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

UNITED STATES OF AMERICA,	)	
	)	
v.	)	**CRIMINAL NO. 2:19cr189**
	)	
JAVAID PERWAIZ,	)	**18 U.S.C. § 1347**
	)	**Health Care Fraud**
Defendant.	)	**(Counts 1-26)**
	)	
	)	**18 U.S.C. § 1035**
	)	**False Statements Related to**
	)	**Health Care Matters**
	)	**(Counts 27-59)**
	)	
	)	**18 U.S.C. § 1028A**
	)	**Aggravated Identity Theft** MLF
	)	**(Counts 60-63)** -61, 63)
	)	
	)	**18 U.S.C. § 982(a)(7)**
	)	**Forfeiture**

SUPERSEDING INDICTMENT

June 2020 Term -- At Norfolk, Virginia

THE GRAND JURY CHARGES THAT:

GENERAL ALLEGATIONS

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

Health Care Benefit Programs

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

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

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

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

5. Anthem Blue Cross Blue Shield ("Anthem"), Optima Health ("Optima"), Humana, Cigna, Aetna, and United are private health care programs that provide insurance contracts and plans, affecting interstate commerce, under which medical benefits, items, and services are provided to individuals in the Eastern District of Virginia and elsewhere.

6. Medicaid, Medicare, TRICARE, Anthem, Optima, Humana, Cigna, Aetna, United, and other health insurance programs referenced herein are all health care benefit programs as defined in 18 U.S.C. § 24(b). They are referred to herein individually by name, or collectively as "health care benefit programs."

Enrollment, Claims and Medical Necessity Criteria

7. In order to receive payments for health care services from the health care benefit programs, many providers are required to submit enrollment applications and periodic updates and attestations that accurately and truthfully disclose past misconduct, including criminal convictions and license and privilege revocations. These disclosure requirements are specified in state and federal regulations, as well as in the agreements with the health care benefit programs and other notifications from the programs. The health care benefit programs rely on truthful disclosures by health care providers in order to determine whether to enroll and maintain enrollment for a provider.

8. The American Medical Association publishes an annual manual of Current Procedural Terminology (CPT) codes. The CPT Manual is a listing of descriptive terms and identifying codes for reporting the nature and complexity of medical services and procedures performed by physicians. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services. In 2000, to implement the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, the Department of Health and Human Services designated the CPT Manual set as a national coding standard for physicians and other health care professionals' services and procedures. As a result, for all financial and administrative health care transactions, CPT codes must be used in describing health care services rendered. Health care benefit programs contractually require health care providers to use CPT codes in submitting reimbursement claims.

9. Health care providers are given and provided with online access to health care benefit program manuals and services bulletins describing proper billing procedures and billing rules and regulations. For instance, providers can only submit claims to health care benefit programs

for medically necessary services they rendered, and providers are required to maintain accurate patient records to verify that the services were provided as described on the claims and make those records available for audits by health care benefit programs. *E.g.*, 42 U.S.C. § 1395y(a)(1)(A); DMAS Physician/Practitioner Manual Ch. 2, pp. 7, 9, 16.

10. To receive payment from a health care benefit program, a provider must submit a claim using a CMS-1500, or Health Insurance Claim Form ("claim form"). Claims can be submitted electronically and by mail.

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

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

13. Health care benefit programs prohibit payment for items and services that are not "reasonable and necessary" for the diagnosis and treatment of an illness or injury. Medicare claim forms, for example, require the provider who makes a claim for reimbursement to certify that the services were "medically indicated and necessary for the health of the patient." The DMAS Manual and other health care benefit program manuals for providers and practitioners state that the physician is responsible for certifying that the service is medically necessary and

that the treatment prescribed is in accordance with the community standards of medical practice. *E.g.*, DMAS Physician/Practitioner Manual Ch. 2, p. 9, 16.

14. Title 42 of the Code of Federal Regulations (CFR) 441, Subpart F, requires valid consent forms for all sterilization procedures. Title 42 CFR § 441.258 and Medicaid Title XIX, in order to be reimbursed for such procedures by Medicaid, require a physician performing sterilization to certify that at least 30 days have passed between the date of the individual's signature on the consent form and the date of the sterilization procedure. This requirement was instituted, in part, to provide protection for vulnerable populations from coerced sterilization.

15. Elective induction of labor in pregnant women – labor induced with no medical need to do so – before 39 weeks of gestation is known to pose health risks and contrary to the medical standard of care. Since 1979, the American College of Obstetricians and Gynecologists ("ACOG") has recommended against elective deliveries or induced labor before 39 weeks of gestation. In late 2012, a joint initiative of numerous Virginia hospitals, organizations, and health care providers worked to reduce early elective deliveries, and announced in 2017 that it had reduced its rate to 1.3%, then the lowest in the nation. In February 2019, ACOG published an opinion again recommending avoidance of nonmedically-indicated delivery before 39 weeks of gestation, noting that "multiple studies have shown increased rates of adverse long-term infant outcomes associated with late-preterm and early-term delivery," including "lower performance scores across a range of cognitive and educational measures compared with their full term peers." By at latest 2017, in Virginia and elsewhere, elective induction of labor prior to 39 weeks was against the standard of care and not medically necessary, and was thus material to the decision of a health care benefit program to reimburse for such a procedure.

The Defendant

16. Defendant JAVAID PERWAIZ, a resident of Chesapeake, Virginia, was a licensed physician, board-certified to practice obstetrics and gynecology. He was first licensed to practice medicine in Virginia in or about April 1980.

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

18. In addition to treating obstetric patients, JAVAID PERWAIZ performed gynecological services, both in his office and at various hospitals and outpatient surgical centers within the Eastern District of Virginia.

19. PERWAIZ was enrolled as a participating provider with Medicare, Medicaid, Anthem, Optima, Humana, and others. As such, he entered into a contract with each provider and was required to be aware of their policies and procedures.

20. In addition, PERWAIZ also routinely provided medical services for patients of TRICARE, Cigna, Aetna, United, and others.

21. PERWAIZ recorded his patients' alleged health statements, findings, and services he claimed to have performed on patient encounter sheets and surgical summary forms, which he then provided to his office staff responsible for submitting claims for prior authorizations and reimbursement to health care benefit programs.

22. On or about October 24, 1983, Maryview Hospital terminated PERWAIZ' staff membership and clinical privileges due to poor clinical judgment, unnecessary surgery, lack of documentation, and discrepancies in recordkeeping. The Virginia Department of Health and Regulatory Board, then the Virginia licensing authority for physicians, conducted an ensuing

investigation and ultimately censured PERWAIZ on or about August 15, 1984, for lack of documentation of patient records and lack of judgment in regards to a sexual relationship with a patient. On or about October 11, 1984, PERWAIZ was presented with a written list of conditions and restrictions in response to his pending re-application for Medical Staff Membership at Maryview Hospital. Rather than accept those conditions and restrictions, PERWAIZ withdrew his application. Although PERWAIZ ultimately returned to staff membership at Maryview Hospital on or about May 1, 1997, he did so under a monitoring program for his surgical cases.

23. On or about April 10, 1996, PERWAIZ was convicted after pleading guilty in the Eastern District of Virginia of two counts of felony tax evasion, in violation of 26 U.S.C. § 7206(1). The convictions stemmed from PERWAIZ filing false and fraudulent tax returns; in part, this included PERWAIZ attempting to claim the purchase of a Ferrari sports car as a business expense by labeling it as a purchase of an ultrasound machine for his practice. He was sentenced to five years of probation along with a fine and restitution, in the form of settling a civil tax liability in the amount of approximately $61,196.84. PERWAIZ also served four months of electronic monitoring in the Home Confinement Program.

