RETURN DATE: JULY 14, 2015

STATE OF CONNECTICUT, Plaintiff,	: Superior Court
v.	: Judicial District of Hartford
ASHWINI SABNIS, SAURAV MOHANTY, and BRIGHTER CONCEPT, INC. Defendants	: JUNE 10, 2015

COMPLAINT

Plaintiff State of Connecticut alleges the following against defendants ASHWINI SABNIS, SAURAV MOHANTY and BRIGHTER CONCEPT, INC. (collectively, "Defendants").

SUMMARY

1. This action seeks treble damages, civil penalties, and other relief for Defendants' participation in a pervasive and illegal scheme to knowingly submit false claims for reimbursement and to knowingly retain overpayments for psychiatric services provided to indigent and/or disabled Connecticut citizens who receive health care goods and services through Connecticut's Medicaid program, administered by the Connecticut Department of Social Services (the DSS or the department) as part of the Connecticut Medical Assistance Program (CMAP). Defendants' conduct, as detailed herein, violated the Connecticut False Claims Act, Connecticut General Statute §§ 17b-301a — p (2009) (amended and re-codified at Connecticut General Statute §§ 4-274 — 4-289 (2014)); Connecticut General Statute §§ 17b-301a — p (2011) (amended and re-codified at Connecticut General Statute §§ 4-274 — 4-289 (2014));

Connecticut General Statute §§ 4-274 — 4-289 (2014); and the Connecticut Unfair Trade Practices Act (CUTPA), Connecticut General Statute § 42-110a. In particular, Counts 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10 seek treble damages, civil penalties and other relief for Defendants' violations of the Connecticut False Claims Act. Counts 11, 12, 13, and 14 seek injunctive relief, restitution, and civil penalties for Defendants' unfair and/or deceptive business practices in violation of the CUTPA.

PARTIES

2. The plaintiff is the STATE OF CONNECTICUT, represented by GEORGE JEPSEN, ATTORNEY GENERAL. This action is brought by virtue of the authority of GEORGE JEPSEN, ATTORNEY GENERAL, pursuant to Connecticut General Statute § 4-276, and at the request of JONATHAN HARRIS, COMMISSIONER OF THE DEPARTMENT OF CONSUMER PROTECTION for the State of Connecticut, pursuant to the CUTPA, Connecticut General Statute § 42-110a *et seq.*

3. Defendant ASHWINI SABNIS, M.D., (hereafter, ASHWINI SABNIS) is a psychiatrist licensed by the State of Connecticut and a resident of Westport, Connecticut. ASHWINI SABNIS transacted business in the State of Connecticut, including in the manner set forth in this Complaint.

4. Defendant BRIGHTER CONCEPT, INCORPORATED (hereafter, BRIGHTER CONCEPT) is a Connecticut corporation. From approximately January 2009 until June 2010, BRIGHTER CONCEPT maintained a New Haven office located at 123 York Street, Suite 1-D, New Haven, Connecticut (hereafter, the York Street Office). In approximately June 2010, BRIGHTER CONCEPT closed the York Street Office and relocated to 1 Long Wharf Drive, Suite 101, New

Haven, Connecticut (hereafter, the Long Wharf Office). The Long Wharf Office remained open through approximately December 31, 2012. Between approximately January 1, 2009 and December 31, 2012, BRIGHTER CONCEPT maintained a second office location at 2000 Post Road, Suite 302, Fairfield, Connecticut (hereafter, the Fairfield Office). BRIGHTER CONCEPT transacted business in the State of Connecticut, including in the manner set forth in this Complaint.

5. Defendant SAURAV "SAM" MOHANTY (hereafter, SAM MOHANTY) is a resident of Westport, Connecticut. SAM MOHANTY transacted business in the State of Connecticut, including in the manner set forth in this Complaint.

6. On information and belief, ASHWINI SABNIS and SAM MOHANTY are married to each other.

7. ASHWINI SABNIS and SAM MOHANTY co-own BRIGHTER CONCEPT.

8. On information and belief, SAM MOHANTY was the office manager for BRIGHTER CONCEPT. SAM MOHANTY exercised management authority and control over BRIGHTER CONCEPT's operations.

9. ASHWINI SABNIS is a psychiatrist who provides psychiatric care to Medicaid patients at BRIGHTER CONCEPT. ASHWINI SABNIS exercised management authority and control over BRIGHTER CONCEPT's operations.

10. Defendant ASHWINI SABNIS has been enrolled as a provider in the CMAP during the time period relevant to the conduct discussed herein.

11. Whenever any reference is made in this Complaint to any representation, act or transaction of BRIGHTER CONCEPT, or any agent, employees or representatives thereof, such

allegations shall be deemed to mean that such principals, officers, directors, employees, agents or representatives of BRIGHTER CONCEPT, while acting within the scope of their actual or apparent authority, whether they were acting on their own behalf or for their own benefit, did or authorized such representations, acts, or transactions on behalf of BRIGHTER CONCEPT.

LEGAL AND PUBLIC POLICY BACKGROUND

12. The federal False Claims Act (FCA) provides in relevant part that any person who: (a) knowingly presents or causes to be presented a false or fraudulent claim for payment or approval; (b) knowingly makes, uses or causes to be made or used, a false record or statement material to a false or fraudulent claim; (c) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government; or (d) conspires to commit a false claims violation, is liable to the United States for relief including civil penalties and treble damages. 31 U.S.C. § 3729(a)(1)(A), (B), (C), and (G).

13. The Connecticut False Claims Act (the Act) is modeled after the FCA. As enacted in 2009, the Act provided in relevant part that any person who: (a) knowingly presents or causes to be presented, to an officer or employee of the state, a false or fraudulent claim for payment or approval under a medical assistance program administered by the DSS; (b) knowingly makes, uses or causes to be made or used, a false record or statement to secure the payment or approval by the state of a false or fraudulent claim under a medical assistance program administered by the DSS; (c) knowingly makes, uses or causes to be made or used, a

false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the state under a medical assistance program administered by the DSS; or (e) conspires to defraud the state by securing the allowance or payment of a false or fraudulent claim under a medical assistance program administered by the DSS, is liable to the State of Connecticut for relief including civil penalties, treble damages, and the costs of investigation and prosecution of this action. Conn. Gen. Stat. §§ 17b-301b(a)(1), (2), (3), (7) and (b) (2009) (current version at §§ 4-275(a)(1), (2), (3), (7) and (b) (2014)).

14. Effective June 13, 2011, the Act was amended to provide, in relevant part, that any person who: (a) knowingly presents or causes to be presented a false or fraudulent claim for payment or approval under a medical assistance program administered by the DSS; (b) knowingly makes, uses or causes to be made or used, a false record or statement material to a false or fraudulent claim under a medical assistance program administered by the DSS; (c) knowingly makes, uses or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state under a medical assistance program administered by the DSS; (d) knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state under a medical assistance program administered by the DSS; or (e) conspires to commit a false claims violation, is liable to the State of Connecticut for relief including civil penalties, treble damages, and the costs of investigation and prosecution of this action. Conn. Gen. Stat. §§ 17b-301b(a)(1), (2), (3), (7), (8) and (b) (2011) (current version at §§ 4-275(a)(1), (2), (3), (7), (8) and (b) (2014)).

