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False Claims Act and *Qui Tam* Quarterly Review

INSIDE...

The *False Claims Act and Qui Tam Quarterly Review* is published by Taxpayers Against Fraud, The False Claims Act Legal Center (TAF). This publication provides an overview of major False Claims Act and *qui tam* developments including case decisions, DOJ interventions, and settlements.

TAF is a nonprofit public interest organization dedicated to combating fraud against the Federal Government through the promotion and use of the *qui tam* provisions of the False Claims Act (FCA). TAF's mission is both activist and educational. Established in 1986, TAF serves to: (1) collect and evaluate evidence of fraud against the Federal Government and facilitate the filing of meritorious FCA *qui tam* suits; (2) work in partnership with *qui tam* plaintiffs, private attorneys, and the Government to effectively prosecute *qui tam* suits; (3) inform and educate the general public, the legal community, and other interested groups about the FCA and its *qui tam* provisions; and (4) advance public, legislative, and government support for *qui tam*.

TAF is based in Washington, D.C., where it maintains a comprehensive FCA library for public use and a staff of lawyers and other professionals who are available to assist anyone interested in the False Claims Act and *qui tam*.

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Public Disclosure Bar and Original Source Exception

U.S. ex rel. Aflatooni v. Kitsap Physicians Services et al., 98 C.D.O.S. 7335 (9th Cir. Sept. 22, 1998)

Rejecting the relator's argument that his suit was not "based upon" publicly disclosed information, and ruling that the relator did not have the requisite "direct knowledge" to qualify as an original source, the 9th Circuit upheld the lower court's § 3730(e)(4) dismissal of a *qui tam* case against one set of defendants. On the other hand, the appellate court reversed the district court's § 3730(e)(4) dismissal of the other defendants, finding that there had been no "public disclosure" of the allegations against them.

Dr. Alfred Aflatooni's *qui tam* suit against Kitsap Physicians Service (KPS) and numerous others alleging that they conspired to submit false Medicare claims was dismissed in its entirety by the district court under the § 3730(e)(4) public disclosure bar. On appeal, the 9th Circuit's analysis separated out the allegations against one set of defendants (referred to by the court as the "PAKC Defendants") from those against the remaining defendants (the "NDI Defendants").

Siller "Derived From" Definition Rejected

Aflatooni conceded that his allegations against the NDI Defendants had been publicly disclosed through the news media. But he argued that his suit was not "based upon" these public disclosures because he was the source of the information provided to the news media. This argument relied on the 4th Circuit's holding in U.S. ex rel. Siller v. Becton Dickinson & Co., 21 F.3d 1339 (4th Cir. 1994), that "based upon" in § 3730(e)(4)(A) means "derived from" and a *qui tam* action is barred only if the relator's source of information was the publicly disclosed information.

The 9th Circuit, however, reaffirmed its recent rejection of Siller in U.S. ex rel. Biddle v. Board of Trustees of the Leland Stanford, Jr. University, 1998 WL 261412 (9th Cir. 1998), 14 TAF QR 1 (July 1998). According to the appellate court, the Siller definition would render the "original source" requirement largely superfluous, would make the "based upon" language merely duplicative of the "direct and independent knowledge" language and thus allow a relator to avoid the voluntariness requirement of the original source exception, and would not further the policies underlying the FCA.

Relator Found to Lack Requisite "Direct Knowledge" of NDI Allegations

Turning to whether Aflatooni qualified as an original source with respect to the NDI allegations, the appellate court stated that Aflatooni had the requisite "independent" knowledge of the alleged fraud because his knowledge preceded the news media disclosures. On the other hand, relying on U.S. ex rel. Devlin et al. v. State of California et al., 84 F.3d 358 (9th Cir. 1996), 6 TAF QR 2 (July 1996), and other precedent, the court ruled that Aflatooni did not have the requisite "direct knowledge."

According to the court, to qualify as an original source a relator "must show that he had first-hand knowledge of the alleged fraud, and that he obtained this knowledge through his 'own labor unmediated by anything else.'" The court found that, in this case, Aflatooni could not recall the name of any Medicare patient who was allegedly charged for unnecessary medical services; Aflatooni's allegations regarding defi-

cient auditing procedures were not evidence of fraud, although perhaps evidence of negligence; and certain expert witness testimony did not constitute "anything more than mere speculation" regarding the alleged fraud.

In affirming the district court's § 3730(e)(4) dismissal with respect to the NDI allegations, the appellate court concluded:

> Dr. Aflatooni does not point to any other evidence in the record which suggests that he has "information," as opposed to speculation, of KPS or NDI's involvement in the submission of false Medicare claims. Therefore, because the purpose of the FCA is to encourage individuals with true "knowledge" of alleged wrongdoing to come forward and provide such information to the Government, the purposes of the Act would not be served by allowing a relator to maintain a qui tam suit based on pure speculation and conjecture.

PAKC Allegations Were Not Publicly Disclosed

Unlike the NDI allegations, the PAKC allegations were not disclosed in the news media prior to the filing of the Aflatooni *qui tam* action. Nevertheless, the defendants argued that the § 3730(e)(4) bar should be triggered with respect to the PAKC Defendants because Aflatooni's complaint alleged one giant conspiracy to submit fraudulent Medicare claims.

According to the appellate court, however, "[a]lthough Dr. Aflatooni does make some references to an overarching conspiracy in his complaint, the complaint carefully breaks down the allegations with respect to each of the Defendants" and involves "separate allegations of fraud against two distinct groups of defendants." Following its decision in U.S. ex rel. Wang v. FMC Corp., 975 F.2d 1412 (9th Cir. 1992), the appellate court found that the district court erred in ruling that the public disclosure bar applied to all of the Aflatooni defendants, including the PAKC Defendants. The court explained:

> The public disclosure bar cannot be applied to the PAKC Defendants unless the evidence supports the district court's finding that the allegations against those particular defendants were disclosed in the news media. However, none of the articles published about NDI discussed PAKC's alleged involvement in a conspiracy . . . . In fact, there is no mention of PAKC at all in the articles.

In addition, the court rejected the argument that an investigation by KPS of the PAKC Defendants triggered the public disclosure bar. Without answering the question of whether the KPS investigation even qualified as an "administrative investigation" under § 3730(e)(4)(A), the court found that the results of the investigation had not been publicly disclosed. The court emphasized that only three individuals associated with KPS had knowledge of the investigation results, the results "were not disclosed to any other member of KPS or PAKC, and the information was not disseminated to members of the public."