24. As a result of his felony tax convictions, PERWAIZ' Virginia medical license was suspended from on or about April 29, 1996 to on or about July 12, 1996, at which point his medical license was reinstated and placed on indefinite stayed suspension with stipulated terms and conditions. Certain health care benefit programs including Priority Healthcare, Blue Cross & Blue Shield, CHAMPUS, Aetna, Cigna, Virginia Health Network, and several others suspended or terminated PERWAIZ' ability to participate in their insurance plans due to his convictions and the indefinite suspension placed upon his medical license. Additionally,

Chesapeake General Hospital suspended PERWAIZ' clinical privileges on or about May 6, 1996. PERWAIZ' clinical privileges were reinstated at Chesapeake General Hospital on or about August 15, 1996. On or about September 30, 1999, the Virginia Department of Health Professions, the current Virginia licensing authority for physicians, determined PERWAIZ complied with all terms and conditions and terminated PERWAIZ' probation. .

Medical Terms Defined

25. "Bilateral Tubal Ligation" or "BTL" is a surgical procedure for sterilization in which a woman's fallopian tubes are clamped or blocked and sealed, either of which prevents eggs from being fertilized by sperm.

26. "Cautery of the cervix" is a surgical procedure that uses heat to destroy abnormal areas on the cervix.

27. "Chromotubation of oviduct" is a surgical procedure usually performed laparoscopically where a colored dye is inserted into the fallopian tubes to confirm if the tubes are open or blocked.

28. "Colposcopy" is a procedure to look at the cervix through a special magnifying device called a colposcope. It shines a light into the vagina and onto the cervix and requires applying a solution to a patient's cervix and vagina. The liquid makes abnormal areas on the cervix visible. This procedure allows the health care provider to find problems that cannot be seen by the naked eye alone.

29. "Cold knife cone biopsy" is a surgical procedure in which a cone-shaped piece of the cervix that may contain abnormal cells is removed.

30. An ovarian "cyst" is a fluid-filled sac or pocket in or on an ovary. Ovarian cysts are very common. "Functional" or "physiologic" ovarian cysts are the most common, form monthly in

correspondence with ovulation, usually cause no symptoms, and almost always resolve in the normal course of a woman's menstrual cycle without treatment. "Simple" cysts are usually "functional" or "physiologic" cysts. Most ovarian cysts are benign. Rarely, a cyst is malignant.

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

32. "Dysmenorrhea" is the term for painful menses.

33. "Endocervical curettage" is a surgical procedure in which superficial cells inside the cervical canal are scraped using an instrument called a curette.

34. "Hysterectomy" is the surgical removal of the uterus. A "salpingo-oophorectomy" and "bilateral salpingo-oophorectomy" ("BSO"), which is the removal of either one or both ovaries and fallopian tubes, respectively, may also be performed during a hysterectomy, or separately. A woman is no longer able to have children after having a hysterectomy. A "total" hysterectomy removes the entire uterus, including the cervix. A "supracervical" (also called "subtotal" or "partial") hysterectomy removes the upper part of the uterus, but the cervix is left in place. A hysterectomy may be performed vaginally, abdominally, or laparoscopically.

35. "Hysteroscopy" is a procedure used to diagnose or treat problems of the uterus through the use of a hysteroscope. A hysteroscope is a thin, lighted telescope-like device. It is inserted through a woman's vagina and cervix into her uterus. In order for the endometrial cavity to be visible, health care providers must use both a proper, functioning light source and a liquid solution to dilate and distend the uterine cavity.

36. "Laparoscopy" is a surgical procedure in which a fiber-optic instrument is inserted through the abdominal wall to view the organs in the abdomen and to permit a surgical procedure.

37. "Lysis of adhesions" is a surgical procedure to cut bands of tissue that form between organs. They are often caused by scar tissue that formed after an earlier surgery.

38. "Menorrhagia" is the term for heavy menstrual bleeding.

39. "Myomectomy" is the surgical removal of fibroids while leaving the uterus in place. If completely removed, fibroids do not regrow after surgery but new fibroids may develop.

40. "Pap smear" is a swab test that takes a sample of cells from the cervix to check for abnormalities.

41. "Uterine Fibroids" are benign growths that develop in or on a woman's uterus. They typically do not require medical intervention if they are asymptomatic. Post-menopausal women rarely develop new fibroids, and those that were pre-existing typically are not symptomatic and do not grow further but instead shrink or stay the same.

42. "Uterine prolapse" occurs when the pelvic floor muscles and ligaments stretch and weaken, no longer providing enough support for the uterus. As a result, the uterus slips down into or protrudes out of the vagina. Symptomatic uterine prolapse, *i.e.*, prolapse that causes problems that a woman notices, may require use of a pessary device or a hysterectomy to remove the uterus. However, most women with uterine prolapse are asymptomatic. Surgery is not medically necessary for asymptomatic uterine prolapse. Other kinds of pelvic organ prolapse, which may require surgery, include a "rectocele" (when the rectum bulges into the vagina) or a "cystocele" (when the bladder bulges into the vagina). The surgery to repair the vaginal walls is known as an anterior or posterior "colporrhaphy."

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

43. Paragraphs 1 through 42 of the General Allegations section of this Superseding Indictment are realleged and incorporated by reference as though fully set forth herein.

44. Beginning at least as early as in or about January 2010 and continuing until on or about November 8, 2019, in the Eastern District of Virginia, and elsewhere, the defendant JAVAID PERWAIZ, did knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud a health care benefit program affecting commerce, as defined in 18 U.S.C. § 24(b), that is Medicare, Medicaid, TRICARE, Anthem, Optima, Humana, Cigna, Aetna, United, and others, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by and under the custody of Medicare, Medicaid, TRICARE, Anthem, Optima, Humana, Cigna, Aetna, United, and others, in connection with the delivery of and payment for health care benefits, items, and services.

Purpose of the Scheme and Artifice

45. It was the purpose of the scheme and artifice for JAVAID PERWAIZ to unlawfully enrich himself through the submission of false and fraudulent claims for services that were: (a) not medically necessary and contrary to the medical standard of care, (b) based upon fraudulent and falsified purported patient statements, diagnoses, and diagnostic procedures, (c) not, in fact, performed, and (d) based upon altered and fraudulent sterilization consent forms.

The Scheme and Artifice

46. JAVAID PERWAIZ submitted and caused the submission of false and fraudulent claims to Medicare, Medicaid, TRICARE, Anthem, Optima, Humana, Cigna, Aetna, United, and other health care benefit programs for procedures and services, including hysteroscopies, colposcopies,

vaginal and abdominal hysterectomies, D&Cs, lysis of adhesions, BSOs, myomectomies, obstetric inductions, BTLs, and others.

47. In perpetrating his scheme, PERWAIZ employed various types of false and fraudulent practices, including but not limited to:

Falsification of Estimated Delivery Dates ("EDD")

48. PERWAIZ routinely scheduled his obstetric patients for early elective inductions of labor so as to ensure that the baby would be delivered on a day he was already scheduled to be at the hospital performing gynecological procedures and surgeries, he would be the health care provider who delivered the baby, and, therefore, he would receive payment from the health care benefit programs for the delivery.

