations stated in this Complaint.

223. Pursuant to Ins. Code § 1871.7(a), it is unlawful to knowingly employ runners, cappers, steerers, or other persons to procure patients for the purpose of submitting a claim to that patient's insurance carrier.

224. From at least January 2010 to the present, Defendant Clinics and Gharib-Danesh have unlawfully employed Attorneys for the purpose of procuring patients to undergo treatment at the Clinics. Defendant Clinics did so in order to submit claims for payment to insurance carriers.

225. From at least January 2010 to the present, Attorneys, acting as the runners, cappers, steerers, or other persons, all conspired with the Defendant Clinics and Gharib-Danesh to violate Ins. Code § 1871.7(a).

226. Because the claims submitted to medical insurers by Defendant Clinics were procured by runners, cappers, steers, and other persons, these claims were false and fraudulent under the California Insurance Frauds Prevention Act.

227. This conduct was a substantial factor in causing damages as detailed herein.

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SECOND CAUSE OF ACTION

(Against All Defendants)

California Insurance Frauds Prevention Act, Presenting or Causing to be Presented False or Fraudulent Claims for the Payment of an Injury Under a Contract of Insurance

(Cal. Ins. Code § 1871.1(b); Cal. Pen. Code § 550(a)(1))

228. *Qui Tam* Plaintiff incorporates herein by reference and realleges all of the allegations stated in this Complaint.

229. From at least January 2010 to the present, Defendants have all either knowingly presented or caused to be presented false and fraudulent claims for the payment of physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment, or aided, abetted, solicited, or conspired to present or caused to be presented such false and fraudulent claims.

230. The claims were fraudulent because:

a. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment prescribed in gross and repeated acts of dishonesty and fraud;

b. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment that were excessively prescribed and prescribed off of Medication Logs and Master Logs without appropriate prior medical examination and independent medical judgment;

c. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy

treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment ordered that were never provided to the patient;

d. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment using medical records that were unlawfully altered, fraudulent, and contained false representations of fact;

e. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment using medical records that were performed and prescribed by unlicensed employees;

f. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment were prescribed by someone impersonating a medical practitioner, or through the use of a medical practitioner's purchased credentials;

g. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for prescription medications, that were dispensed in disregard of a patient's right to choose without providing patients with the freedom to select who fills their prescriptions; and

h. Defendants knowingly sought, and falsely represented, they were entitled to claims that had been "upcoded," inflated, or never provided at all. Consequently, the services identified on the claims were more costly than actually provided or performed on the patients. Defendants, therefore, unlawfully manipulated the rates permitted under the Official Medical Fee Schedule ("OMFS"), which governs the rates than may be charged for particular services in the workers' compensation system.

231. Defendants either directly presented such false claims for payment to insurers, or caused such false claims to be presented.

232. This conduct was a substantial factor in causing the damages as detailed herein.

THIRD CAUSE OF ACTION

(Against All Defendants)

California Insurance Frauds Prevention Act, Knowingly Preparing or Making Any Writing in Support of a False or Fraudulent Claim

(Cal. Ins. Code § 1871.1(b); Cal. Pen. Code § 550(a)(5))

233. *Qui Tam* Plaintiff incorporates herein by reference and realleges all of the allegations stated in this Complaint.

234. From at least January 2010 to the present, Defendants have all either knowingly prepared, made, or subscribed a writing, with the intent to present or use it, or allow it to be presented, in support of false and fraudulent claims for the payment of physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment, or aided, abetted, solicited, or conspired to prepare, make, or subscribe such a writing.