> *U.S. ex rel. Foust and Gedrich v. Group Hospitalization and Medical Services, Inc., d/b/a Blue Cross and Blue Shield of the National Capital Area et al., Memorandum Opinion, No. 93-2285 (NHJ) (D.D.C. Sept. 8, 1998)*

Federal government auditors cannot "voluntarily" report fraud to the Government and therefore can never qualify as original sources in order to overcome the public disclosure bar, ruled a D.C. district court. According to the

court, government auditors' job responsibilities include the reporting of fraud and auditors are paid sufficient compensation — their salaries — to do so.

Steven Foust and Richard Gedrich, both former federal government auditors in the Insurance Audit Division of the Office of Personnel Management (OPM) Office of Inspector General, filed this *qui tam* action on November 4, 1993 against Blue Cross Blue Shield of the National Capital Area (BCBSNCA) and several individual Blue Cross Blue Shield organizations known as participating plans. The relators alleged that the participating plans failed to credit to the Government discounts, refunds, and rebates they customarily received from health care providers and that BCBSNCA failed to collect this money from the participating plans for credit to the Government.

After leaving the OPM Office of Inspector General, but prior to filing this *qui tam* suit,the relators worked for an auditing firm which performed audits of government funded insurance plans pursuant to contracts with the OPM. In April 1993, the relators privately contracted with the FDIC to audit BCBSNCA. Their contract with the FDIC precluded them from using any information obtained under the contract for any purpose other than the performance of the contract and precluded disclosure of such information to anyone outside the FDIC.

Relators' Complaint Was Based Upon Publicly Disclosed Information

The multiple defendants in this case moved the court to dismiss the relators' complaint for lack of subject matter jurisdiction on public disclosure grounds. After performing a § 3730(e)(4)(A) public disclosure bar analysis, the court ruled that the relators' complaint was based upon publicly disclosed information from three prior civil suits, published articles, and OPM audits.

The court quickly established that three prior civil suits filed by Dana Corporation, General Electric, and AT & T against participating plans, including some of the same defendants in this case and all involving allegations of failures to pass on health care provider refunds, could "plainly constitute a public disclosure in a civil hearing under the False Claims Act." The court based its conclusion on its interpretation of the statutory phrase "civil hearing," one of the enumerated means through which allegations and transactions can be publicly disclosed under § 3730(e)(4)(A), which the court found to be roughly synonymous with "proceeding." According to the court, a civil proceeding includes publicly available pleadings such as complaints.

The court then relied on U.S. ex rel. Findley v. FPC-Boron Employees' Club, 105 F.3d 675 (D.C. Cir.), 9 TAF QR 1 (Apr. 1997), to reach its holding that the relators' complaint was based upon the allegations and transactions in the three prior civil complaints. In Findley, the D.C. Circuit had found that the relators' complaint was based upon public disclosures which, although not concerning identical allegations or parties, "raised a suspicion of fraud" and sufficiently disclosed the fraudulent scheme to alert the Government. Quoting Findley, the court likewise found in this case that the relators' complaint revealed "allegations which substantially repeat what the public already knows and add only the identity of particular [organizations] engaged in the . . . previously documented generic practice."

Alternatively, the court held that the relators' complaint was based upon several published news articles that publicized the three prior lawsuits. Additionally, the court concluded that disclosures resulting from OPM Office of Inspector General administrative audits also raised the jurisdictional bar. Several of the audits involved parties named in the relators' complaint and all concerned the failure of the

participating plans to credit refunds received from health care providers.

With regard to those audits involving plans not named in the relators' complaint, the court rejected the relators' contention that information provided by the Government to the plans' employees in the course of an audit does not constitute a public disclosure. The court found that, as the companies were not accused of any wrongdoing at the time, the employees had no incentive to conceal the subject of OPM's inquiry.

Government Auditors Cannot "Voluntarily" Report Fraud

The court proceeded to perform a § 3730(e)(4)(B) original source analysis to determine whether the relators could qualify as original sources, thereby overcoming the public disclosure bar. The court ruled that, due to their positions as government auditors, the relators could not have presented their information to the Government "voluntarily" as required by the statute.

The statute provides that a relator who seeks to overcome the jurisdictional bar must have "voluntarily provided the information to the Government before filing an action." § 3730(e)(4)(B). According to the court, the relators had obtained the information regarding violations of the Act in the course of their duties as federal government auditors. The court also included that period of time when the relators were under a duty to report fraud in their capacities as government contractors for the FDIC. The court stated that in each situation the relators were compelled to disclose fraud by the very terms of their employment. In return for their reports of fraud to the Government, relators received "valuable consideration" — their salaries — and therefore their reports could not have been voluntary.

The court stated that any other conclusion "would lead to extremely harmful incentives." Government auditors might spend time looking for personally profitable cases rather than doing their assigned work, might conceal information regarding fraud from their superiors in order to capitalize on it for personal gain, or might use the power conferred upon them as federal investigators for their own personal financial interests.

State Entities as FCA Defendants

U.S. ex rel. Zissler v. Regents of the University of Minnesota, 1998 WL 560138 (8th Cir. Sept. 4, 1998)

States are "persons" who may be liable under the False Claims Act, according to the 8th Circuit, and therefore the district court's dismissal of a *qui tam* action alleging research grant fraud by a state university was reversed. The 8th Circuit is the first federal appeals court to rule on the issue of whether states are considered "persons" under the FCA; the issue is currently pending before other circuit courts. The 8th Circuit found that the Federal Government is the real party in interest in FCA cases and its ability to sue states does not alter the usual constitutional balance between federal and state powers. As such, the district court should not have ruled that Congress's intent to include states as liable parties must be evident from "unmistakably clear" language in the statute. Employing ordinary rules of statutory interpretation, the 8th Circuit found that Congress did intend to include states within the "persons" who may be sued under the FCA.

In 1995, James Zissler filed a *qui tam* suit against the Regents of the University of Minnesota alleging that the University fraudulently submitted grant applications to the National Institutes of Health (NIH) for research on organ transplantation. The

Government subsequently intervened and claimed that the University had made false and incomplete statements in administering its NIH research grant funds. In July 1997, a Minnesota district court held that the FCA does not apply to states (or hence, to state universities) as defendants because Congress did not clearly state such in the FCA's language. Invoking the "plain statement rule," the district court dismissed the Government's and relator's FCA allegations. *See* 11 TAF QR 10 (Oct.1997). On appeal, the 8th Circuit reversed and remanded, holding that states are "persons" within the liability provision of the FCA.