49. PERWAIZ routinely changed and falsified his obstetric patients' EDD, without medical indication, in the patients' medical records so it appeared that the scheduled induction of the labor occurred at least 39 weeks into gestation. This routinely resulted in PERWAIZ inducing labor prior to 39 weeks' gestation, contrary to the standard of care and placing the mother and newborn at increased risk.

50. In 2019, PERWAIZ billed Medicaid and TRICARE for 84 deliveries. At least 33 of these women were early induced labors, without medical indication, before the mother reached 39 weeks of gestation, for which PERWAIZ then billed Medicaid and TRICARE.

51. Examples in 2018 and 2019 include:

a. Based on A.B.'s initial ultrasound, A.B.'s correct EDD was September 15, 2018. Without medical indication, PERWAIZ changed her EDD to September 7, 2018. PERWAIZ then scheduled and performed an elective induction of A.B. on or about

September 1, 2018, when A.B. was only approximately 38 weeks and 0 days into gestation.

b. Based on C.L.'s last menstrual period ("LMP") and ultrasound, C.L.'s correct EDD was March 12, 2019. Without medical indication, PERWAIZ changed her EDD to March 9, 2019. PERWAIZ then scheduled and performed an elective induction of C.L. on or about March 2, 2019, when C.L. was only approximately 38 weeks and 4 days into gestation.

c. Based on patient L.R.'s LMP, patient L.R.'s correct EDD was July 5, 2019. Without medical indication, PERWAIZ changed her EDD to June 28, 2019. PERWAIZ then scheduled and performed an elective induction of L.R. on or about June 22, 2019, when L.R. was only approximately 38 weeks and 1 day into gestation.

d. Based on A.C.'s ultrasounds, A.C.'s correct EDD was October 2, 2019. Without medical indication, PERWAIZ changed her EDD to September 27, 2019. PERWAIZ then scheduled and performed an elective induction of A.C. on or about September 21, 2019, when A.C. was only approximately 38 weeks and 2 days into gestation.

e. Based on H.M.'s initial ultrasound, H.M.'s correct EDD was October 28, 2019. Without medical indication, PERWAIZ changed her EDD to October 22, 2019. PERWAIZ then scheduled and performed an elective induction of H.M. on or about October 19, 2019, when H.M. was only approximately 38 weeks and 5 days into gestation.

f. Based on B.P.'s initial ultrasound, B.P.'s correct EDD was October 30, 2019. Without medical indication, PERWAIZ changed her EDD to October 25, 2019. PERWAIZ then scheduled and performed an elective induction of B.P. on or about

October 19, 2019, when B.P. was only approximately 38 weeks and 3 days into gestation.

g. Based on A.B.'s ultrasound, A.B.'s correct EDD was November 10, 2019. Without medical indication, PERWAIZ changed her EDD to November 2, 2019. PERWAIZ then scheduled and performed an elective induction of A.B. on or about October 26, 2019, when A.B. was only approximately 37 weeks and 6 days into gestation.

52. PERWAIZ would then bill health care benefit programs for the elective induction and delivery knowing the patients had not reached 39 weeks' gestation, and the early induction was not medically necessary and contrary to the standard of care.

53. For A.B. in 2018 and for A.B. and others in 2019, PERWAIZ billed at least $102,000 in 2019 for pre-39 week, elective inductions of labor, to Medicaid and TRICARE.

Falsified Patient Symptoms/Statements/Diagnoses and False Cancer Scares

54. PERWAIZ routinely and aggressively encouraged women to consent to irreversible, invasive, and unnecessary gynecological procedures and surgeries.

55. For instance, PERWAIZ routinely told patients that she would develop cancer if she did not undergo surgery and that she already had cancer and required surgery.

56. For instance, PERWAIZ routinely did not counsel and offer less-invasive medical options to his patients other than the invasive gynecological procedures and surgeries.

57. To support PERWAIZ' billing for unnecessary procedures and surgeries, PERWAIZ routinely falsified medical records to include statements and symptoms the patients did not actually suffer and which the patients did not relay to PERWAIZ. PERWAIZ used these purported patient statements and symptoms to document and justify billing diagnostic and surgical gynecological procedures to the health care benefit programs.

58. As a result of this scheme and artifice to defraud, patients unknowingly underwent unnecessary procedures and surgeries. All patients identified below as undergoing a hysterectomy suffered serious bodily injury as defined in 18 U.S.C. § 1365(h)(3)(D). Additionally, as described below, at least one of these patients incurred serious bodily injury. For example:

a. In 2012, PERWAIZ told M.C. she needed a hysterectomy. On about October 6, 2012, PERWAIZ performed a vaginal hysterectomy and combined anterior posterior colporrhaphy on M.C. To support his claim for payment to the health care benefit program, PERWAIZ falsely documented the diagnostic reason for the procedure as uterine prolapse and a complex ovarian cyst. He stated M.C., a non-native English speaker, complained of pelvic and back pain and an increasing protrusion in her vagina. In truth and fact, M.C. had no gynecological complaints and the surgery was unnecessary.

b. In 2012, patient C.O. went to PERWAIZ after an abnormal Pap smear with another medical provider. In a nine-month period, PERWAIZ allegedly performed two colposcopies, a cold knife cone biopsy, a diagnostic hysteroscopy, an ultrasound, a D&C, and a laparoscopic surgical procedure to remove adnexal structures on C.O. PERWAIZ told C.O. that these procedures showed abnormal cells that could lead to cancer and she needed a hysterectomy. On or about October 13, 2012, PERWAIZ performed a vaginal hysterectomy and combined anterior posterior colporrhaphy on C.O. To support his claim for payment to the health care benefit program, PERWAIZ falsely documented the diagnostic reason for the procedure as symptomatic uterine prolapse. He stated C.O. complained a protrusion in her vagina. In truth and fact,

C.O. had not complained of a protrusion in her vagina and the surgery was unnecessary.

c. In 2012, patient D.A. went to PERWAIZ after an abnormal Pap smear with another medical provider. PERWAIZ allegedly performed a colposcopy and cold knife cone biopsy. PERWAIZ told D.A. the colposcopy detected precancerous cells and she needed a hysterectomy. D.A. objected to the invasive surgery and believed she and PERWAIZ reached a decision to move forward with an outpatient laparoscopic surgery in which only her ovaries would be removed. On or about December 29, 2012, PERWAIZ performed a total abdominal hysterectomy and combined anterior posterior colporrhaphy on D.A. To support his claim for payment to the health care benefit program, PERWAIZ falsely documented the diagnostic reason for the procedure as symptomatic uterine prolapse. He stated D.A. complained of pelvic and back pain and a protrusion in her vagina. D.A. suffered serious bodily injury as a result of PERWAIZ' actions.

d. In 2013, PERWAIZ told D.C. she needed her ovaries removed. On or about August 17, 2013, PERWAIZ performed a total vaginal hysterectomy on D.C. Following the surgery, D.C. was surprised when PERWAIZ told her he removed her uterus and one ovary as she believed he was removing both ovaries and not her uterus. To support his claim for payment to the health care benefit program, PERWAIZ falsely documented the diagnostic reason for the procedure was symptomatic uterine prolapse. He stated D.C. complained of increasing pelvic and back pain and she requested the removal of her uterus. In truth and fact, D.C. had not complained of

pelvic and back pain, did not request for her uterus to be removed, and the surgery was unnecessary.