15. Effective June 13, 2014, the Act was expanded to prohibit false and fraudulent claims made to "a state-administered health or human services program" and re-codified. Conn. Gen. Stat. §§ 4-274(7) and 4-275(a)(1), (2), (7), and (8) (2014).

16. For the purposes of the Act, "knowing" and "knowingly" means that a person, with respect to information: (a) has actual knowledge of the information; (b) acts in deliberate ignorance of the truth or falsity of the information; or (c) acts in reckless disregard of the truth or falsity of the information, without regard to whether the person intends to defraud. Conn. Gen. Stat. § 4-274(1).

17. Medicaid is a joint federal-state program that provides health care benefits for certain groups, including the indigent and disabled. The federal Medicaid statutes set forth the minimum requirements for state Medicaid programs to qualify for federal funding. 42 U.S.C. § 1396a. The federal share of each state's Medicaid payments is based on the state's per capita income compared to the national average. 42 U.S.C. § 1396d(b). State Medicaid programs pay the balance, which is referred to as the "state share." During the relevant time period of this Complaint, the "state share" for the State of Connecticut's Medicaid program was approximately fifty (50%) percent.

18. The State of Connecticut, through the DSS, administers the CMAP. CMAP includes the State of Connecticut's Medicaid program. The Commissioner of DSS is authorized to promulgate regulations as are necessary to administer CMAP, including the State of Connecticut's Medicaid program. Regulations of Connecticut State Agencies § 17b-262-523(13). CMAP, via the DSS, pays for health benefits provided to program recipients.

CMAP PROVIDER ENROLLMENT AND PARTICIPATION

19. Providers of goods and services to CMAP recipients are obligated to adhere to CMAP requirements in order to participate in and receive payment from CMAP via the DSS. Regulations of Connecticut State Agencies § 17b-262-522.

20. "Provider" means "any individual or entity that furnishes Medical Assistance Program goods or services pursuant to a provider agreement with the department and is duly enrolled and in good standing or, as the context may require, an individual or entity applying for enrollment in the Medical Assistance Program." Regulations of Connecticut State Agencies § 17b-262-523(22).

21. "Provider agreement" means "the signed, written, contractual agreement between the department and the provider of services or goods." Regulations of Connecticut State Agencies § 17b-262-523(23).

22. The DSS enters into a CMAP Provider Enrollment Agreement (Provider Agreement) with every provider to establish their eligibility to participate in the program. The Provider Agreement contains a certification that provides, in relevant part: "**THE UNDERSIGNED BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE, BOTH INDIVIDUALLY AND ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL OF THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN.**" Connecticut

Department of Social Services, Medical Care Administration, Provider Enrollment Agreement, page 12 (2011).

23. In the Provider Agreement, the provider agrees to "abide by the DSS' Medical Assistance Program Provider Manual(s), as amended from time to time, as well as all bulletins, policy transmittals, notices, and amendments . . . ." Connecticut Department of Social Services, Medical Care Administration, Provider Enrollment Agreement, ¶ 10 (2008).

24. The provider also agrees in the Provider Agreement to "submit only those claims for goods and services that are covered by the Connecticut Medical Assistance Program and documented by Provider as being: . . . for compensation that Provider is legally entitled to receive . . . ." *Id.* at ¶ 15.

25. The provider also agrees in the Provider Agreement to "cooperate fully and make available upon demand by federal and state officials and their agents all records and information that such officials have determined to be necessary to assure the appropriateness of DSS payments made to the Provider . . . ." *Id.* at ¶ 22.

26. In addition, under a section in the Provider Agreement entitled **Fraud and Abuse; Penalties**, the provider agrees to comply with, *inter alia*, the Act, and the provider expressly acknowledges and understands that the prohibitions set forth in the Act include, but are not limited to, (a) "false statements, claims, misrepresentation, concealment, failure to disclose and conversion of benefits"; and (b) "charging or receiving reimbursement in excess of that provided by the State." *Id.* at ¶ 26.

27. The CMAP distinguishes providers based on type and specialty. Regulations of Connecticut Agencies § 17b-252-524(e).

28. Psychiatrists are enrolled in the CMAP as physicians with a specialty in psychiatry. Accordingly, psychiatrists are required to follow DSS' provider manuals, regulations, and policy transmittals applicable to psychiatrists, as well as DSS' provider manuals, regulations, and policy transmittals applicable to all physicians.

29. A "psychiatrist" is defined as "a physician licensed pursuant to section 20-10 of the Connecticut General Statutes who specializes in the study, diagnosis, treatment, and prevention of mental and social disorders." Regulations of Connecticut State Agencies § 17b-262-453(26).

CMAP PAYMENT REQUIREMENTS

30. To receive payment for goods and services, providers are required to *inter alia*: (a) meet and maintain all applicable licensing, accreditation and certification requirements; (b) meet and maintain all DSS enrollment requirements including the timely submission of a complete provider enrollment or reenrollment form and submission of all enrollment information and such affidavits as the DSS may require; and (c) have a valid Provider Agreement on file which is signed by the provider and the DSS. This agreement, which is periodically updated, remains in effect for the duration specified in the agreement. The Provider Agreement specifies conditions and terms that govern the program and to which the provider is mandated to adhere in order to participate in the program. Regulations of Connecticut State Agencies §§ 17b-262-454; 17b-262-524.

31. Like all CMAP enrolled providers, psychiatrists are required to "maintain a specific record for all services received for each client eligible for Medical Assistance Program payment including, but not limited to: name, address, birth date, Medical Assistance Program identification number; pertinent diagnostic information, a current treatment plan signed by the psychiatrist, documentation of services provided, and the dates the services were provided." Regulations of Connecticut State Agencies § 17b-262-463(a).

32. If the service provided to a CMAP recipient is a time-based service (*i.e.*, codes are used to report the total duration of time spent by a physician providing psychiatric care services to a patient), the psychiatrist must document the amount of face-to-face time spent with the patient. Regulations of Connecticut State Agencies § 17b-262-463(e).

33. Psychiatrists must maintain all documentation for five years and the documentation is subject to review by authorized personnel. Regulations of Connecticut State Agencies § 17b-262-463(b).

34. "In event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater." Regulations of Connecticut State Agencies § 17b-262-463(b).

35. "Failure to maintain all required documentation shall result in the disallowance and recovery by the [DSS] of any amounts paid to the psychiatrist for which the required documentation is not maintained or provided to the [DSS] upon request." Regulations of Connecticut State Agencies § 17b-262-463(c).

36. Payment for services provided by psychiatrists are limited to "medically necessary and medically appropriate psychiatric services for Medical Assistance Program eligible clients which are provided by a licensed physician who specializes in the study, diagnosis, treatment, and prevention of mental and social diseases." Regulations of Connecticut State Agencies § 17b-262-457.

37. The DSS will not pay for "any procedures, goods, or services of an unproven, educational, social, research, experimental, or cosmetic nature; for any diagnostic, therapeutic, or treatment goods or services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history." Regulations of Connecticut State Agencies §17b-262-531(g).