Usual Constitutional Balance Between Federal and State Powers Not Altered

Citing Supreme Court precedent, the appellate court noted that when Congress intends to alter the usual constitutional balance between states and the Federal Government, it must make its intention to do so clear in the legislative language. For purposes of this case, the court analyzed, the threshold question is therefore whether that balance is altered by a *qui tam* suit.

The Government is the real party in interest in False Claims Act cases, the court held, "because of its significant control over the course of the litigation and its dominant share of the proceeds thereof." According to the court, even when the Government does not intervene, these factors have weighed heavily in favor of a conclusion that the Government is the real party in interest. But especially when the Government has intervened, as in this case, it must be recognized as the real party in interest.

As the real party in interest, "the federal government's power to sue a State is well within the usual constitutional balance of federal and state powers," the court stated. This principle is not changed by the Supreme Court's opinion in Seminole Tribe v. Florida, 517 U.S. 44 (1996), because that decision only addressed the question of whether Congress could authorize a private party to sue a state and explicitly distinguished the power of the Federal Government to do so. According to the 8th Circuit, Seminole Tribe does nothing to change the analysis that states have no 11th Amendment immunity against the Federal Government. Therefore, "there is no reason Congress would have displaced it in the False Claims Act."

In addition, applying the FCA to states does not disrupt the usual balance of power through coercion, the court held. "There is no coercion in subjecting States to the same conditions for federal funding as other grantees: States may avoid these requirements simply by declining to apply for and to accept these funds." Further, the court stated, "the University should not have needed explicit notice of the basic understanding that the grants were to be obtained and administered without fraud."

Finally, the court rejected the University's argument that the FCA's "extracompensatory" remedies alter the usual balance between the Federal Government and the states. The court noted that, while in some cases private plaintiffs' ability to recover more than compensatory damages from states has been limited, the Federal Government is not under any similar restrictions. Moreover, the Supreme Court has determined that the Government is entitled to "rough remedial justice" which may involve imprecise formulas or multiple damages, and the FCA's treble damages have been held to be compensatory.

"Persons" Include States Under the FCA

In finding that an FCA action against a state falls within the usual constitutional balance between states and the Federal Government, the court therefore went on to hold that Congress's intent to include states as liable parties "need not be manifest in 'unmistakably clear' language." Instead, the court proceeded

to interpret the statute under the ordinary canons of statutory construction.

The 8th Circuit rejected the University's argument that the FCA should be presumed to exclude states because they are sovereigns. According to the court, the presumption of sovereign exclusion applies only to the enacting sovereign, in this case the Federal Government. Moreover, this presumption is invoked only when the statute's purpose is in doubt. Here, the court found that the FCA's purpose, subject matter, context, legislative history, and executive interpretation all point to including states as liable parties. As support, the court noted that the FCA is intended to reach all types of fraud, that the 1986 amendments to the FCA were intended to enhance and modernize the Government's ability to recover losses, and that states now receive a significant and growing amount of federal funding, with grants exceeding $228 billion each year.

The court also found that the legislative history of the 1986 FCA amendments supports the inclusion of states as liable "persons." The Senate Report accompanying the 1986 amendments includes a statement in its history and court interpretation section that the FCA reaches all parties who submit false claims, including states. The University argued that this statement should be given little weight because it was not the view of the 1863 Congress that enacted the original FCA and it had no relationship to the pending amendments in 1986. The 8th Circuit disagreed and pointed out that the 1986 amendments included an alteration in the statutory language which designates who is liable. As a result, "Congress's understanding (whether right or wrong) of court interpretations of 'person' was relevant background."

In addition, the 8th Circuit found that interpreting "person" in the FCA to include states is consistent with the use of "person" in other provisions of the FCA. Certainly states are included in the "persons" who are authorized under the Act to bring suit as *qui tam* plaintiffs. As such, "[i]n the absence of language to the contrary, they should also be 'persons' when sued as defendants," the court stated. In addition, the civil investigative demand section of the FCA expressly includes states in its definition of "person." The court was not persuaded by the University's argument that "person" was defined to include states only for purposes of the civil investigative demand section, and that the Program Fraud Civil Recoveries Act indicates legislative intent to exclude states from liable "persons." According to the court, neither argument can carry the day given the stronger evidence, in the FCA itself, that Congress intended "persons" to include states.

U.S. ex rel. Rodgers et al. v. State of Arkansas et al., 1998 WL 559768 (8th Cir. Sept. 4, 1998)

Whether or not the Government intervenes, states are not immune from *qui tam* actions, ruled the 8th Circuit. According to the court, the 11th Amendment does not protect states from suit by the Federal Government and, even in *qui tam* actions the Government declines, the Government is the real party in interest.

Frankie Rodgers and Delbert Lewis brought this *qui tam* action against the State of Arkansas, its Department of Education, and several school districts alleging that the defendants falsely claimed compliance with federal civil rights laws. According to the decision, assurance of compliance is a prerequisite to the continued receipt of certain federal funds. The Department of Justice declined to intervene. The defendants moved to dismiss the complaint on the basis that the 11th Amendment protects states from FCA suits. The district court denied the motion, and the defendants appealed.

The defendants argued that when the Federal Government declines to prosecute an FCA case, the suit is not brought by the United States for 11th Amendment purposes. The 8th Circuit disagreed, pointing out that even when the Government declines to intervene, the FCA permits the Government to have various types of control over the litigation and allocates the bulk of any recovery to the Government. Thus, the Government is the real party in interest which, as the court noted, is consistent with decisions from other circuits.

One circuit judge dissented, claiming that the Government's level of control over declined *qui tam* actions is not sufficient to render it the real party in interest for purposes of 11th Amendment restrictions.

Section 3730(b)(5) First-to-File Provision

U.S. ex. rel. LaCorte, Clausen, and Miller v. SmithKline Beecham Clinical Laboratories, Inc., 149 F.3d 227 (3rd Cir. July 23, 1998)

The 3rd Circuit ruled that FCA § 3730(b)(5) bars all later-filed *qui tam* actions which "arise from events that are already the subject of existing suits," not just those based upon identical facts. The appellate court therefore affirmed the district court's dismissal of three later-filed *qui tam* actions which alleged the same elements of fraud as those in earlier suits.

In a matter of first impression for the 3rd Circuit, the appellate court was asked to interpret § 3730(b)(5) of the False Claims Act, a provision intended to prevent duplicative lawsuits. Jeffrey Clausen, William LaCorte and Donald Miller (the relators) appealed the district court's dismissal of their *qui tam* suits pursuant to § 3730(b)(5).