e. In 2014, patient T.D.C. went to PERWAIZ because she wanted the Essure birth control system removed from her fallopian tubes. PERWAIZ recorded the presence of a right ovarian cyst. PERWAIZ requested and received authorization from the health care benefit program for removal of an ovarian mass on T.D.C.'s right ovary. Prior to surgery, T.D.C. gave written consent for the removal of the right ovarian mass. On or about August 9, 2014, PERWAIZ performed a laparotomy and excised a mass on T.D.C.'s left ovary. Afterwards, PERWAIZ altered T.D.C.'s written consent to read "left" ovarian mass. PERWAIZ then billed Optima for the excision of an ovarian cyst. In truth and fact, PERWAIZ performed an unnecessary surgical procedure of a functional cyst on the left ovary in contradiction of his diagnosis and the patient's consent, and did not state to the health care benefit program that the true purpose of the surgery was to remove the Essure.

f. In 2015, PERWAIZ performed a Pap smear and caused an ultrasound to be performed on patient W.B. PERWAIZ then told W.B. she had cancer and needed a hysterectomy. On or about November 14, 2015, PERWAIZ performed a vaginal hysterectomy and colporrhaphy on W.B. To support his claim for payment to the health care benefit program, PERWAIZ falsely documented the diagnostic reason for the procedure as symptomatic uterine prolapse. He stated W.B. complained of pelvic and back pain and "something protruding" in her vagina. In truth and fact, W.B. had not complained of pelvic and back pain and a protrusion in her vagina, she did not have cancer, and the surgery was unnecessary.

g. In 2016, patient A.N. went to PERWAIZ to obtain medical assistance for infertility. PERWAIZ told A.N. her insurance, Medicaid, would not pay for tests, treatments, or procedures related to fertility. PERWAIZ advised A.N. he would have to lie about the true reason for the tests and procedures so Medicaid would cover them. On or about March 18, 2016, PERWAIZ performed, among other things, laparoscopic lysis of adhesions and a D&C on A.N. PERWAIZ then billed Medicaid for these procedures claiming they were performed, in part, due to patient's abnormal uterine bleeding. In truth and fact, A.N. did not have abnormal uterine bleeding and the procedures were not medically indicated and therefore unnecessary.

h. In 2016, PERWAIZ allegedly performed a diagnostic hysteroscopy, and caused an ultrasound to be performed, on patient D.P. On or about October 3, 2016, PERWAIZ then told D.P. she had cancer and needed a hysterectomy. Approximately five days later, on or about October 8, 2016, PERWAIZ performed an abdominal supracervical hysterectomy, BSO, and lysis of adhesions on D.P. To support his claim for payment to the health care benefit program, PERWAIZ falsely documented that D.P. insisted on having the surgeries and stated she complained of frequent, prolonged, and irregular vaginal bleeding. In truth and fact, D.P. had not complained of frequent, prolonged, and heavy vaginal bleeding, she did not have cancer, she did not insist on the surgery, and the surgery was not medically indicated and therefore unnecessary. D.P. suffered serious bodily injury as a result of PERWAIZ' actions.

i. In 2016, PERWAIZ allegedly performed, among other procedures, a colposcopy, and cold knife cone biopsy on S.N. PERWAIZ then told S.N. she had cancer and needed a hysterectomy. On or about December 10, 2016, PERWAIZ performed a vaginal

hysterectomy and posterior colporrhaphy on S.N. To support his claim for payment to the health care benefit program, PERWAIZ falsely documented that S.N. complained of pelvic and back pain, felt something in her vagina, and that hysterectomy was necessary due to, in part, symptomatic uterine prolapse. In truth and fact, S.N. had not complained of pelvic and back pain and feeling something in her vagina, she did not have cancer, and the surgery was not medically indicated and therefore unnecessary. S.N. suffered serious bodily injury as a result of PERWAIZ' actions.

j. In a three day period in November 2017, PERWAIZ allegedly performed a diagnostic hysteroscopy, a colposcopy, a cold knife cone biopsy, and a surgical hysteroscopy, and caused an ultrasound to be performed on W.H.W. PERWAIZ then told W.H.W. she had cancer and needed a hysterectomy. On or about July 21, 2018, PERWAIZ performed a supracervical abdominal hysterectomy on W.H.W. To support his claim for payment to the health care benefit program, PERWAIZ falsely documented that the hysterectomy was necessary due, in part, to W.H.W.'s pelvic pain, menorrhagia, and dysmenorrhea. In truth and fact, W.H.W. did not have pelvic pain, menorrhagia, and dysmenorrhea, she did not have cancer, and the surgery was not medically indicated and therefore unnecessary.

k. In 2018, patient A.G. went to PERWAIZ due to heavy vaginal bleeding. PERWAIZ allegedly performed a diagnostic hysteroscopy and caused an ultrasound to be performed on A.G. PERWAIZ then told A.G. she had cancer and needed a hysterectomy. Two days later, on or about March 10, 2018, PERWAIZ performed a vaginal hysterectomy and posterior colporrhaphy on A.G. To support his claim for

payment to the health care benefit program, PERWAIZ falsely documented that the hysterectomy and colporrhaphy was necessary due to, in part, uterine prolapse. In truth and fact, A.G. did not complain of symptoms involving uterine prolapse, did not have cancer, and the surgery was not medically indicated and therefore unnecessary.

l. On or about August 21, 2018, patient M.F. went to PERWAIZ for her annual gynecological exam. On or about August 22, 2018, PERWAIZ caused an ultrasound to be performed on M.F. PERWAIZ then told M.F. she had a complex ovarian cyst that would become cancerous and she needed a hysterectomy. On or about August 25, 2018, PERWAIZ performed an abdominal hysterectomy on M.F. To support his claim for payment to the health care benefit program, PERWAIZ falsely documented that the hysterectomy and other procedures were necessary due, in part, to M.F.'s pelvic pain, fibroids, and a complex ovarian cyst. In truth and fact, M.F. did not have pelvic pain, the fibroids did not cause any symptoms, the cyst was not at increased risk to become cancerous, and the surgery was not medically indicated and therefore unnecessary.

m. In 2019, patient Y.S. went to PERWAIZ and complained of bleeding during intercourse. PERWAIZ caused an ultrasound to be performed on Y.S and allegedly performed a surgical hysteroscopy. PERWAIZ then told Y.S. she had fibroids that could become cancerous and she needed a hysterectomy. On or about March 30, 2019, PERWAIZ performed a vaginal hysterectomy and colporrhaphy. To support his claim for payment to the health care benefit program, PERWAIZ falsely documented that the hysterectomy and colporrhaphy were necessary, in part, due to Y.S.' symptomatic prolapse and irregular bleeding. PERWAIZ documented the

alleged symptoms of her prolapse, to include pelvic pain, back pain, and something protruding in the vagina, in his medical records. In truth and fact, Y.S. did not have pelvic pain or back pain, did not feel something protruding from her vagina, the fibroid was not at increased risk to become cancerous, and the surgery was not medically indicated and therefore unnecessary.