38. The DSS will not pay "for canceled office visits and appointments not kept." Regulations of Connecticut State Agencies §17b-262-531(h).

39. "Any payment, or part thereof, for Medical Assistance Program good or services which represents an excess over the payment authorized, or a violation due to abuse or fraud, shall be payable to the department." Regulations of Connecticut State Agencies § 17b-262-533. The regulations define "overpayment" to mean "any payment that represents an excess over the allowable payment under state law including, but not limited to, amounts obtained through fraud and abuse". Regulations of Connecticut State Agencies § 17b-262-523(18).

40. The reimbursement amounts that the DSS pays enrolled providers for providing services to CMAP recipients are based upon the rates established by the DSS Commissioner (Fee Schedule). Regulations of Connecticut State Agencies §§ 17b-262-461; 17b-262-530(a).

41. The Fee Schedule is based upon various codes found in the American Medical Association's (AMA) Current Procedural Terminology (CPT) codes that correspond to the level of serviced provided.

42. The fees which the DSS pays for services vary depending upon the type of the service provided, the amount of face-to-face time spent with the patient while providing the service or the complexity of the service provided, and the type of provider who provided the services. Reimbursement rates for services provided to CMAP recipients are thus based upon the level of service provided by the enrolled provider.

43. Included within the fee schedules are the reimbursement amounts for behavioral health services provided by an enrolled psychiatrist. The following chart lists the behavioral health CPT codes most relevant to this Complaint and a description of the services required to be provided in order to charge for the particular CPT code. These CPT codes and descriptions were applicable between January 1, 2010 and December 31, 2012.[1]

CPT Code	Description of Services Provided
90815	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, with medical evaluation and management services,

[1] The CPT codes and their descriptions are periodically modified by the AMA. The CPT codes in effect during the time period alleged in this Complaint are the 2010, 2011, and 2012 CPT codes.

	approximately 75 to 80 minutes face-to-face with the patient.
90813	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, with medical evaluation and management services, approximately 45 to 50 minutes face-to-face with the patient.
90812	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient.
90807	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, with medical evaluation and management services, approximately 45 to 50 minutes face-to-face with the patient.
90805	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, with medical evaluation and management services, approximately 20 to 30 minutes face-to-face with the patient.
90862	Pharmacologic management, including prescription, use and review of medication with no more than minimal medical psychotherapy.

THE SUBMISSION OF FALSE CLAIMS TO THE CMAP

44. Between January 1, 2010, and December 31, 2014, ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT violated the Act by knowingly: (a) submitting claims for services that were not rendered; (b) overbilling for services provided; and (c) making false statements and creating false documents to conceal and retain overpayments. Moreover, by conspiring to falsify appointment records in an attempt to avoid repaying the DSS, ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT sought to prevent the DSS from recouping overpayments sustained through Defendants' fraud.

45. The relevant time period for the conduct and causes of action set forth below is for the time period including January 1, 2010, through December 31, 2014.

46. During this time period ASHWINI SABNIS was a licensed physician practicing psychiatry and holding Connecticut Department of Public Health license #043546.

47. At various times during the relevant time period, ASHWINI SABNIS was also enrolled as a provider in the Medicare program and certain commercial health insurance plans. BRIGHTER CONCEPT was the business entity at which ASHWINI SABNIS delivered psychiatric services to her patients, including CMAP recipients. ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT presented or caused to be presented claims for reimbursement to the DSS, and received payment from the DSS, for claims for psychiatric services provided by ASHWINI SABNIS to CMAP recipients.

48. During the relevant time period, BRIGHTER CONCEPTS used different cloud-based electronic health records software vendors to maintain its patient medical records and manage patient appointments. Among these cloud-based software vendors were AdvancedMD and Practice Fusion.

49. On or about July 17, 2012, examiners from the DSS, Office of Quality Assurance, Investigation Division, conducted an unannounced field visit at the Fairfield Office to inspect medical records and information for certain CMAP recipients. The field visit is part of what is sometimes referred to by the DSS as an "integrity review", and was prompted by information the Investigation Division received from other sources. The DSS examiners conducted two subsequent field visits at the Fairfield Office on July 20th and 23rd, 2012.

50. As a result of the DSS examiners' review and analysis of the documents and information obtained from BRIGHTER CONCEPT, as well as additional sources of information, the DSS referred the matter to the Office of the Connecticut Attorney General (OAG) on November 1, 2013, so that the OAG could assess whether to conduct an independent investigation of possible violations of the Act stemming from claims for reimbursement ASHWINI SABNIS submitted or caused to be submitted to the DSS. As part of the OAG's investigation, the OAG served investigative subpoenas (collectively referred to as the "Attorney General's Subpoenas") to certain third parties and to BRIGHTER CONCEPT for certain documents and information relevant to the investigation. With respect to the subpoenas served on BRIGHTER CONCEPT, the OAG sought, *inter alia*, appointment books and medical records related to psychiatric services ASHWINI SABNIS purportedly provided to her Medicaid patients.

51. ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT submitted claims for reimbursement to the DSS for services and received payment of approximately $768,171 for psychiatric services allegedly provided to CMAP recipients by ASHWINI SABNIS between January 1, 2010, and July 17, 2012.

THE SCHEME – A PERVASIVE PATTERN OF FRAUD

52. From approximately January 2010 through at least early July 2012, ASHWINI SABNIS and SAM MOHANTY engaged in a systematic and persistent pattern of submitting false and fraudulent claims to the DSS for psychiatric services that were never rendered to CMAP recipients or were grossly upcoded.

53. The practice of "upcoding" occurs when a provider knowingly uses a higher-paying code on the claim form for a CMAP recipient to falsely reflect the use of a more expensive service, procedure or device than was actually used or was medically necessary.

54. Billing for a service not rendered occurs when a provider submits a claim for a service to the DSS that was never provided to the CMAP recipient.

55. During the time period January 2010 through January 2012, approximately 73% of all claims ASHWINI SABNIS submitted to the DSS for her Medicaid patients were for the two most complex CPT codes, CPT 90815 (approximately 75-80 minutes spent face-to-face with the patient) and CPT 90813 (approximately 45-50 minutes spent face-to-face with the patient).

56. In contrast, during that same time period, less than approximately 1% of all claims ASHWINI SABNIS submitted to the DSS were for CPT 90862, the code a psychiatrist used to indicate pharmacologic management, which includes, *inter alia*, prescribing and monitoring the effects of medications, behavioral health education and collaboration with the patient and/or family member. The code description for CPT 90862 specifically states that the amount of psychotherapy the psychiatrist spends with the patient should be "minimal".

57. Similarly, during that same time period, less than approximately 1% of all claims ASHWINI SABNIS submitted to the DSS were for CPT 90805 (20-30 minutes face-to-face time with the patient).

58. In response to the Attorney General's Subpoenas, BRIGHTER CONCEPT produced myriad documents, including electronically stored patient appointment books and medical records. Included within the medical records were patient SOAP notes. SOAP notes are a

standard method of documentation employed by health care providers to write out notes in a patient's chart documenting patient encounters.