Clausen, LaCorte and Miller were the final of six relators to file their *qui tam* suits against SmithKline Beecham Clinical Laboratories, Inc. (SmithKline) during a nearly three year seal period beginning in November 1993. All six complaints alleged that SmithKline had used a variety of fraudulent schemes to defraud federal and state healthcare programs. The Government settled with SmithKline for $325 million dollars on September 25, 1996.

The three original relators stipulated to the fairness, adequacy, and reasonableness of the settlement, and agreed among themselves as to how to divide any relator's share. Clausen, La Corte, and Miller challenged the settlement in the district court. The district court ruled that all but one of the later-filed claims, LaCorte's "urinalysis claim," were covered by the settlement agreement and were barred by § 3730(b)(5). LaCorte was permitted to sever and pursue separately his urinalysis claim.

Plain Meaning of § 3730(b)(5) Calls for Broad Interpretation

The 3rd Circuit began by examining the plain meaning of § 3730(b)(5), which provides:

> When a person brings an action under this subsection, no person other than the Government may intervene or bring a related action based on the facts underlying the pending action.

The court determined that the provision's plain meaning clearly contradicted the relators' contention that § 3730(b)(5) bars only later *qui tam* actions arising from facts identical to those underlying a previous suit. The court stated: "Giving each word its ordinary meaning, the phrase 'related action based on the facts underlying the pending action' clearly bars claims arising from events that are already the subject of existing suits." The court further added:

> A later case need not rest on precisely the same facts as a previous claim to run afoul of this statutory bar. Rather, if a later allegation states all the essential facts of a previously-filed claim, the two are related and section 3730(b)(5) bars the later claim, even if that claim incorporates somewhat different details.

The court also stated that the relators' interpretation would "defeat the law's primary objectives." According to the court, § 3730 of the statute is intended to meet the conflicting goals of preventing opportunistic suits while also encouraging citizens to act as whistleblowers. The relators' narrow interpretation would defeat these goals because too many relators would expect to share a recovery stemming from the same conduct, thereby reducing their incentive to bring a *qui tam* action in the first place.

The court listed other reasons why defining "facts underlying the pending action" as identical facts would be too narrow an interpretation. First, if the statute barred only identical claims, early filing relators might resist extending the seal period out of fear that additional suits would be filed, thereby reducing each relator's share of the *qui tam* award. This would be troublesome in complex cases where prolonged investigations might be necessary. In addition,later-filing relators alleging the same material facts as in prior suits should not share in the *qui tam* award as their allegations would be unlikely to increase the total recovery. Finally, such later-filed claims would not help reduce fraud or return additional money to the federal treasury, as once the Government has the essential information it should be able to discover related frauds.

The court rejected the relators' assertion that, unless § 3730(b)(5) is limited to suits alleging identical facts, relators will purposely plead a very broad cause of action so as to preempt later-filed claims. The court stated that Rule 9(b), which requires plaintiffs to plead fraud with particularity, would act as a sufficient deterrent to such overly broad allegations.

Relators' Claims Barred by § 3730(b)(5)

Having reached its interpretation of § 3730(b)(5), the court began to compare Clausen, LaCorte, and Miller's claims to those of the three original relators. After performing a detailed, fact-specific analysis of each allegation in the relators' complaints, the court found that the relators' claims were identical to the original relators' allegations or that they contained the same "material elements." The court therefore ruled that § 3730(b)(5) barred the claims at issue in this appeal.

FCA Liability/Fiscal Intermediary Immunity

U.S. ex rel. Body v. Blue Cross and Blue Shield of Alabama, Inc., Memorandum Opinion, No. 95-6429 (11th Cir. June 26, 1998)

In a controversial opinion affirming the lower court's dismissal of a *qui tam* suit, the 11th Circuit ruled that a Medicare intermediary is immune from liability to the Government stemming from payments certified and disbursed by its officers. According to the court, this holding does not leave the Government without remedies for punishing Medicare fraud and is in keeping with "the efficient administration of the Medicare system."

Frank Body brought this *qui tam* action alleging that Blue Cross/Blue Shield of Alabama (BCBSA), in its role as fiscal intermediary for Medicare Part A in Alabama, reimbursed Alabama hospitals for interest costs that are not chargeable to Medicare. Body was an employee of BCBSA from 1973 to 1989, and was a senior

auditor starting in 1984. The Government declined to intervene in his *qui tam* suit.

The district court dismissed the suit for lack of subject matter jurisdiction, on the grounds that 42 U.S.C. § 405(h) deprived the court of jurisdiction, and that the § 3732(a) jurisdictional provision of the False Claims Act could not save Body's claims.

Qui Tam Suit Does Not "Arise Under" Medicare Act

The first issue on appeal, therefore, was whether the jurisdictional preclusion of subsection 405(h) applied to a False Claims Act action, brought by or for the United States against a fiscal intermediary, to recover money improperly paid to Medicare providers. The 11th Circuit reversed the district court's holding that subsection 405(h) applied to Body's claims, but ultimately affirmed the dismissal on the alternative ground that BCBSA had immunity from Body's suit pursuant to 42 U.S.C. § 1395h(i)(3). Both issues were a matter of first impression in the federal courts.

Subsection 405(h), a provision of the Social Security Act made applicable to the Medicare Act by 42 U.S.C. §1395ii, deprives district courts of subject matter jurisdiction under 28 U.S.C. § 1331 with regard to all cases "arising under"the Medicare Act. The third sentence of subsection 405(h) states:

> No action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

In order to determine whether Body's *qui tam* claim "arose under" the Medicare Act and would therefore be subject to subsection 405(h), the court examined the system for administrative and judicial appeals of Medicare claims. The court found that section 405 was designed to channel disputes over eligibility or the amount of benefits awarded under the Medicare Act through the prescribed administrative and appeals process, and to prevent circumvention of the administrative process by Medicare beneficiaries. However, the court found nothing in subsection 405(h) which would eliminate subject matter jurisdiction over all actions implicating the Medicare Act, regardless of whether there exists administrative and judicial review within the Medicare administrative scheme.

The court added:

> Dismissal of Body's claim on that ground, however, would have an anomalous result: the Government could bring an FCA claim against BCBSA under the jurisdictional grant in 28 U.S.C. § 1345, but the *qui tam* provisions of the FCA would be rendered useless. The FCA's incentives for informed agents to monitor their employers and bring suit for violations would thus be destroyed. We do not believe that this result is either necessary or correct.