n. In 2019, patient A.F. went to PERWAIZ after an abnormal Pap smear with another medical provider. PERWAIZ allegedly performed a colposcopy and then told A.F. she required a cold knife cone biopsy. PERWAIZ told A.F. that she would get cancer if she did not get a hysterectomy. To support his claim for payment to the health care benefit program, PERWAIZ falsely documented findings from the colposcopy and stated the patient wanted a cold knife cone biopsy. On or about July 19, 2019, PERWAIZ performed a cold knife cone biopsy and endocervical curettage. In truth and fact, A.F. had a negligible risk of developing cancer, and a cold knife cone biopsy and endocervical curettage were not medically indicated and therefore unnecessary.

o. In August 2019, patient N.B. first went to PERWAIZ. PERWAIZ told N.B. that she would get cancer if she did not get a hysterectomy due to her "low uterus." On or about September 11, 2019, PERWAIZ allegedly performed a diagnostic hysteroscopy and caused an ultrasound to be performed and then told N.B. she required a hysterectomy as soon as possible due to the danger of cancer. On September 14, 2019, PERWAIZ performed a vaginal hysterectomy and colporrhaphy on N.B. To support his claim for payment to the health care benefit program, PERWAIZ falsely documented that N.B. experienced uterine prolapse, rectocele, menorrhagia and dysmenorrhea. PERWAIZ documented N.B. experienced "frequent, prolonged and

extremely heavy" vaginal bleeding with pelvic pain and had 2nd degree uterine prolapse in his medical records. In truth and fact, PERWAIZ grossly exaggerated N.B.'s supposed symptoms, N.B. had a negligible risk of developing cancer, and a hysterectomy was not medically indicated and therefore unnecessary. N.B. suffered serious bodily injury as a result of PERWAIZ' actions.

p. On or about February 16, 2019, PERWAIZ performed a surgical hysteroscopy, D&C, and cautery of the cervix on patient L.G. L.G. returned to PERWAIZ on or about September 11, 2019. PERWAIZ documented that L.G. complained of severe cramps and prolonged bleeding. L.G. had an ultrasound, and PERWAIZ told her she had uterine fibroids and needed a myomectomy. PERWAIZ scheduled her for surgery on October 18, 2019. PERWAIZ submitted and caused to be submitted a preapproval request for the procedure to the health care benefit program, and claimed L.G. had menorrhagia, dysmenorrhea, fibroids and anemia. In truth and fact, L.G. did not have and complain of cramps and menorrhagia, did not have fibroids, and the surgery was not medically indicated and therefore unnecessary.

q. In September 2019, patient D.B. went to PERWAIZ due to intermittent bleeding. PERWAIZ performed an exam and told D.B. she was at risk for developing cancer and, to make sure she did not get cancer, she needed a total hysterectomy. On or about October 19, 2019, PERWAIZ performed a total abdominal hysterectomy and BSO on D.B. To support his claim for payment to the health care benefit program, PERWAIZ falsely documented, in part, that D.B. had pelvic pain. In truth and fact, D.B. did not have any pelvic pain, had little chance of developing cancer, and a hysterectomy was not medically indicated and therefore unnecessary.

Falsified Hysteroscopies and Colposcopies

59. PERWAIZ claimed to perform and billed for performing diagnostic and other procedures such as hysteroscopies and colposcopies in his medical offices. In addition to billing for these procedures, despite the fact that he did not actually perform them, PERWAIZ used the alleged results of those procedures to justify that a woman undergo additional procedures and surgery, sometimes within mere days. In truth and fact, PERWAIZ did not perform the procedures and, at times, did not even have an operating medical device to perform the procedure.

60. Regarding in-office diagnostic hysteroscopies, there were long periods of times that the hysteroscope was not functional, but PERWAIZ still claimed to perform hysteroscopies and billed and attempted to bill the health care benefit programs.

61. For example, for at least part of 2010, 2016, and 2019, the hysteroscope in PERWAIZ' office was inoperable. Despite this fact, PERWAIZ still claimed to perform diagnostic hysteroscopies and billed health care benefit programs.

62. In June 2016, PERWAIZ claimed to perform diagnostic hysteroscopies on patients A.M.B., J.B., and J.P. In truth and fact, PERWAIZ did not perform the diagnostic hysteroscopies because the hysteroscope was inoperable. Despite this, PERWAIZ billed health care benefit programs for the procedures.

63. In addition, in order to properly perform a diagnostic hysteroscopy and look in the patient's uterus, the hysteroscope required the use of a distending medium, such as saline, to dilate the cervix and distend the uterus. PERWAIZ never used distending medium of any kind. Thus, the procedure was useless yet PERWAIZ still billed and attempted to bill health care benefit programs for the procedure.

64. Between 2010 and 2019, PERWAIZ billed health care benefit programs approximately $620,856 for false and fraudulent diagnostic hysteroscopies.

65. Regarding in-office colposcopies, colposcopies require applying a solution to a patient's cervix and vagina. The liquid makes any abnormal areas more visible. PERWAIZ never used any solution of any kind. Thus, the procedure was ineffective, yet PERWAIZ still billed and attempted to bill health care benefit programs for the procedure.

66. PERWAIZ virtually never took biopsies during in-office colposcopy procedures, which made the procedure incomplete and contrary to the medical standard of care. PERWAIZ also falsely documented that the patient refused the in-office biopsies. In truth and fact, PERWAIZ never offered an in-office colposcopy biopsy to his patients. Rather, PERWAIZ routinely proceeded to cold knife cone biopsies, which increased the future risk of preterm deliveries to his patients.

67. For example, PERWAIZ allegedly performed colposcopies on patients C.O., D.A., S.N., W.H.W., A.B., and A.F.

68. Between 2010 and 2019, PERWAIZ billed and attempted to bill approximately $137,806 to health care benefit programs for colposcopies.

69. Between 2010 and 2019, PERWAIZ billed approximately $2,338,106 for gynecological procedures and surgeries that were based upon, at least in part, never-performed diagnostic hysteroscopies and colposcopies.

Falsified Sterilization Consent Forms

70. PERWAIZ frequently pressured patients to rush and undergo permanent sterilization procedures by, in part, falsely asserting the procedures were easily reversed. He instilled in his

patients a false sense of urgency and intentionally circumvented the 30-day Medicaid sterilization consent requirement.

71. PERWAIZ directed employees and others to have patients undergoing BTL sterilization operations sign blank Medicaid sterilization consent forms. All portions of the form, including the description of the specific type of operation, were intentionally left blank. PERWAIZ also directed employees and others to have the patients leave the date field blank on the Medicaid sterilization consent form when the patient signed it.