59. For a significant number of dates of service for which claims were submitted, neither the information contained in the appointment books nor the information recorded in the patient SOAP notes supported the highest level CPT codes, CPT 90815 and CPT 90813, that were billed to the CMAP.

60. Specifically, the appointment books and patient medical records corresponding to claims with CPT 90815 (approximately 75-80 minutes spent face-to-face with the patient) and CPT 90813 (approximately 45-50 minutes spent face-to-face with the patient) invariably establish:

a. ASHWINI SABNIS' Medicaid patient appointments listed in the appointment books were reserved for thirty (30) minute sessions even though she submitted or caused to be submitted claims for reimbursement to the DSS for these patients on these dates of service using CPT 90815 (approximately 75-80 minutes spent face-to-face with the patient) or CPT 90813 (approximately 45-50 minutes spent face-to-face with the patient).

b. A very large number of the thirty (30) minute time slots ASHWINI SABNIS reserved for Medicaid patients were overbooked, meaning she reserved the time slot for one, two, three, and sometimes even four patients, yet she submitted or caused to be submitted claims for reimbursement to the DSS for these patients on these dates of service using CPT 90815

(approximately 75-80 minutes spent face-to-face with the patient) or CPT 90813 (approximately 45-50 minutes spent face-to-face with the patient).

c. ASHWINI SABNIS also submitted or caused to be submitted claims for reimbursement to the DSS when there was no corresponding entry in BRIGHTER CONCEPT's appointment books indicating the Medicaid patient had a scheduled appointment with ASHWINI SABNIS for a psychiatric counseling session.

d. ASHWINI SABNIS submitted or caused to be submitted a significant number of claims for reimbursement to the DSS when the corresponding entry in BRIGHTER CONCEPT's appointment books indicates that the appointment had been cancelled or that the patient had not shown for the scheduled appointment.

e. SOAP notes were often blank or contained minimal information indicating either that no treatment was provided or if any treatment was provided, the treatment was much shorter than the time-based value (*i.e.*, approximately 75-80 minutes spent face-to-face with the patient) that corresponded to the CPT code entered on the claim for reimbursement.

61. Additionally, Defendants' scheme to submit false or fraudulent claims to the DSS included the knowing submission of claims purportedly rendered to CMAP recipients by ASHWINI SABNIS between June 23, 2010 and July 9, 2010 when she was traveling outside the United States.

62. Accordingly, during the time period January 2010 through January 2012, ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT knowingly and systematically submitted or caused to be submitted claims for services using the highest level CPT codes when services were (a) never rendered to CMAP recipients; and/or (b) the time spent with CMAP recipient was considerably below the length or type of service required by the CPT code.

63. The DSS believed that the information contained in the claims for reimbursement ASHWINI SABNIS submitted or caused to be submitted for her Medicaid patients was accurate and truthful, and thus, the DSS relied on this information in making its decision to pay the claims.

64. ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT's pervasive fraud allowed Defendants to obtain and illegally retain payments from the DSS that constituted significant overpayments. The following table portrays ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT'S fraudulent scheme in terms of excessive hours billed for dates of service during the time period January 2010 through January 2012:

HOURS PER DATE OF SERVICE	**# OF DATES OF SERVICE**
Greater than 40 hours	14
Greater than 30 hours, less than 40 hours	51
Greater than 24 hours, less than 30 hours	48
Greater than 16 hours, less than 24 hours	38
Greater than 12 hours, less than 16 hours	79
Total	230

THE SCHEME EVOLVES IN RESPONSE TO INCREASED SCRUTINY

65. Beginning in late January 2012 and continuing until July 2012, ASHWINI SABNIS fundamentally changed her billing pattern but nevertheless continued to perpetuate a scheme to submit false and fraudulent claims to the CMAP.

66. Instead of using CPT codes 90815 and 90813 as she did during the time period January 2010 through January 2012, ASHWINI SABNIS shifted her pattern and began systematically billing the DSS for CPT 90805. This shift in ASHWINI SABNIS' billing pattern during January 2012 corresponds to the due date for her response to a separate investigation conducted by one of the private health insurance payors with whom she contracted with, and which related to billing misconduct similar to the conduct alleged herein.

67. Armed with the knowledge that her billing conduct was under scrutiny, ASHWINI SABNIS tried to conceal her scheme by switching the time-based CPT codes she used to a lower-level code so that approximately 76% percent of all claims ASHWINI SABNIS submitted or caused to be submitted to the DSS for her Medicaid patients during the time period February 2012 through July 2012 were for CPT 90805, the psychiatric service code with a time-based value of approximately 20-30 minutes face-to-face with the patient. This pattern is in marked contrast to her use of CPT 90805 for the preceding time period (January 2010 through January 2012) where claims for that CPT code represented less than approximately 1% of her claims to the DSS.

68. Although ASHWINI SABNIS altered her billing pattern for the time period February 2012 through July 2012 and she submitted claims or caused claims to be submitted for reimbursement for a lower-level CPT code, a significant number of the reimbursement claims

ASHWINI SABNIS knowingly submitted or caused to be submitted to the DSS continued, nonetheless, to be false and fraudulent in that they represented a claim for (a) services never rendered or (b) upcoded services.

DEFENDANTS' KNOWING AND IMPROPER RETENTION OF OVERPAYMENTS

69. Along with upcoding and billing for services not rendered, ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT knowingly made, and cause to be made, false records and false statements, and illegally agreed to obstruct the DSS and the Attorney General's respective investigations. Defendants knowingly engaged in this conduct in order to improperly retain overpayments made by the DSS.

70. ASHWINI SABNIS made false statements to the DSS auditors regarding the availability of certain records the auditors requested to inspect during the unannounced site visit to ASHWINI SABNIS' Fairfield Office. Specifically, on July 17, 2012, the DSS auditors requested to inspect approximately 130 Medicaid patient records. Rather than allowing the auditors access to the records as required by the terms of her Provider Agreement and the DSS Regulations, ASHWINI SABNIS falsely stated that her Medicaid patient records were only accessible via one computer and that only one individual at a time could log-in to the Medicaid patient record database. ASHWINI SABNIS knew at the time that this statement was not true but used the misrepresentation as an excuse to persuade the auditors to agree to return at a later date when she indicated she would make the records available.

71. Over the next few days, ASHWINI SABNIS continued her attempts to stall the DSS auditors' access to the records. On July 19, 2012, an attorney, acting on ASHWINI SABNIS' behalf,

contacted the DSS and asserted that the computer containing the requested recipient records "crashed" on March 10, 2012. The attorney further asserted that, as a result of the crash, all patient treatment notes for services rendered prior to March 10, 2012, had been destroyed. The statements concerning a computer crash that allegedly destroyed patient treatment notes were untrue.

72. Moreover, ASHWINI SABNIS and SAM MOHANTY intentionally concealed from the DSS auditors the identity of certain third-party companies BRIGHTER CONCEPT utilized to store cloud-based patient electronic health records. Among these cloud-based software vendors were AdvancedMD.