Therefore, the court ruled that *qui tam* actions such as Body's, which did not seek payment from the Government and which could not be brought under section 405, are not barred by section 405(h).

Fiscal Intermediary Immune from Liability to Government Under Medicare Administrative Scheme

The 11th Circuit affirmed the district court's dismissal of Body's suit, however, on the alternative ground that BCBSA is immune from liability to the Government under 42 U.S.C. § 1395h(i)(3). Subsection 1395h(i)(3) provides that fiscal intermediaries will not be liable to the Government for payments its offi-

cers certify and disburse to Medicare beneficiaries. There is no clause, as in subsections 1395(h)(i)(1) and (2), limiting immunity to payments not involving gross negligence or fraud. The court, therefore, was "not persuaded that Congress did not intend for this immunity to extend to fraudulent payments certified and disbursed to Medicare Part A providers."

The court also stated that "its reading of the subsection is consistent with the broader goals of section 1395(h) and the efficient administration of the Medicare system." According to the court, fiscal intermediaries like BCBSA function much like an administrative agency, carrying out the administrative responsibilities imposed by the Medicare Act. As evidence of this, the court noted that Medicare regulations require that contracts with fiscal intermediaries contain clauses providing for indemnification with respect to actions taken on behalf of the Health Care Financing Administration.

Moreover, the court stated that this system "does not leave the Government without any remedies for punishing Medicare fraud." Other remedies include recoupment of overpayments from the recipients of the funds, bringing an FCA action against any individual who participated in a fraudulent scheme, or holding the intermediary liable for charges to the Government for services never performed. The court further stated that "if the government discovered rampant fraud and abuse of Medicare by a fiscal intermediary, we do not doubt that it could find sufficient civil and criminal grounds to punish the fiscal intermediary and its officers, and/or recoup any lost money."

Therefore, the court concluded that Body's *qui tam* action was "premised upon precisely the types of payments for which Congress provided the fiscal intermediaries with immunity." Allowing Body to circumvent the immunity would "destroy the integrity of the system that Congress designed."

Anti-Kickback and Self-Referral Violations/Constitutionality

U.S. ex rel. Thompson v. Columbia/HCA Healthcare Corp. et al., Order, Civil Action No. C-95-110 (S.D. Tex. Aug. 18, 1998)

A Texas district court ruled on remand that Columbia/HCA's alleged violations of Medicare anti-kickback and self-referral laws could be pursued under the False Claims Act. Important to the decision was the court's finding that the Government conditions Medicare payments and continued Medicare eligibility on annual cost report certifications assuring compliance with applicable laws. Also rejecting the defendants' argument that the *qui tam* provisions are unconstitutional, the court cleared the way for discovery to begin at last in this closely watched case.

Relator James Thompson, M.D., alleged that Columbia/HCA Healthcare Corporation and certain affiliated entities created incentive arrangements and provided financial inducements to physicians for patient referrals in violation of the anti-kickback statute and self-referral laws. In October 1996, the district court held that Thompson failed to state a claim for relief under the FCA. *See* 7 TAF QR 11 (Oct. 1996). In October 1997, the 5th Circuit reversed and remanded in part,holding that a claimant submits a false or fraudulent claim when falsely certifying compliance with a statute or regulation where the Government has conditioned payment upon such certification. *See* 12 TAF QR 5 (Jan. 1998). On remand, the district court agreed with the relator that he sufficiently stated claims for three separate violations of the FCA, i.e., the allegedly false certifications of compliance with all applicable Medicare statutes and regulations on which the Government conditioned payments, the submission of Medicare claims in violation of the Stark laws' express prohibition,

and the submission of claims for services rendered in violation of the anti-kickback statute.

Qui Tam Provisions Held to be Constitutional

As a threshold issue, the district court first addressed the constitutionality of the *qui tam* provisions. Defendants argued that the court should follow the decision rendered by Judge Hoyt within the same district in U.S. ex rel. Riley v. St. Luke's Episcopal Hospital, 982 F. Supp. 1261 (S.D. Tex. 1997),12 TAF QR 1 (Jan. 1998). That case held, for the first time, that *qui tam* plaintiffs do not have standing under the Constitution to pursue their claims. (Riley is currently on appeal to the 5th Circuit.)

The Thompson court disagreed with Riley "because it goes against 134 years of case law specifically concluding or assuming that the *qui tam* provisions are constitutional and/or that the relator has standing to bring the action even though the relator has suffered no injury." The court instead concurred with the numerous circuit courts that have addressed the issue and found the *qui tam* provisions to be constitutional. Citing other circuit decisions, the court noted that where the Government has suffered an injury-in-fact, the relator merely steps in as its representative or assignee to carry out the statute's purpose of remedying fraud against the Government. Moreover, the FCA provides sufficient executive control of the *qui tam* suit and the relator has a personal stake in the outcome of his suit. The court also observed that "appellate courts scrutinize their jurisdiction before reviewing the issues of each case, and none, including the Supreme Court, in ruling on FCA cases has yet determined that it lacked jurisdiction because an FCA *qui tam* relator lacked standing."

Cost Report Certifications Are a Condition of Medicare Payments and Eligibility

The court held that an FCA claim is stated by the allegation that the defendants falsely certified that the Medicare services identified in their annual hospital cost reports complied with applicable law and regulations. According to the court, the alleged prohibited financial relationships among the defendants and referring physicians made the certifications false statements. Moreover, relators and the Government (through an amicus submission) provided evidence that the Government relied on the cost report certifications in determining the issue of payment, as well as continued eligibility for participation in the Medicare program. Because the certifications are alleged to be false and the Government conditioned payment on such certifications, the court concluded that such allegations state a claim for relief under the FCA.

Stark Laws' Prohibition on Payment for Services in Violation is Actionable Under FCA

The court further concluded that the Stark laws' express prohibition on payment for services rendered in violation of the Stark laws' own terms makes such violations actionable under the FCA. Under the Stark laws, the defendants would not have been eligible to participate in the Medicare program if they were in violation of the laws' provisions. Agreeing with the relator that "a pecuniary injury to the public fisc is no longer required for an actionable claim under the FCA," the court noted that the Government sustains at least some form of injury when payments are made to ineligible entities. Moreover, there are additional monetary losses resulting from investigative and administrative costs.