72. PERWAIZ then backdated the Medicaid sterilization consent form so it appeared to be signed by the patients at least 30 days prior to the procedure. For example:

a. On or about October 30, 2010, PERWAIZ performed a BTL on patient D.B.D. D.B.D. did not sign the sterilization consent form at least 30 days prior to the procedure. In fact, D.B.D. was not a patient of PERWAIZ 30 days prior to the procedure. Per instruction, D.B.D. signed the form within 30 days of the BTL and left the date blank. PERWAIZ then filled in the date so it appeared that the consent form was signed at least 30 days prior to the procedure.

b. On or about August 17, 2011, PERWAIZ performed a BTL on patient A.D. A.D. did not sign the sterilization consent form at least 30 days prior to the procedure. In fact, per instruction, A.D. signed the consent form at her final obstetric visit in August 2011, approximately one week prior to her BTL, and left the date blank. PERWAIZ then filled in the date so it appeared that the consent form was signed at least 30 days prior to the procedure.

c. On or about July 23, 2016, PERWAIZ performed a BTL on patient D.W. D.W. did not sign the sterilization consent form at least 30 days prior to the procedure. In fact,

D.W. was not a patient of PERWAIZ 30 days prior to the procedure. Per instruction, D.W. signed the form within 30 days of the BTL and left the date blank. PERWAIZ then filled in the date so it appeared that the consent form was signed at least 30 days prior to the procedure.

d. On or about February 18, 2017, PERWAIZ performed a BTL on patient T.T. T.T. did not sign the sterilization consent form at least 30 days prior to the procedure. In fact, T.T. was not a patient of PERWAIZ 30 days prior to the procedure. Per instruction, T.T. signed the form within 30 days of the BTL and left the date blank. PERWAIZ then filled in the date so it appeared that the consent form was signed at least 30 days prior to the procedure.

e. On or about October 20, 2018, PERWAIZ performed a BTL on patient A.P.C. A.P.C. did not sign the sterilization consent form at least 30 days prior to the procedure. In fact, A.P.C. was not a patient of PERWAIZ 30 days prior to the procedure. Per instruction, A.P.C. signed the form within 30 days of the BTL and left the date blank. PERWAIZ then filled in the date so it appeared that the consent form was signed at least 30 days prior to the procedure.

f. On or about February 9, 2019, and February 23, 2019, PERWAIZ attempted to and performed a BTL on patient T.C. T.C. did not sign the sterilization consent form at least 30 days prior to the procedure. In fact, T.C. was not a patient of PERWAIZ 30 days prior to the procedure. Per instruction, T.C. signed the form within 30 days of the BTL and left the date blank. PERWAIZ then filled in the date so it appeared that the consent form was signed at least 30 days prior to the procedure.

73. PERWAIZ billed Medicaid for the sterilization procedures, despite knowing he falsified the consent forms and did not comply with the requirements.

Acts in Furtherance of the Scheme and Artifice

74. On or about the dates set forth below, JAVAID PERWAIZ submitted and caused to be submitted, and attempted to do so, claims for reimbursement to health care benefit programs that were false and fraudulent as outlined in the following executions of the scheme to defraud. Each set of claims is a separate count of this Superseding Indictment as indicated:

Count	On or About Service Dates	Health Care Benefit Program	Patient	Description of the Item Billed	Approximate Amount Billed	False/Fraudulent Representation
1.	September 1, 2018	Medicaid	A.B.	Delivery	$1,650	EDD
2.	March 2, 2019	Medicaid	C.L.	Delivery	$1,650	EDD
3.	June 22, 2019	Medicaid	L.R.	Delivery	$3,300	EDD
4.	September 21, 2019	Medicaid	A.C.	Delivery	$4,000	EDD
5.	October 19, 2019	TRICARE	H.M.	Delivery	$3,300	EDD
6.	October 19, 2019	Medicaid	B.P.	Delivery	$4,000	EDD
7.	October 26, 2019	Medicaid	A.B.	Delivery (Attempt)	$1,650	EDD
8.	November 14, 2015	Medicaid	W.B.	Hysterectomy Colporrhaphy	$1,500 $1,500	Fraudulent Diagnosis and Representation of Patient Statements.

Count	On or About Service Dates	Health Care Benefit Program	Patient	Description of the Item Billed	Approximate Amount Billed	False/Fraudulent Representation
9.	March 16, 2016 - March 18, 2016	Medicaid	A.N.	Diagnostic Hysteroscopy Ultrasound D&C Chromotubation of Oviduct Lysis of Adhesions Laparoscopy with Lesions of Ovary	$350 $300 $500 $300 $1,000 $1,500	Diagnostic Hysteroscopy Not Performed, Fraudulent Diagnosis and Representation of Patient Statements.
10.	June 29, 2016	Medicaid	A.M.B.	Diagnostic Hysteroscopy	$350	Diagnostic Hysteroscopy Not Performed.
11.	June 29, 2016	TRICARE	J.B.	Diagnostic Hysteroscopy	$350	Diagnostic Hysteroscopy Not Performed.
12.	June 29, 2016	Medicaid	J.B.	Diagnostic Hysteroscopy	$350	Diagnostic Hysteroscopy Not Performed.
13.	June 29, 2016	Medicaid	J.P.	Diagnostic Hysteroscopy Diagnostic Hysteroscopy	$350 $350	Diagnostic Hysteroscopy Not Performed.
14.	August 16, 2016 - August 25, 2018	Optima	M.F.	Diagnostic Hysteroscopy (Attempt) Hysterectomy	$350 $2,100	Diagnostic Hysteroscopy Not Performed, Fraudulent Diagnosis and Representation of Patient Statements.

Count	On or About Service Dates	Health Care Benefit Program	Patient	Description of the Item Billed	Approximate Amount Billed	False/Fraudulent Representation
15.	October 3, 2016 - October 8, 2016	Medicaid	D.P.	Diagnostic Hysteroscopy Hysterectomy	$60 $188	Diagnostic Hysteroscopy Not Performed, Fraudulent Diagnosis and Representation of Patient Statements.
16.	October 3, 2016 - October 8, 2016	Medicare	D.P.	Diagnostic Hysteroscopy Ultrasound Hysterectomy BSO (Attempt) Lysis of Adhesions (Attempt)	$350 $300 $1,800 $1,200 $600	Diagnostic Hysteroscopy Not Performed, Fraudulent Diagnosis and Representation of Patient Statements.
17.	November 3, 2016	TRICARE	S.N.	Colposcopy (Attempt)	$400	Colposcopy Not Performed
18.	November 3, 2016	Medicaid	S.N.	Hysterectomy Colporrhaphy	$1,500 $1,200	Fraudulent Diagnosis and Representation of Patient Statements.

Count	On or About Service Dates	Health Care Benefit Program	Patient	Description of the Item Billed	Approximate Amount Billed	False/Fraudulent Representation
19.	November 9, 2017 -July 21, 2018	Optima	W.H.W.	Diagnostic Hysteroscopy Colposcopy Ultrasound Surgical Hysteroscopy with Biopsy Cold Knife Cone Biopsy (Attempt) Hysterectomy	$350 $300 $300 $700 $800 $1800	Diagnostic Hysteroscopy and Colposcopy Not Performed, Fraudulent Diagnosis and Representation of Patient Statements.
20.	March 8, 2018 - March 10, 2018	Medicaid	A.G.	Diagnostic Hysteroscopy Hysterectomy (Attempt) Colporrhaphy	$350 $1,500 $1,200	Diagnostic Hysteroscopy Not Performed, Fraudulent Diagnosis and Representation of Patient Statements.
21.	March 8, 2018 - March 10, 2018	Anthem	A.G.	Diagnostic Hysteroscopy (Attempt) Hysterectomy Colporrhaphy	$350 $1,500 $1,200	Diagnostic Hysteroscopy Not Performed, Fraudulent Diagnosis and Representation of Patient Statements.
22.	March 30, 2019	TRICARE	Y.S.	Hysterectomy Colporrhaphy	$1,500 $1,000	Fraudulent Diagnosis and Representation of Patient Statements.
23.	July 8, 2019 – July 19, 2019	Humana	A.F.	Colposcopy Cold Knife Cone Biopsy	$300 $800	Colposcopy Not Performed, Fraudulent Representation of Patient Statements.