73. In a further effort to obstruct the DSS' integrity audit, ASHWINI SABNIS and SAM MOHANTY knowingly withheld from the DSS auditors the fact that Practice Fusion (the cloud-based appointment scheduler BRIGHTER CONCEPT did identify to the DSS auditors) maintained an audit log of all additions, deletions, and other changes made to the appointments entered therein. Instead of providing full access to the appointment records in their native format, ASHWINI SABNIS merely printed hardcopy Practice Fusion appointment logs for the auditors. The printed Practice Fusion appointment logs, however, would not reflect any edits made to the initial appointments records, including who entered or edited the appointments, or the dates and times any edits were made to the original appointments.

74. ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT's efforts to conceal the fact they obtained and retained overpayments from the DSS as a result of their illegal scheme was not limited to obstructing the DSS integrity audit.

75. In their response to the Attorney General's subpoenas, ASHWINI SABNIS and SAM MOHANTY withheld the production of documents responsive to a request for all of the third-party companies they utilized to store cloud-based electronic health records. Among these cloud-based software vendors were AdvancedMD.

76. The Attorney General obtained the documents directly from AdvancedMD. The patient appointment records maintained in AdvancedMD evidence, among other things, that ASHWINI SABNIS scheduled her Medicaid patients for appointments as brief as five minutes and billed the DSS for cancelled appointments.

77. In addition, once the Attorney General was ultimately able to obtain production of the Practice Fusion audit log in its native format, the audit log clearly revealed significant evidence of ASHWINI SABNIS and SAM MOHANTY's efforts to create or alter documents.

78. For instance, the audit log evidences that beginning on July 17, 2012 (the date of the DSS auditors' initial record request) and continuing into July 20, 2012 (the rescheduled date for the DSS auditors' record review), SAM MOHANTY and ASHWINI SABNIS, along with several other individuals acting at their direction, spent hours upon hours entering, deleting, and altering patient appointment records stored in Practice Fusion. The effect of these actions was to modify a large number of appointments, some of which dated as far back as 2009.

79. The effect of these efforts was to revise the original appointment records to make it appear that ASHWINI SABNIS' workday was longer than in fact it was, and patient appointments that were initially scheduled in overlapping fifteen minute time slots became more evenly spaced and/or scheduled in longer intervals.

80. The audit log for February 20, 2012 provides a good example of the efforts ASHWINI SABNIS and SAM MOHANTY engaged in to conceal the existence of the overpayments:

a. The original February 20, 2012 appointment book maintained in Practice Fusion reflected that ASHWINI SABNIS began seeing patients at 9:00 a.m. and that her last appointment was for 5:45 p.m. The alterations made to the Practice Fusion records on July 20, 2012, however, stretched the time frame during which ASHWINI SABNIS saw patients on February 20, 2012, changing her first appointment to 7:00 a.m. and her last appointment to 9:45 p.m.

b. The number of patients originally entered into specific appointment slots were altered to reduce the number of patients scheduled for each slot. For instance, as originally entered on February 20, 2012, four patients were scheduled to see ASHWINI SABNIS during the same 15 minute slot at 9:00 a.m. After the alterations on July 20, 2012, only two patients were scheduled to see ASHWINI SABNIS during the same fifteen minutes time slot at 9:00 a.m. The other two patients' appointments were altered to reflect two separate twenty minute appointments at 7:00 a.m. and 7:20 a.m., respectively.

81. In total, the edits to the audit log entries for July 17th, 18th, 19th, and 20th amount to approximately 650 printed pages.

82. Additionally, the audit log reflects that patient appointments were not the only records modified during the four days in July 2012. The audit log reflects that ASHWINI SABNIS accessed SOAP notes for patients. In doing so, she inserted false information into the SOAP notes, created new SOAP notes, and deleted SOAP notes. According to the audit log, ASHWINI SABNIS modified SOAP notes for psychiatric counseling sessions stretching as far back as 2009.

83. Accordingly, ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT illegally agreed to create and/or alter documents supporting the services rendered to her Medicaid patients, and knowingly made false statements and omitted material information, in order conceal their fraudulent scheme and illegally retain overpayments made by the DSS.

CAUSES OF ACTION

COUNT 1
Connecticut State False Claims Act (2009)
Conn. Gen. Stat. §§ 17b-301b(a)(1), (b) (2009) (*current version at* §§ 4-275(a)(1), (b) (2014))
PRESENTATION OF FALSE OR FRAUDULENT CLAIMS

84. The allegations of ¶¶1 — 83 of this Complaint are incorporated herein as allegations of Count 1 as if fully set forth herein. The STATE OF CONNECTICUT further alleges as follows.

85. The provisions of Connecticut General Statute § 17b-301b(a)(1) (2009) (*current version at* Connecticut General Statute § 4-275(a)(1) (2014)), prohibit the knowing presentation, to an officer or employee of the state a false or fraudulent claim for payment or approval under a medical assistant program administered by the DSS.

86. Between January 2010 and June 12, 2011, ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT knowingly presented or caused to be presented, to an officer or employee of the state a false or fraudulent claim for payment or approval under a medical assistant program administered by the DSS.

87. Between January 2010 and June 12, 2011, ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT knowingly engaged in conduct that would, and did, result in a long-term pattern and practice of submission of false claims to the DSS including: (a) services that were not rendered and (b) claims for payments that falsely inflated or exaggerated the level of service provided.

88. By virtue of the false or fraudulent claims made or caused to be made by ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT the state has suffered damages.

89. Defendants are jointly and severally liable to the state for treble damages under the Act, in an amount to be determined at trial, plus a civil penalty of $5,000 to $10,000 for each false claim presented or caused to be presented by Defendants.

COUNT 2
Connecticut State False Claims Act (2011)
Conn. Gen. Stat. §§ 17b-301b(a)(1), (b) (2011) (*current version at* §§ 4-275(a)(1), (b) (2014))
PRESENTATION OF FALSE OR FRAUDULENT CLAIMS

90. The allegations of ¶¶1 — 83 of this Complaint are incorporated herein as allegations of Count 2 as if fully set forth herein. The STATE OF CONNECTICUT further alleges as follows.

91. The provisions of Connecticut General Statute § 17b-301b(a)(1) (2011) (*current version at* Connecticut General Statute § 4-275(a)(1) (2014)), prohibit the knowing presentation of a false or fraudulent claim for payment or approval under a medical assistant program administered by the DSS.

92. Between June 13, 2011, and June 12, 2014, ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT knowingly presented or caused to be presented a false or fraudulent claim for payment or approval under a medical assistant program administered by the DSS.

93. ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT knowingly engaged in conduct that would, and did, result in a long-term pattern and practice of submission of false claims to the DSS including: (a) services that were not rendered and (b) claims for payments that falsely inflated or exaggerated the level of service provided.

94. By virtue of the false or fraudulent claims made or caused to be made by ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT the state has suffered damages.

95. Defendants are jointly and severally liable to the state for treble damages under the Act, in an amount to be determined at trial, plus a civil penalty of $5,500 to $11,000, or as adjusted from time to time by the Federal Civil Penalties Inflation Adjustment Act of 1990, 28 U.S.C. § 2461, for each false claim presented or caused to be presented by Defendants.