Violation of Anti-Kickback Statute States a Claim Under FCA

The Medicare anti-kickback statute, 42 U.S.C. §1320a 7b(a) and (b), prohibits the solicitation or receipt of remuneration in return for referrals of Medicare patients, and the offer or payment of remuneration to induce such referrals. It also

prohibits the making of any false statements,failing to disclose material information, or making false statements or representations to qualify as a certified Medicare provider. Thompson alleged that the defendants' certifications of compliance with relevant laws and regulations were false, and the Government would not have paid the defendants' claims had it known of the self-referral and kickback violations.

In agreeing with the relator, the court cited 5th Circuit precedent in Peterson v. Weinberger, 508 F.2d 45 (5th Cir.), cert. denied, 423 U.S. 830 (1975), and adopted the more recent and more on-point rationale in U.S. ex rel. Pogue v. American Healthcorp., Inc., 914 F. Supp. 1507 (M.D. Tenn. 1996), 5 TAF QR 2 (Apr. 1996). In that case the court relied on both the legislative history of the FCA and a recent trend of cases to conclude that a violation of Medicare anti-kickback and self referral laws also constitutes a violation of the FCA. Quoting from Pogue, the court stated that "'the False Claims Act was intended to govern not only fraudulent acts that create a loss to the government[,] but also those fraudulent acts that cause the government to pay out sums of money to claimants it did not intend to benefit.'"

Finding also that the complaint was pled with sufficient particularity to satisfy Rule 9(b) and that the relator could file an amended complaint, the court cleared the way for discovery to finally begin on Thompson's case which was filed in 1995.

Primary Jurisdiction

U.S. ex rel. Haskins et al. v. Omega Institute, Inc. et al., 11 F.Supp.2d 555 (D.N.J. July 2, 1998)

In a case involving allegations of fraud in federally funded student assistance programs by an adult education school, a New Jersey district court declined to stay or dismiss the *qui tam* action pending completion of a Department of Education (DOE) administrative review. The court rejected the defendants' argument that the DOE had primary jurisdiction, particularly since it is only the Department of Justice (DOJ) that has the authority to adjudicate FCA actions. Moreover, noting that DOJ could have chosen an alternate remedy, but instead simply declined to intervene in the *qui tam* suit, the court found no reason to grant the defendants' motion to delay or dismiss the action.

Relators Diane Haskins, Beverlee Ralph, and Tamara Livingston attended the paralegal training program at Omega Institute, Inc. (Omega), a private, post-secondary school providing alternative adult education. In January 1995, they brought a *qui tam* suit alleging that Omega made false statements in documents filed with the DOE, thereby receiving financial aid funds to which it was not entitled. More specifically, the relators alleged that the school did not provide the number of instruction hours, quality of instructors, or attendance policies in keeping with the written statements it submitted to the DOE. The Government declined to intervene in the *qui tam* suit.

Also in 1995, the DOE began an enforcement action and program review of Omega's compliance with federal funding regulations and its administration of Title IV student financial assistance programs. The investigation was ongoing at the time the court ruled in this case.

Primary Jurisdiction Doctrine Inapplicable

The defendants, relying on the doctrine of primary jurisdiction, asked the court to dismiss the relators' *qui tam* action without prejudice or stay the action pending completion of the DOE's program review. However, the court ruled that the doctrine of primary jurisdiction did not apply in this case.

According to the court, because the Government had declined to intervene in the *qui tam* suit, instead electing to conduct an administrative review, relators retained the right to proceed in the district court. In reaching this ruling, the court relied on U.S. ex rel. Dunleavy v. County of Delaware, 123 F.3d 734 (3d Cir. 1997), 11 TAF QR 1 (Oct. 1997), in which it was unclear whether a separate settlement between HUD and the defendant was intended to extinguish the Government's False Claims Act claims. However, as the Government had declined to intervene in that *qui tam* suit, the 3rd Circuit ruled that the relator could proceed.

The court further stated that the doctrine of primary jurisdiction would not apply because only the Department of Justice and the Attorney General have authority to investigate false or fraudulent claims. According to the court, the DOE was reviewing Omega based on the same facts alleged in the relators' suit, but not for false or fraudulent claims. Therefore, in not applying the doctrine, the court would not be contravening any statutory scheme whereby Congress might have intended for an agency vested with the authority to resolve the issues in question.

In addition, even if the DOE had authority to adjudicate FCA claims, the DOE could not exercise this jurisdiction because the Government had declined to intervene. Because the Government could have chosen to move the matter to an administrative agency but had declined to do so, the court did not find the DOE action to be a § 3730(c)(5) alternate proceeding in which the relators could participate.

Relators May Bring FCA Action Against Corporate Officers in Their Individual Capacities

Having determined that the DOE's program review did not affect the relators' right to proceed, the court turned to certain defendants' assertion that the relators' complaint contained no allegations against them in their individual capacities, but only nominally as officers of Omega. The court rejected this argument, finding that the complaint sufficiently alleged wrongdoing against all of the defendants in their individual capacities, not just as corporate officers. Moreover, the court rejected the defendants' assertion that the plaintiffs did not sufficiently plead the right circumstances to "pierce the corporate veil." Not only did the court find veil-piercing to be inapplicable to this case, but also that the relators had sufficiently plead against the defendants in their individual capacities to satisfy Rule 9(b).

As to the defendants' assertion that they acted within the scope of their employment and therefore should not be held liable, the court first noted that the defendants misstated the way liability is allocated along agency lines. The defendants had mistakenly asserted that because an agent's fraudulent acts may impute liability to the principal, that the agent would not also be personally liable. In addition, while the defendants' positions with Omega may have required them to file documents with the Government, their job responsibilities clearly did not include filing false documents.

Other defendants argued that the plaintiffs had not produced any evidence that they had violated various provisions of § 3729 of the Act. After examining the evidence produced by the plaintiffs on a claim by claim basis, the court ruled that in all but one instance the plaintiffs had produced enough evidence for their case to go forward.

Relators' Complaint "Substantially" Based Upon Public Disclosures

The court also addressed § 3730(e)(4) public disclosure bar and original source issues.

The relators filed their original *qui tam* complaint on January 5, 1995 and an amended complaint on January 14, 1997. In October 1994,

February 1995, and September 1996, the relators obtained DOE audit files and reports through Freedom of Information Act requests. While the court acknowledged that some of the DOE files may have resulted from investigations stemming from the relators' suit, the court still held that the relators' complaint "substantially" relied upon publicly disclosed information.

The court further ruled that, in this case, the relators could only have "direct" and "independent" knowledge sufficient to qualify as original sources by means of their personal observations as students at Omega. Therefore, the court limited the scope of the relators' complaint to only those time periods in which the relators were enrolled at Omega.