Count	On or About Service Dates	Health Care Benefit Program	Patient	Description of the Item Billed	Approximate Amount Billed	False/Fraudulent Representation
24.	September 11, 2019 - September 14, 2019	Anthem	N.B.	Diagnostic Hysteroscopy Ultrasound Hysterectomy Colporrhaphy	$350 $300 $1,500 $1,000	Diagnostic Hysteroscopy Not Performed, Fraudulent Diagnosis and Representation of Patient Statements.
25.	September 30, 2019	Optima	L.G.	Myomectomy (Attempt)	Attempt	Fraudulent Diagnosis and Representation of Patient Statements.
26.	October 2, 2019	Medicaid	L.G.	Myomectomy (Attempt)	Attempt	Fraudulent Diagnosis and Representation of Patient Statements.

(In violation of Title 18, United States Code, Sections 1347 and 1349.)

COUNTS TWENTY-SEVEN THROUGH FIFTY-SEVEN
(18 U.S.C. § 1035- False Statement Related to Health Care Matters)

75. Paragraphs 1 through 74 of this Superseding Indictment are realleged and incorporated by reference as though fully set forth herein.

76. On or about the dates set forth below, in the Eastern District of Virginia, JAVAID PERWAIZ, the defendant, in a matter involving a health care benefit program as defined in Title 18, United States Code, Section 24(b), knowingly and willfully did make a materially false, fictitious, and fraudulent statement and representation, and make and use a materially false writing and document knowing the same to contain a materially false, fictitious, and fraudulent statement and entry, in connection with the delivery of and payment for health care benefits, items, and services, in that the defendant submitted and caused to be submitted to the indicated health care benefit program, the following claims for health care benefit payments, each of which falsely and fraudulently represented that the defendant had provided medically necessary care and services to a recipient and were pursuant to all necessary requirements, and included false, fictitious, and fraudulent statements, as indicated, when in truth and fact, as the defendant well knew, (a) the services were not medically necessary and contrary to the medical standard of care, (b) the services were based upon fraudulent and falsified purported patient statements, diagnoses, and diagnostic procedures, (c) the services were not, in fact, performed, and (d) the services were based upon altered and fraudulent sterilization consent forms. Each set of claims is a separate count of this Superseding Indictment as indicated:

Count	On or About Service Date	Health Care Benefit Program	Patient	Description of the Item Billed	Approximate Amount Billed	False, Fictitious, and Fraudulent Statement
27.	July 23, 2016	Medicaid	D.W.	BTL	$800	False and Fraudulent Provider Application
28.	February 18, 2017	Medicaid	T.T.	BTL	$800	False and Fraudulent Provider Application
29.	October 20, 2018	Medicaid	A.C.	BTL	$800	False and Fraudulent Provider Application
30.	February 23, 2019	Medicaid	T.C.	BTL	$600	False and Fraudulent Provider Application
31.	September 1, 2018	Medicaid	A.B.	Delivery	$1,650	EDD
32.	March 2, 2019	Medicaid	C.L.	Delivery	$1,650	EDD
33.	June 22, 2019	Medicaid	L.R.	Delivery	$3,300	EDD
34.	September 21, 2019	Medicaid	A.C.	Delivery	$4,000	EDD
35.	October 19, 2019	TRICARE	H.M.	Delivery	$3,300	EDD
36.	October 19, 2019	Medicaid	B.P.	Delivery	$4,000	EDD
37.	October 26, 2019	Medicaid	A.B.	Delivery (Attempt)	$1,650	EDD
38.	November 14, 2015	Medicaid	W.B.	Hysterectomy Colporrhaphy	$1,500 $1,500	Fraudulent Diagnosis and Representation of Patient Statements.
39.	March 16, 2016 - March 18, 2016	Medicaid	A.N.	Diagnostic Hysteroscopy Ultrasound D&C Chromotubation of Oviduct	$350 $300 $500 $300	Diagnostic Hysteroscopy Not Performed, Fraudulent Diagnosis and Representation of Patient Statements.

				Lysis of Adhesions Laparoscopy with Lesions of Ovary	$1,000 $1,500	
40.	June 29, 2016	Medicaid	A.M.B.	Diagnostic Hysteroscopy	$350	Diagnostic Hysteroscopy Not Performed.
41.	June 29, 2016	TRICARE	J.B.	Diagnostic Hysteroscopy	$350	Diagnostic Hysteroscopy Not Performed.
42.	June 29, 2016	Medicaid	J.B.	Diagnostic Hysteroscopy	$350	Diagnostic Hysteroscopy Not Performed.
43.	June 29, 2016	Medicaid	J.P.	Diagnostic Hysteroscopy Diagnostic Hysteroscopy	$350 $350	Diagnostic Hysteroscopy Not Performed.
44.	August 16, 2016 - August 25, 2018	Optima	M.F.	Diagnostic Hysteroscopy (Attempt) Hysterectomy	$350 $2,100	Diagnostic Hysteroscopy Not Performed, Fraudulent Diagnosis and Representation of Patient Statements.
45.	October 3, 2016 - October 8, 2016	Medicaid	D.P.	Diagnostic Hysteroscopy Ultrasound Hysterectomy	$60 $23 $188	Diagnostic Hysteroscopy Not Performed, Fraudulent Diagnosis and Representation of Patient Statements.
46.	October 3, 2016 - October 8, 2016	Medicare	D.P.	Diagnostic Hysteroscopy Hysterectomy BSO (Attempt)	$350 $1,800 $1,200 $600	Diagnostic Hysteroscopy Not Performed, Fraudulent Diagnosis and Representation of Patient Statements.

				Lysis of Adhesions (Attempt)		
47.	November 3, 2016	TRICARE	S.N.	Colposcopy (Attempt)	$400	Colposcopy Not Performed
48.	November 3, 2016	Medicaid	S.N.	Hysterectomy Colporrhaphy	$1,500 $1,200	Fraudulent Diagnosis and Representation of Patient Statements.
49.	November 9, 2017 - July 21, 2018	Optima	W.H.W.	Diagnostic Hysteroscopy Colposcopy Ultrasound Surgical Hysteroscopy with Biopsy Cold Knife Cone Biopsy (Attempt) Hysterectomy	$350 $300 $300 $700 $800 $1800	Diagnostic Hysteroscopy and Colposcopy Not Performed, Fraudulent Diagnosis and Representation of Patient Statements.
50.	March 8, 2018 - March 10, 2018	Medicaid	A.G.	Diagnostic Hysteroscopy Hysterectomy (Attempt) Colporrhaphy	$350 $1,500 $1,200	Diagnostic Hysteroscopy Not Performed, Fraudulent Diagnosis and Representation of Patient Statements.
51.	March 8, 2018 - March 10, 2018	Anthem	A.G.	Diagnostic Hysteroscopy (Attempt) Hysterectomy Colporrhaphy	$350 $1,500 $1,200	Diagnostic Hysteroscopy Not Performed, Fraudulent Diagnosis and Representation of Patient Statements.
52.	March 30, 2019	TRICARE	Y.S.	Hysterectomy Colporrhaphy	$1,500 $1,000	Fraudulent Diagnosis and Representation of

						Patient Statements.
53.	July 8, 2019 – July 19, 2019	Humana	A.F.	Colposcopy Cold Knife Cone Biopsy	$300 $800	Colposcopy Not Performed, Fraudulent Representation of Patient Statements.
54.	September 11, 2019 - September 14, 2019	Anthem	N.B.	Diagnostic Hysteroscopy Ultrasound Hysterectomy Colporrhaphy	$350 $300 $1,500 $1,000	Diagnostic Hysteroscopy Not Performed, Fraudulent Diagnosis and Representation of Patient Statements.
55.	September 30, 2019	Optima	L.G.	Myomectomy (Attempt)	Attempt	Fraudulent Diagnosis and Representation of Patient Statements.
56.	October 2, 2019	Medicaid	L.G.	Myomectomy (Attempt)	Attempt	Fraudulent Diagnosis and Representation of Patient Statements.
57.	October 19, 2019	Anthem	D.B.	Hysterectomy (Attempt) BSO (Attempt)	$1,800 $1,200	Fraudulent Diagnosis and Representation of Patient Statements.