COUNT 3
Connecticut State False Claims Act
Conn. Gen. Stat. §§ 17b-301b(a)(2), (b) (2009) (*current version at* §§ 4-275(a)(2), (b) (2014))
FALSE RECORDS OR STATEMENTS

96. The allegations of ¶¶1 — 83 of this Complaint are incorporated herein as allegations of Count 3 as if fully set forth herein. The STATE OF CONNECTICUT further alleges as follows:

97. The provisions of Connecticut General Statute § 17b-301b(a)(2) (2009) (*current version at* Connecticut General Statute § 4-275(a)(2) (2014)), prohibit the knowing use of false records or statements to secure the payment or approval by the state of false or fraudulent claims under a medical assistance program administered by the DSS.

98. Compliance with all laws, regulations, and the DSS enrollment requirements is an express condition of payment for providing services under the Medicaid program. Regulations of Connecticut State Agencies §§ 17b-262-524 and 17b-262-526.

99. Between January 2010 and June 12, 2011, the business practices of Defendants ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT resulted in a long-term pattern and practice of the submission of psychiatric claims to the DSS, including: (a) services that were not rendered and (b) claims for payments that falsely inflated or exaggerated the level of service provided.

100. Between January 2010 and June 12, 2011, Defendants ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT knowingly made, used or caused to be made or used, false

records or statements to secure the payment or approval by the state of false or fraudulent claims under a medical assistance program administered by the DSS.

101. By virtue of the false records or false statements made or caused to be made by ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT the state has suffered damages.

102. Defendants are jointly and severally liable to the state for treble damages under the Act, in an amount to be determined at trial, plus a civil penalty of $5,000 to $10,000 for each false record or statement or claim presented or caused to be presented by Defendants.

COUNT 4
Connecticut State False Claims Act
Conn. Gen. Stat. §§ 17b-301b(a)(2), (b) (2011) (*current version at* §§ 4-275(a)(2), (b) (2014))
FALSE RECORDS OR STATEMENTS

103. The allegations of ¶¶1 — 83 of this Complaint are incorporated herein as allegations of Count 4 as if fully set forth herein. The STATE OF CONNECTICUT further alleges as follows:

104. The provisions of Connecticut General Statute § 17b-301b(a)(2) (2011) (*current version at* Connecticut General Statute § 4-275(a)(2) (2014)), prohibit the knowing use of false records or statements material to false or fraudulent claims under a medical assistance program administered by the DSS.

105. Compliance with all laws, regulations, and the DSS enrollment requirements is an express condition of payment for providing services under the Medicaid program. Regulations of Connecticut State Agencies §§ 17b-262-524 and 17b-262-526.

106. Between June 13, 2011, and June 12, 2014, the business practices of Defendants ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT resulted in a long-term pattern and practice of the submission of psychiatric claims to the DSS, including: (a) services that were not rendered and (b) claims for payments that falsely inflated or exaggerated the level of service provided.

107. The false records or false statements made by Defendants ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT were material in that they had a natural tendency to influence or were capable of influencing the DSS in its decision to remit payment for the false or fraudulent claims Defendants ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT submitted to the DSS.

108. Between June 13, 2011, and June 12, 2014, Defendants ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT knowingly made, used or caused to be made or used, false records or statements to get false or fraudulent claims paid or approved by the DSS.

109. By virtue of the false records or false statements made or caused to be made by ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT the state has suffered damages.

110. Defendants are jointly and severally liable to the state for treble damages under the Act, in an amount to be determined at trial, plus a civil penalty of $5,500 to $11,000, or as adjusted from time to time by the Federal Civil Penalties Inflation Adjustment Act of 1990, 28 U.S.C. § 2461, for each false record or statement or claim presented or caused to be presented by Defendants.

COUNT 5
Connecticut State False Claims Act
Conn. Gen. Stat. §§ 17b-301b(a)(7), (b) (2009) (*current version at* §§ 4-275(a)(7), (b) (2014))
KNOWINGLY MAKING FALSE RECORDS OR STATEMENTS MATERIAL TO AN OBLIGATION TO PAY THE STATE

111. The allegations of ¶¶1 — 83 of this Complaint are incorporated herein as allegations of Count 5 as if fully set forth herein. The STATE OF CONNECTICUT further alleges as follows:

112. The provisions of Connecticut General Statute § 17b-301b(a)(7) (2009) (*current version at* Connecticut General Statute § 4-275(a)(7) (2014)), prohibit the knowing use of false records or statements to conceal, avoid or decrease an obligation to pay or transmit money or property to the state under a medical assistance program administered by the DSS.

113. Between January 2010 and June 12, 2011, ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT knowingly made, used or caused to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the state under a medical assistance program administered by the DSS.

114. By virtue of the false records or false statements made or caused to be made by ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT the state has suffered damages.

115. Defendants are jointly and severally liable to the state for treble damages under the Act, in an amount to be determined at trial, plus a civil penalty of $5,000 to $10,000 for each false record or statement or claim presented or caused to be presented by Defendants.

COUNT 6
Connecticut State False Claims Act
Conn. Gen. Stat. §§ 17b-301b(a)(8), (b) (2011) (*current version at* §§ 4-275(a)(8), (b) (2014))
CONCEALMENT TO AVOID AN OBLIGATION TO PAY THE STATE

116. The allegations of ¶¶1 — 83 of this Complaint are incorporated herein as allegations of Count 6 as if fully set forth herein. The STATE OF CONNECTICUT further alleges as follows:

117. The provisions of Connecticut General Statute § 17b-301b(a)(8) (2011) (*current version at* Connecticut General Statute § 4-275(a)(8) (2014)), prohibit the knowing concealment or knowing improper avoidance or decrease of an obligation to pay or transmit money or property to the state under a medical assistance program administered by the DSS.

118. Between June 13, 2011, and June 12, 2014, ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT knowingly concealed or knowingly improperly avoided or decreased an obligation to pay or transmit money or property to the state under a medical assistance program administered by the DSS.

119. By virtue of their knowingly concealing or knowingly improperly avoiding or decreasing an obligation to pay or transmit money or property, ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT have caused the state to suffer damages.

120. Defendants are jointly and severally liable to the state for treble damages under the Act, in an amount to be determined at trial, plus a civil penalty of $5,500 to $11,000, or as adjusted from time to time by the Federal Civil Penalties Inflation Adjustment Act of 1990, 28

U.S.C. § 2461, for each false record or statement or claim presented or caused to be presented by Defendants.

COUNT 7
Connecticut State False Claims Act
Conn. Gen. Stat. §§ 4-275(a)(8), (b) (2014)
CONCEALMENT TO AVOID AN OBLIGATION TO PAY THE STATE

121. The allegations of ¶¶1 — 83 of this Complaint are incorporated herein as allegations of Count 7 as if fully set forth herein. The STATE OF CONNECTICUT further alleges as follows:

122. The provisions of Connecticut General Statute § 4-275(a)(8) (2014), prohibit the knowing concealment or knowing improper avoidance or decrease of an obligation to pay or transmit money or property to the state under a state-administered health or human services program.

123. Between June 13, 2014, and December 31, 2014, ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT knowingly concealed or knowingly improperly avoided or decreased an obligation to pay or transmit money or property to the state under a state-administered health or human services program.