235. The writings include bills for payment presented to insurance carriers, and invoices prepared in support of such bills for payment. Such bills for payment constitute false or fraudulent claims because through those bills:

a. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment prescribed in gross and repeated acts of dishonesty and fraud;

b. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment that were excessively prescribed and prescribed off of Medication Logs and Master Logs and without appropriate prior medical examination and independent medical judgment;

c. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment ordered that were never provided to the patient;

d. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment using medical records that were unlawfully altered, fraudulent, and contained false representations of fact;

e. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy

treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment using medical records that were performed and prescribed by unlicensed employees;

f. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment were prescribed by someone impersonating a medical practitioner, or through the use of a medical practitioner's purchased credentials;

g. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for prescription medications, that were dispensed in disregard of a patient's right to choose without providing patients with the freedom to select who fills their prescriptions; and

h. Defendants knowingly sought, and falsely represented, they were entitled to claims that had been "upcoded," inflated, or never provided at all. Consequently, the services identified on the claims were more costly than actually provided or performed on the patients. Defendants, therefore, unlawfully manipulated the rates permitted under the OMFS.

236. Defendants either directly presented such false claims for payment to insurers, or caused such false claims to be presented.

237. This conduct was a substantial factor in causing the damages as detailed here.

FOURTH CAUSE OF ACTION

(Against All Defendants)

California Insurance Frauds Prevention Act, Knowingly Making or Causing to Be Made Any False or Fraudulent Claim for Payment of a Health Care Benefit

(Cal. Ins. Code § 1871.1(b); Cal. Pen. Code § 550(a)(6))

238. *Qui Tam* Plaintiff incorporates herein by reference and realleges all of the allegations stated in this Complaint.

239. From at least January 2010 to the present, Defendants have all either knowingly presented or caused to be presented false and fraudulent claims for the payment of physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment, or aided, abetted, solicited, or conspired to present or caused to be presented such false and fraudulent claims.

240. The claims were fraudulent because:

a. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment prescribed in gross and repeated acts of dishonesty and fraud;

b. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment that were excessively prescribed and prescribed off of Medication Logs and Master Logs without appropriate prior medical examination and independent medical judgment;

c. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy

treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment ordered that were never provided to the patient;

d. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment using medical records that were unlawfully altered, fraudulent, and contained false representations of fact;

e. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment using medical records that were performed and prescribed by unlicensed employees;

f. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment were prescribed by someone impersonating a medical practitioner, or through the use of a medical practitioner's purchased credentials;

g. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for prescription medications, that were dispensed in disregard of a patient's right to choose without providing patients with the freedom to select who fills their prescriptions; and

h. Defendants knowingly sought, and falsely represented, they were entitled to claims that had been "upcoded," inflated, or never provided at all. Consequently, the services identified on the claims were more costly than actually provided or performed on the patients. Defendants, therefore, unlawfully manipulated the rates permitted under the OMFS.

241. Defendants either directly presented such false claims for payment to insurers, or caused such false claims to be presented.

242. This conduct was a substantial factor in causing the damages as detailed herein.

FIFTH CAUSE OF ACTION

(Against All Defendants)

California Insurance Frauds Prevention Act, Soliciting, Accepting, and Referring Business to or from an Individual or Entity That Intends to Violate Section 550 of the Penal Code or Section 1871.4 of the Insurance Code

(Cal. Ins. Code § 1871.1(b); Cal. Pen. Code § 549)

243. *Qui Tam* Plaintiff incorporates herein by reference and realleges all of the allegations stated in this Complaint.

244. From at least January 2010 to the present, Defendants have all solicited, accepted, or referred business to or from an entity or individual that intends to violate Section 550 of the Penal Code or Section 1871.4 of the Insurance Code.

245. The claims were fraudulent because:

a. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment prescribed in gross and repeated acts of dishonesty and fraud;

b. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment were excessively prescribed and prescribed off of Medication Logs and Master Logs and without appropriate prior medical examination and independent medical judgment;

c. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment ordered that were never provided to the patient;

d. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment using medical records that were unlawfully altered, fraudulent, and contained false representations of fact;

e. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment using medical records that were performed and prescribed by unlicensed employees;

f. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment that

were prescribed by someone impersonating a medical practitioner, or through the use of a medical practitioner's purchased credentials;

g. Defendants knowingly sought, and falsely represented they were entitled to, reimbursement for prescription medications, that were dispensed in disregard of a patient's right to choose without providing patients with the freedom to select who fills their prescriptions; and

h. Defendants knowingly sought, and falsely represented, they were entitled to claims that had been "upcoded," inflated, or never provided at all. Consequently, the services identified on the claims were more costly than actually provided or performed on the patients. Defendants, therefore, unlawfully manipulated the rates permitted under the OMFS.