U.S. ex rel. Johnson et al. v. Shell Oil Company et al., Order, Civil Action No. 9:96 CV 66 (E.D. Tex. July 23, 1997)

The defendants' motion to dismiss on primary jurisdiction grounds was denied by a Texas district court in a *qui tam* case alleging underpayment of oil royalties. The court rejected the defendants' contention that the doctrine of primary jurisdiction compelled the deferral of the case to the Department of Interior, which the defendants argued must first determine certain preliminary issues before the district court could properly assert jurisdiction.

According to the *qui tam* action, in which the Government intervened, various private oil companies knowingly undervalued oil extracted from federal and Indian lands in order to reduce royalties paid to the Government and Indian nations. Under Department of Interior (D.O.I.) mineral lease agreements, the defendant companies were required to pay the Government a percentage of the value of the extracted oil as a royalty. The collection of these royalties was overseen by the D.O.I. Minerals Management Service (M.M.S.).

Primary Jurisdiction Dismissal Rejected

The defendants argued that, under the doctrine of primary jurisdiction — whereby the court may dismiss or stay the action pending resolution of some portion of the action by an administrative agency — the district court should dismiss the *qui tam* action because, as an initial matter, the M.M.S. had to determine the accuracy of each "M.M.S.-2014 form" submitted by the defendants to the Government over a ten to twelve year period. The district court stated that, "[i]n considering whether to defer to an agency's primary jurisdiction, the court must weigh the benefits of obtaining the agency's aid against the need to resolve the litigation expeditiously." Rejecting the defendants' motion to dismiss, the court concluded that "deferral to the D.O.I. would [not] be of benefit in resolving the issues posed by this litigation" and "would prolong unnecessarily the resolution of the dispute."

Statute of Limitations

Jana, Inc. v. United States, Opinion and Order, No. 94-203C (Fed. Cl. Sept. 3, 1998)

Ruling on an unsettled statute of limitations issue, the Court of Federal Claims held that in FCA cases seeking damages (as opposed to those seeking only civil penalties) the statute of limitations does not begin to run until the Government has made payment on the alleged false claim. Courts have split on the issue of whether submission of a false claim or payment of a false claim triggers the statute.

Jana, Inc., a contractor for the Navy, moved for partial summary judgment on government counterclaims for fraud under the FCA. At issue, among other things, was the event triggering the FCA's statute of limitations. The contractor argued that the FCA's statute of limitations begins to run on the date the false claim is sub-

mitted, regardless of when, or whether, the claim gets paid. The Government argued that, with respect to an FCA claim for damages, the limitations period does not begin to run until the date the false claim is paid since it isn't until then that the Government incurs actual damages.

The court noted that there is no binding precedent on this issue from the Supreme Court, the Federal Circuit, or the Court of Claims, and that other circuits have split on the issue. According to the court, the majority of district courts considering the issue have concluded that, if the Government makes payment on a submitted false claim, the FCA's statute of limitations starts running on the date payment is made rather than on the date the claim is submitted.

The court applied the principle that a cause of action accrues when all events necessary to state a claim have occurred. According to the court, "[i]n the case of an FCA claim seeking civil penalties, all events necessary to state a claim have occurred upon the submission of the false claims to the government. However, in the case of a FCA claim for actual damages, all the events necessary to state the government's claim do not occur until the government has made full payment on the claim, since the government does not incur actual damages until then."

Definition of "Claim"/Res Judicata/Section 3730(e)(3)

U.S. ex rel. Costner et al. v. URS Consultants et al., 153 F.3d 667 (8th Cir. Aug. 17, 1998)

False claims allegedly made to a private trust fund established for environmental cleanup as a result of negotiations involving the Federal Government cannot be considered "claims" within the meaning of the FCA,the 8th Circuit ruled. On the other hand, the appellate court upheld the district court's denial of the defendants' Rule 12(b)(6) motion to dismiss with respect to false claims allegedly submitted to the U.S. Environmental Protection Agency (EPA). The court also affirmed the denial of motions to dismiss on res judicata, FCA § 3730(e)(3), and CERCLA § 113(h) grounds.

The *qui tam* case at hand alleged a pattern of false claims for the performance of hazardous waste treatment and disposal services at the extremely contaminated Vertac Chemical Plant site in Jacksonville, Arkansas. In 1979, after the Centers for Disease Control concluded that the Vertac site constituted a significant risk to public health, Vertac Chemical Corporation entered into a compact with the EPA and the state to take certain remedial measures. However, subsequent litigation by the state and EPA was necessary to move forward the cleanup of the site. Among other things, the EPA initiated an emergency removal action under the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA), and various agreements were reached with Vertac Chemical and consent decrees approved by the federal court — including that Vertac would establish a multi-million dollar trust fund, overseen by the state, for the cleanup of the site. In 1992, after it became clear that this trust fund would not be sufficient to complete the cleanup, the EPA assumed primary responsibility for the site and approved a federal removal action using federal funds.

Meanwhile, over the years various lawsuits were filed by outside parties regarding the Vertac cleanup. The defendants pointed to prior litigation involving two of the current relators as plaintiffs, and litigation involving the EPA as a defendant, in arguing that the Vertac *qui tam* suit should be dismissed under the doctrine of res judicata or FCA § 3730(e)(3).

Res Judicata, FCA § 3730(e)(3), and CERCLA Do Not Bar *Qui Tam* Action

The district court denied the defendants' motion to dismiss on these grounds, and the appellate court affirmed. Noting that the prior litigation "was an effort to prevent perceived harm to the environment and public health by seeking enforcement of state and federal environmental regulations," whereas the *qui tam* suit seeks to redress the alleged submission of false claims for payment of government funds, the appellate court concluded:

> Although both claims have their genesis in the Vertac site cleanup, they are independent of each other and seek to redress different injuries resulting from distinct conduct. Thus, the FCA allegations are not, as defendants assert, simply a repackaging of prior claims, but constitute a new set of charges . . . upon which no final judgment has been previously rendered. Therefore, the claims are not precluded on grounds of res judicata.

Likewise, rejecting the defendants' argument that prior litigation involving challenges to Vertac cleanup in which the EPA was a defendant invokes the § 3730(e)(3) jurisdictional bar against *qui tam* actions "based upon allegations or transactions which are the subject of a civil suit . . . in which the Government is already a party," the appellate court concluded:

> The present suit is based upon allegations of fraud involving the submission of false claims for payment for environmental remediation work completed at the Vertac site. Such allegations or transactions have never before been the subject of a FCA suit or any other suit or proceeding brought by the government or anyone else.