124. By virtue of their knowingly concealing or knowingly improperly avoiding or decreasing an obligation to pay or transmit money or property, ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT have caused the state to suffer damages.

125. Defendants are jointly and severally liable to the state for treble damages under the Act, in an amount to be determined at trial, plus a civil penalty of $5,500 to $11,000, or as

adjusted from time to time by the Federal Civil Penalties Inflation Adjustment Act of 1990, 28 U.S.C. § 2461, for each false record or statement or claim presented or caused to be presented by Defendants.

COUNT 8
Conn. Gen. Stat. §§ 17b-301b(a)(3), (b) (2009) (*current version at* §§ 4-275(a)(3), (b) (2014))
CONSPIRACY

126. The allegations of ¶¶1 — 83 of this Complaint are incorporated herein as allegations of Count 8 as if fully set forth herein. The STATE OF CONNECTICUT further alleges as follows:

127. The provisions of Connecticut General Statute § 17b-301b(a)(3) (2009) (*current version at* Connecticut General Statute § 4-275(a)(3) (2014)), prohibit conspiring to defraud the state by securing the allowance or payment of a false or fraudulent claim under a medical assistance program administered by the DSS.

128. By virtue of the acts between January 2010 and June 12, 2011, described above, Defendants ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT have conspired to defraud the state by securing the allowance or payment of a false or fraudulent claim under a medical assistance program administered by the DSS.

129. By virtue of their conspiracy to commit false claims violations, ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT have caused the state to suffer damages.

130. Defendants are jointly and severally liable to the state for treble damages under the Act, in an amount to be determined at trial, plus a civil penalty of $5,000 to $10,000 for each

false record or statement or claim presented or caused to be presented, or each act of concealment committed by Defendants.

COUNT 9
Conn. Gen. Stat. §§ 17b-301b(a)(3), (b) (2011) (*current version at* §§ 4-275(a)(3), (b) (2014))
CONSPIRACY

131. The allegations of ¶¶1 — 83 of this Complaint are incorporated herein as allegations of Count 9 as if fully set forth herein. The STATE OF CONNECTICUT further alleges as follows:

132. The provisions of Connecticut General Statute § 17b-301b(a)(3) (2011) (*current version at* Connecticut General Statute § 4-275(a)(3) (2014)), prohibit conspiring to commit false claims violations.

133. By virtue of the acts between June 13, 2011, and June 12, 2014, described above, Defendants ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT have conspired to defraud the state by committing the false claims violations, in the manner pleaded above.

134. By virtue of their conspiracy to commit false claims violations, ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT have caused the state to suffer damages.

135. Defendants are jointly and severally liable to the state for treble damages under the Act, in an amount to be determined at trial, plus a civil penalty of $5,500 to $11,000, or as adjusted from time to time by the Federal Civil Penalties Inflation Adjustment Act of 1990, 28 U.S.C. § 2461, for each false record or statement or claim presented or caused to be presented, or each act of concealment committed by Defendants.

COUNT 10
Conn. Gen. Stat. §§ 4-275(a)(3), (b) (2014)
CONSPIRACY

136. The allegations of ¶¶1 — 83 of this Complaint are incorporated herein as allegations of Count 10 as if fully set forth herein. The STATE OF CONNECTICUT further alleges as follows:

137. The provisions of Connecticut General Statute § 4-275(a)(3) (2014) prohibit conspiring to commit false claims violations.

138. By virtue of the acts between June 13, 2014, and December 31, 2014, described above, Defendants ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT have conspired to defraud the state by committing the false claims violations, in the manner pleaded above.

139. By virtue of their conspiracy to commit false claims violations, ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT have caused the state to suffer damages.

140. Defendants are jointly and severally liable to the state for treble damages under the Act, in an amount to be determined at trial, plus a civil penalty of $5,500 to $11,000, or as adjusted from time to time by the Federal Civil Penalties Inflation Adjustment Act of 1990, 28 U.S.C. § 2461, for each false record or statement or claim presented or caused to be presented by Defendants.

COUNT 11
Connecticut Unfair Trade Practices Act
Conn. Gen. Stat. §§ 42-110n & 42-110o
DECEPTIVE TRADE PRACTICES

141. The allegations of ¶¶1 — 83 of this Complaint are incorporated herein as allegations of Count 11 as if fully set forth herein. The STATE OF CONNECTICUT further alleges as follows:

142. ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT, acting individually and in concert with each other, through their words and actions have made or caused to be made, directly or indirectly, explicitly or by implication, representations to the DSS, which are false and likely to mislead, to the effect that:

a. ASHWINI SABNIS provided psychiatric services to CMAP recipients in exchange for reimbursement by the DSS. The services ASHWINI SABNIS provided were (i) in accordance with federal and state law, DSS regulations, CMAP rules and requirements, and the Provider Agreement; (ii) consistent with the claims submissions made to the DSS in terms of the description of services rendered; and (iii) accurate in terms of the complexity and length of service provided.
b. ASHWINI SABNIS and BRIGHTER CONCEPT maintained records to support the payments for services made by the DSS.
c. ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT truthfully and fully complied with requests for Medicaid patient records and information during the investigative review process.

143. In truth and in fact, contrary to Defendants' representations:

a. ASHWINI SABNIS, SAM MOHANTY, AND BRIGHTER CONCEPT violated federal and state laws governing the CMAP, DSS rules and regulations, and breached the terms of ASHWINI SABNIS' Provider Agreement.
b. ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT misrepresented the nature and extent of psychiatric services provided to CMAP recipients.

c. ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT created and altered business documents and patient medical records to conceal the true extent of services provided to CMAP recipients.
d. ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT concealed documents and patient medical records to obstruct the DSS and the Attorney General's investigations.
e. ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT's acts and practices alleged herein directly and proximately caused substantial injury to consumers within the State of Connecticut.

144. The misrepresentations of defendants, as alleged herein, are material, false, and likely to mislead, and, therefore, constitute deceptive acts or practices in violation of Connecticut General Statute § 42-110b(a).

COUNT 12
Connecticut Unfair Trade Practices Act
Conn. Gen. Stat. §§ 42-110n & 42-110o
WILFUL USE OF DECEPTIVE TRADE PRACTICES

145. The STATE OF CONNECTICUT incorporates by reference all paragraphs of Count 11 as if fully set forth herein and further alleges as follows:

146. All of the Defendants have used deceptive trade practices and willfully violated Connecticut General Statute § 42-110b(a).

147. Under the provisions of Connecticut General Statute § 42-110o(b), Defendants are each liable for civil penalties of up to $5,000 for each willful violation of the statute.

148. These costs and civil penalties are in additional to and not a substitute for the claim for restitution and other equitable relief alleged in this Complaint.