246. Defendants either directly presented such false claims for payment to insurers, or caused such false claims to be presented.

247. This conduct was a substantial factor in causing the damages as detailed herein.

SIXTH CAUSE OF ACTION

(Against All Defendants)

California False Claims Act for Presentation or Cause of Presentation of False Claims to Medi-Cal

(Cal. Gov. Code § 12651(a)(1))

248. *Qui Tam* Plaintiff incorporates herein by reference and realleges all of the allegations stated in this Complaint.

249. By the conduct described above, from at least January 2010 to the present, Defendants have knowingly presented, or caused to be presented, false and fraudulent claims for payment or approval from California's Medi-Cal system.

250. The claims were fraudulent because:

a. Defendants knowingly sought, and falsely represented that they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment that were excessively prescribed and prescribed off of Medication Logs and Master Logs and without appropriate prior medical examination and independent medical judgment.

b. Defendants knowingly sought, and falsely represented that they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment ordered that were never provided to the patient;

c. Defendants knowingly sought, and falsely represented that they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment using medical records that were unlawfully altered, fraudulent, and contained false representations of fact;

d. Defendants knowingly sought, and falsely represented that they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment using medical records that were performed and prescribed by unlicensed employees;

e. Defendants knowingly sought, and falsely represented that they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations,

prescription medications, and durable medical equipment that were prescribed by someone impersonating a medical practitioner, or through the use of a medical practitioner's purchased credentials; and

f. Defendants knowingly sought, and falsely represented that they were entitled to, reimbursement for prescription medications, that were dispensed without providing patients with the freedom to select who fills their prescriptions.

251. Defendants either directly presented such false claims for payment to insurers, or caused such false claims to be presented.

252. This conduct was a substantial factor in causing the damages as detailed herein.

SEVENTH CAUSE OF ACTION

(Against All Defendants)

California False Claims Act for Making, Using, or Causing to be Made or Used, a False Record or Statement Material to a False or Fraudulent Claim to Medi-Cal

(Cal. Gov. Code § 12651(a)(2))

253. *Qui Tam* Plaintiff incorporates herein by reference and realleges all of the allegations stated in this Complaint.

254. By the conduct described above, from at least January 2010 to the present, Defendants have knowingly presented, or caused to be presented, false and fraudulent claims for payment or approval from California's Medi-Cal system.

255. The claims were fraudulent because:

a. Defendants knowingly sought, and falsely represented that they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment that were excessively prescribed and prescribed off of Medication

Logs and Master Logs and without appropriate prior medical examination and independent medical judgment.

b. Defendants knowingly sought, and falsely represented that they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment ordered that were never provided to the patient;

c. Defendants knowingly sought, and falsely represented that they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment using medical records that were unlawfully altered, fraudulent, and contained false representations of fact;

d. Defendants knowingly sought, and falsely represented that they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment using medical records that were performed and prescribed by unlicensed employees;

e. Defendants knowingly sought, and falsely represented that they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment that were prescribed by someone impersonating a medical practitioner, or through the use of a medical practitioner's purchased credentials; and

f. Defendants knowingly sought, and falsely represented that they were entitled to, reimbursement for prescription medications,

that were dispensed without providing patients with the freedom to select who fills their prescriptions.

256. Defendants either directly presented such false claims for payment to insurers, or caused such false claims to be presented.

257. This conduct was a substantial factor in causing the damages as detailed herein.

EIGHTH CAUSE OF ACTION

(Against All Defendants)

California False Claims Act for Conspiracy to Commit False Claims to Medi-Cal

(Cal. Gov. Code § 12651(a)(3))

258. *Qui Tam* Plaintiff incorporates herein by reference and realleges all of the allegations stated in this Complaint.