(In violation of Title 18, United States Code, Section 1035(a)(2).)

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

77. Paragraphs 1 through 76 of this Superseding Indictment are realleged and incorporated by reference as though fully set forth herein.

Provider Applications

78. On or about January 13, 2015, PERWAIZ submitted, and caused to be submitted, a revalidation provider application to Medicare. The application required an identification of any "final adverse legal actions." Such actions include any felony convictions within the last 10 years preceding enrollment, revalidation, and, without time limitation, any re-enrollment the revocation of Medicare billing privileges, and any suspension or revocation of a license to provide health care by any State licensing authority. 42 C.F.R. § 424.502. PERWAIZ' application did not identify any final adverse legal actions. On July 7, 2015, CMS sent PERWAIZ a letter notifying him that his application was approved. The letter informed PERWAIZ that he was "required by regulations found at 42 CFR 424.516 to submit updates and changes to your enrollment information in accordance with specified timeframes," including "final adverse legal actions, including felony convictions, license suspensions or revocations of a health care license, an exclusion or department from participation in Federal or State health program, or a Medicare revocation by a different Medicare contractor." PERWAIZ did not thereafter submit any corrections or notifications to his application.

79. On or about April 13, 2015, PERWAIZ submitted, and caused to be submitted, a revalidation submission to Medicaid. Despite PERWAIZ' past felony convictions and license and privilege suspensions, his submission answered "no" to the following two questions: "Criminal Offenses: Has any individual or organization who has any ownership or controlling interest in the applicant ever been convicted or assessed fines or penalties for any health related

crimes or misconduct, or excluded from any Federal or State health care program due to fraud, obstruction of any investigation, a controlled substance violation or any other crime or misconduct?" and "Has the application ever had any adverse legal actions imposed by Medicare, Medicaid, or any other Federal or State agency or program, or any licensing or certification agency?" The submission contained the notification that a knowing submission containing false, incomplete, or misleading information could lead to criminal or civil penalties.

80. On or about July 6, 2017, PERWAIZ submitted, and caused to be submitted, an attestation regarding his provider application with Anthem. Despite his felony tax convictions, the attestation answered "no" to the question, "Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?" Instead, PERWAIZ characterized the convictions in the attestation as "federal tax issues," never revealing that they were in fact criminal felony convictions. Additionally, in response to a question regarding whether his clinical privileges or medical staff membership at any hospital or healthcare institution were ever suspended or revoked, the attestation disclosed only revocations following the "federal tax issues," and did not disclose Maryview Hospital's revocations in 1983.

81. On or about August 26, 2019, PERWAIZ submitted, and caused to be submitted, an attestation regarding his provider application with Optima. Despite his felony tax convictions, the attestation answered "no" to the question, "Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?" Instead, it characterized them in the attestation as "federal tax issues," never revealing that they were in fact criminal felony convictions. Additionally, in response to a question regarding whether his clinical privileges or medical staff membership at any hospital or healthcare institution were ever suspended or revoked, the

attestation disclosed only revocations following the "federal tax issues," and did not disclose Maryview Hospital's revocations in 1983.

82. On or about the dates set forth below, in the Eastern District of Virginia, JAVAID PERWAIZ, the defendant, in a matter involving a health care benefit program as defined in Title 18, United States Code, Section 24(b), knowingly and willfully did make a materially false, fictitious, and fraudulent statement and representation, and make and use a materially false writing and document knowing the same to contain a materially false, fictitious, and fraudulent statement and entry, in connection with the delivery of and payment for health care benefits, items, and services, in that the defendant submitted and caused to be submitted provider applications that included materially false, fictitious, and fraudulent statements. Each application is a separate count of this Superseding Indictment as indicated:

Count	On or About Application Date	Health Care Benefit Program	False, Fictitious, and Fraudulent Statement
58.	July 6, 2017	Anthem	Attestation in Provider Application
59.	August 26, 2019	Optima	Attestation in Provider Application

(In violation of Title 18, United States Code, Section 1035(a)(2).)

COUNTS SIXTY THROUGH SIXTY-THREE
(18 U.S.C. § 1028A - Aggravated Identity Theft)

83. Paragraphs 1 through 82 of this Superseding Indictment are realleged and incorporated by reference as though fully set forth herein.

84. On or about the dates listed below, within the Eastern District of Virginia, defendant JAVAID PERWAIZ did knowingly use the means of identification of another person without lawful authority during and in relation to a felony enumerated in 18 U.S.C. § 1028(c), namely health care fraud in violation of 18 U.S.C. § 1347, described as Related Counts identified below, that is, JAVAID PERWAIZ knowingly transferred and used the name and Medicaid identification number of persons known to the grand jury, listed by their initials below, by obtaining and attempting to obtain money from Medicaid in the amount listed below:

Count	Date of Related Services	Related Count	Individual	Amount Billed
60.	March 16, 2016 - March 18, 2016	NINE	A.N.	$3,950
61.	October 3, 2016 - October 8, 2016	FIFTEEN	D.P.	$248
62.	November 9, 2017 - July 21, 2018	NINETEEN	W.H.W.	$4,250
63.	March 3, 2018 - March 10, 2018	TWENTY	A.G.	$3,050

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

FORFEITURE

THE GRAND JURY FURTHER FINDS PROBABLE CAUSE THAT:

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

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

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

a. A sum of money in the amount of the proceeds JAVAID PERWAIZ obtained from the health care fraud scheme charged in Counts One through Twenty-Six, in the amount of at least $1,461,445;

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

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

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

e. Two membership units representing a 1.0% interest in Bon Secours Surgery Center at Harbor View, LLC subscribed to Javaid A. Perwaiz, M.D.

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

United States v. Javaid Perwaiz
Criminal No. 2:19cr189

Pursuant to the E-Government Act, the original of this page has been filed under seal in the Clerk's Office.

A TRUE BILL:

[redacted]

FOREPERSON

G. Zachary Terwilliger
United States Attorney

By: _____

Elizabeth M. Yusi
Virginia Bar No. 91982
Assistant United States Attorney
Attorney for the United States
United States Attorney's Office
8000 World Trade Center
101 West Main Street
Norfolk, VA 23510
Phone: (757) 441-6331
Fax: (757) 441-6689
E-Mail: elizabeth.yusi@usdoj.gov

By: _____

E. Rebecca Gantt
Virginia Bar No. 83180
Assistant United States Attorney
Attorney for the United States
United States Attorney's Office
8000 World Trade Center
101 West Main Street
Norfolk, VA 23510
Phone: (757) 441-6331
Fax: (757) 441-6689
E-Mail: rebecca.gantt @usdoj.gov