COUNT 13
Connecticut Unfair Trade Practices Act
Conn. Gen. Stat. §§ 42-110n & 42-110o
UNFAIR TRADE PRACTICES

149. The allegations of ¶¶1 — 83 of this Complaint are incorporated herein as allegations of Count 13 as if fully set forth herein. The STATE OF CONNECTICUT further alleges as follows:

150. The acts, practices, and course of wrongful conduct by ASHWINI SABNIS, SAM MOHANTY, and BRIGHTER CONCEPT, acting (i) individually, (ii) jointly, as part of a conspiracy among defendants, and (iii) jointly through their aiding and abetting of each other, as alleged above, violated several public policies of the State of Connecticut, including the following:

a. The public policy against using false records or statements material to false or fraudulent claims, as embodied in 31 U.S.C. § 3729(a)(1)(B); Connecticut General Statute § 17b-301b(a)(2) (2009) (amended and re-codified at Connecticut General State § 4-275(a)(2) (2014)); Connecticut General Statute § 17b-301b(a)(2) (2011) (amended and re-codified at Connecticut General State § 4-275(a)(2) (2014)); and Connecticut General Statute § 4-275(a)(2) (2014);
b. The public policy against conspiring to violate the federal and state False Claims Acts, as embodied in 31 U.S.C. § 3729(a)(1)(C); Connecticut General Statute § 17b-301b(a)(3) (2009) (amended and re-codified at Connecticut General State § 4-275(a)(3) (2014)); Connecticut General Statute § 17b-301b(a)(3) (2011) (amended and re-codified at Connecticut General State § 4-275(a)(3) (2014)); and Connecticut General Statute § 4-275(a)(3) (2014);
c. The public policy against presenting false or fraudulent claims, as embodied in 31 U.S.C. § 3729(a)(1)(A); Connecticut General Statute § 17b-301b(a)(1) (2009) (amended and re-codified at Connecticut General State § 4-275(a)(1) (2014)); Connecticut General Statute § 17b-301b(a)(1) (2011) (amended and re-codified at Connecticut General State § 4-275(a)(1) (2014)); and Connecticut General Statute § 4-275(a)(1) (2014);

d. The public policy against conspiracies to commit fraud, as embodied in 18 U.S.C. § 371;
e. The public policy against health care fraud, as embodied in 18 U.S.C. § 1347;
f. The public policy against making or causing to be made false statements or representations in connection with payments under federal health care programs, as embodied in 42 USC § 1320a–7b;
g. The public policy requiring all CMAP providers to adhere to all federal and state laws and regulations concerning CMAP, including Medicaid, as embodied in Regulations of Connecticut State Agencies § 17b-262-526;
h. The public policy requiring all CMAP providers to adhere to all program requirements as a condition of receiving payment, as embodied in Regulations of Connecticut State Agencies § 17b-262-522;
i. The public policy against larceny, as embodied in Connecticut General Statute § 53a-118, et seq.;
j. The public policy against vendor fraud, as embodied in Connecticut General Statute §§ 17b-99 and 53a-290, et seq.; and/or
k. The public policy against health insurance fraud, as embodied in Connecticut General Statute § 53-440, et seq.

151. Defendants' course of wrongful conduct was immoral, unethical, oppressive and unscrupulous.

152. Defendants' acts and practices alleged herein directly and proximately caused substantial injury to consumers within the State of Connecticut.

153. Defendants' acts and practices, as alleged herein, constitute unfair acts or practices in violation of Connecticut General Statute § 42-110b(a).

COUNT 14
Connecticut Unfair Trade Practices Act
Conn. Gen. Stat. §§ 42-110n & 42-110o
WILFUL USE OF UNFAIR TRADE PRACTICES

154. The STATE OF CONNECTICUT incorporates by reference all paragraphs of Count 13 as if fully set forth herein and further alleges as follows:

155. Defendants have used unfair trade practices and willfully violated Connecticut General Statute § 42-110b(a).

156. Under the provisions of Connecticut General Statute § 42-110o(b), Defendants are each liable for civil penalties of up to $5,000 for each willful violation of the statute.

157. These costs and civil penalties are in addition to and not a substitute for the claim for restitution and other equitable relief alleged in this Complaint.

PRAYER FOR RELIEF

WHEREFORE, pursuant to Connecticut General Statute § 17-301b(b) (2009) (amended and re-codified at Connecticut General Statute §4-275(b) (2014)); Connecticut General Statute § 17b-301b(b) (2011) (amended and re-codified at Connecticut General Statute §4-275(b) (2014)); Connecticut General Statute §§ 4-275(b), 4-276, 42-110m and 42-110o, the STATE OF CONNECTICUT requests the following relief:

As to Count 1, Count 3, Count 5, and Count 8:

158. A civil penalty of not less than five thousand dollars or more than ten thousand dollars and for each violation of the Act;

159. Three times the amount of damages that the STATE OF CONNECTICUT sustained because of the acts of Defendants, jointly and severally;

160. Costs of investigation and prosecution of this action;

As to Count 2, Count 4, Count 6, Count 7, Count 9, and Count 10:

161. A civil penalty of not less than five thousand five hundred dollars or more than eleven thousand dollars, or as adjusted from time to time by the Federal Civil Penalties Inflation Adjustment Act of 1990, 28 U.S.C. § 2461, and for each violation of the Act;

162. Three times the amount of damages that the STATE OF CONNECTICUT sustained because of the acts of Defendants, jointly and severally;

163. Costs of investigation and prosecution of this action;

As to Count 11, Count 12, Count 13, and Count 14:

164. A finding that each of the Defendants has engaged in unfair or deceptive acts or practices in the course of trade or commerce which constitute violations of the Connecticut Unfair Trade Practices Act;

165. An order preliminarily and permanently enjoining each of the Defendants from the use of acts or practices that violate the Connecticut Unfair Trade Practices Act, including, but not limited to, the unlawful acts and practices pleaded in this Complaint;

166. An order preliminarily and permanently enjoining each of the Defendants to take whatever actions are necessary to abate the use of acts or practices that violate the Connecticut Unfair Trade Practices Act, including, but not limited to, the unlawful acts and practices pleaded in this Complaint;

167. An order requiring each of the Defendants to pay restitution for any loss resulting from the acts or practices that violate the Connecticut Unfair Trade Practices Act, as alleged herein;

168. An order pursuant to Conn. Gen. Stat. § 42-110m directing Defendants to disgorge all revenue, profits, and gains achieved in whole or in part through the unfair and/or deceptive acts or practices complained of herein;

169. An order requiring each of the Defendants to submit to an accounting;

170. An order requiring each of the Defendants to pay the costs for the investigation and prosecution of this action, including reasonable attorneys' fees; and

As to Count 12 and Count 14:

171. An order requiring each of the Defendants to pay a civil penalty in an amount not to exceed $5,000 per violation for each willful violation of the Connecticut Unfair Trade Practices Act;

As to All Counts:

172. Such other relief as is just and equitable to effectuate the purposes of this action.

Dated at Hartford, Connecticut, this 10th day of June, 2015.

PLAINTIFF
STATE OF CONNECTICUT

BY: GEORGE JEPSEN
ATTORNEY GENERAL

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RETURN DATE: JULY 14, 2015

STATE OF CONNECTICUT, Plaintiff,	: Superior Court
v.	: Judicial District of Hartford
ASHWINI SABNIS, SAURAV MOHANTY, and BRIGHTER CONCEPT, INC. Defendants	: JUNE 10, 2015

AMOUNT IN DEMAND

The amount, legal interest, or property in demand is $15,000.00 or more, exclusive of interests or costs.

PLAINTIFF
STATE OF CONNECTICUT

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