259. By the conduct described above, from at least January 2010 to the present, Defendants have knowingly presented, or caused to be presented, false and fraudulent claims for payment or approval from California's Medi-Cal system.

260. The claims were fraudulent because:

a. Defendants knowingly sought, and falsely represented that they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment that were excessively prescribed and prescribed off of Medication Logs and Master Logs and without appropriate prior medical examination and independent medical judgment.

b. Defendants knowingly sought, and falsely represented that they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment

ordered that were never provided to the patient;

c. Defendants knowingly sought, and falsely represented that they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment using medical records that were unlawfully altered, fraudulent, and contained false representations of fact;

d. Defendants knowingly sought, and falsely represented that they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment using medical records that were performed and prescribed by unlicensed employees;

e. Defendants knowingly sought, and falsely represented that they were entitled to, reimbursement for physical therapy treatments, diagnostic tests, psychological evaluations, prescription medications, and durable medical equipment that were prescribed by someone impersonating a medical practitioner, or through the use of a medical practitioner's purchased credentials; and

f. Defendants knowingly sought, and falsely represented that they were entitled to, reimbursement for prescription medications, that were dispensed without providing patients with the freedom to select who fills their prescriptions.

261. Defendants either directly presented such false claims for payment to insurers, or caused such false claims to be presented.

262. This conduct was a substantial factor in causing the damages as detailed herein.

IX. PRAYER FOR RELIEF

WHEREFORE, Plaintiff, by and through *Qui Tam* Plaintiff, prays for judgment in its favor and against Defendants, and each of them, as follows:

Pursuant to the California Insurance Frauds Prevention Act:

TO THE PEOPLE OF CALIFORNIA AND *QUI TAM* PLAINTIFF:

1. For civil penalties of $10,000 to be imposed for each and every false and fraudulent claim for payment submitted, presented, or caused to be submitted or presented to an insurance company;

2. For an assessment of three-times the amount of each claim for compensation made by Defendants;

3. For an injunction mandating Defendants be prohibited from:

   (a) employing, or acting as runners, cappers, steerers, or other persons for the purpose of procuring patients;

   (b) paying illegal kickbacks to chiropractors, doctors, lawyers, and other persons for referring patients to Defendants;

   (c) inflating the cost of treatments, tests, and medications above that which is allowable under California law; and

   (e) performing non-medically necessary treatments and tests, and prescribing non-medically necessary medications.

4. For pre and post-judgment interest;

5. For reasonable attorneys' fees, costs, and expenses incurred in bringing this case;

6. For an award of such other and further relief as this Court deems just and proper; and

7. That the *Qui Tam* Plaintiff be awarded the maximum percentage of any recovery allowed to her pursuant to Cal. Ins. Code § 1871.7.

Pursuant to the California False Claims Act:

TO THE PEOPLE OF CALIFORNIA AND *QUI TAM* PLAINTIFF:

1. For civil penalties of $10,000 to be imposed for each and every false and fraudulent claim for payment submitted, presented or caused to be submitted or presented to Medi-Cal for payment;

2. For treble damages resulting to the Medi-Cal system from the conduct of Defendants, and each of them;

3. For pre and post-judgment interest;

4. For reasonable attorneys' fees, costs, and expenses incurred in bringing this case; and

5. That *Qui Tam* Plaintiff be awarded the maximum percentage of any recovery allowed to her pursuant to the California False Claims Act.

Dated: July 12, 2012

COTCHETT, PITRE & McCARTHY, LLP

By: _____
Philip L. Gregory
Attorneys for Qui Tam Plaintiff

DEMAND FOR JURY TRIAL

Qui Tam Plaintiff ANNA MARIA CHRISTINA SILLS hereby demands a jury trial on all issues so triable.

Dated: July 12, 2012

COTCHETT, PITRE & McCARTHY, LLP

By: _____

Philip L. Gregory
Attorneys for Qui Tam Plaintiff