In addition, the court ruled that CERCLA § 113(h) — which provides that "[n]o federal court shall have jurisdiction . . . to review any challenges to removal or remedial action selected" by the EPA under CERCLA — was not a bar to the *qui tam* action.

False Claims Against Private Trust Fund Not Covered by FCA

Lastly, the appellate court turned to the defendants' contention that false claims that were presented to the Vertac trust fund were not claims made against the Federal Government and thus not covered by the FCA. The relators argued that the EPA's participation in the negotiations that resulted in the trust fund was sufficient to make any claims against that fund susceptible to the Act. The court, however, responded that "[w]e do not believe the FCA has as elastic an application as relators suggest."

After reviewing the definition of "claim" in the FCA and relevant Supreme Court precedent, the 8th Circuit stated: "Essentially, then, only those actions by the claimant which have the purpose and effect of causing the United States to pay out money it is not obligated to pay, or those actions which intentionally deprive the United State of money it is lawfully due, are properly considered 'claims' within the meaning of the FCA." In this case, none of the money in the Vertac trust fund was provided by the Government, no federal funds were ever intermingled with the fund, the Government had no access to or control over the fund (which was overseen by the state), and no money disbursed from the fund was ever reimbursed by the Government. Thus, concluded the court, claims made against the Vertac fund "had no nexus to the United States" and were not subject to the FCA.

On the other hand, the appellate court made clear that alleged false claims made to the federal Superfund under the supervision of the EPA were covered by the FCA, and with respect

to those claims denial of the defendants' motion to dismiss was correct.

Relator Intervention/Section 3730(c)(5) "Alternate Remedy"

U.S. ex rel. LaCorte v. Roche Biomedical Laboratories, Memorandum and Order, 2:96CV00417 (M.D.N.C. Aug. 21, 1998)

A North Carolina district court allowed relators from a prior settled *qui tam* action against a medical laboratory to intervene to protect their interests in a subsequent settlement involving one of the same defendants. The court ruled that the FCA's bar on intervention is not absolute when combined with the rights that relators have to participate in any "alternate remedy" sought by the Government. Here, the relators from the earlier action argued that they have an interest in any portion of the subsequent settlement that was derived from the lab's obligation to disclose wrongdoing under a compliance agreement that was part of the settlement of their case.

On November 21, 1996, a Global Settlement was reached between the Government, various medical laboratories (Roche Biomedical Laboratories ("Roche"), National Health Laboratories ("NHL"), Laboratory Corporation of American ("LabCorp"), and Allied Clinical Laboratories ("Allied")), two relators who filed *qui tam* actions against Roche, and two relators who filed *qui tam* actions against NHL. Approximately two weeks after the Global Settlement was made public, Ramona Wagner and Jeanine Dehner ("the Relators") filed a motion to intervene. Wagner and Dehner had filed a previous *qui tam* action in Ohio against Allied that was settled in 1995. As part of that settlement, Allied had entered into a Corporate Integrity Agreement ("CIA") in which it agreed to submit periodic reports to the Government regarding any improprieties. The Relators argued in their intervention motion that they have an interest in the Global Settlement if any part of it arose from disclosures made by Allied pursuant to its CIA negotiated as a part of their *qui tam* case (the "Ohio case"). The court granted the motion to intervene based on its conclusion that the FCA allows intervention in this situation and the Rules of Civil Procedure require it.

FCA's "Alternate Remedy" Rights for Relators is Exception to Restriction on Intervention

With respect to the FCA, the court found that the Act's restriction on intervention at § 3730(b)(5) is not absolute because another part of the statute appears to grant an exception to the non-intervention rule. Subsection 3730(b)(5) states that "[w]hen a person brings an action under this subsection, no person other than the Government may intervene or bring a related action based on the facts underlying the pending action." However, according to the court, under § 3730(c)(5), relators are granted an unconditional right to participate in any "alternate remedy" pursued by the Government. The court noted that the particular facts of this case illustrate the conflict between § 3730(b)(5) and § 3730(c)(5).

> If, as the Relators argue, some portion of the Global Settlement is attributable to the information on which they based the Ohio case or information arising from the Ohio case and they are otherwise entitled to some fraction of the relevant portion, subsection (c)(5) would seem to allow them to intervene, while subsection (b)(5) would seem to prevent their intervention.

To resolve the conflict between the subsections, the court examined the legislative history and the overall purpose and scheme of the statute. The court found that the legislative history fails

to "reflect any recognition of the possibility of a case such as this one, in which the Relators are seeking to intervene in a suit which they claim is effectively a revival of their own." Turning to the purposes of the FCA, the court concluded that "[c]onstruing the FCA to prevent Relators from intervening in this case would contradict Congress' clearly expressed purpose of encouraging citizens to report fraud by awarding them some portion of any recovery obtained by the Government based on their reports." The court went on to state:

> If citizens felt that the Government could intervene in a *qui tam* case, dismiss the case, and then seek a settlement from the defendant without including the relator(s) in the settlement discussions, their incentive to report fraud would be undercut.

In this case, the court ruled that the Relators have the right to enter the case to determine if some portion of the Global Settlement constitutes an "alternate remedy" under § 3730(c)(5).

Rule 24 Allows the Relators to Intervene as a Matter of Right

After finding that the FCA permits intervention in this situation,the court proceeded to an analysis of whether the Federal Rules of Civil Procedure allow the requested intervention. Citing 4th Circuit precedent, the court set out what an applicant must demonstrate for a Rule 24 intervention: (1) an interest in the subject matter of the action; (2) the protection of the interest would be impaired because of the action; and (3) the applicant's interest is not adequately represented by existing parties to the litigation. In this case, the court found that there was no question that the Relators' ability to protect any interest they may have in the Global Settlement would be impaired if the case were dismissed, and their interest would not be adequately protected by existing parties. Therefore, the only question, according to the court, involves whether the Relators have an interest in the subject matter of the action.

Citing Supreme Court precedent, the court noted that an interest sufficient under Rule 24 is one which is "significantly protectable." The 4th Circuit has held that an intervenor whose interest was contingent on the outcome of other litigation had a significantly protectable interest. This holding and others, the court stated, suggests that the Rule 24 standard may be satisfied by a showing of "the mere possibility of a valid claim or defense," which the Relators in this case can demonstrate.

While the Government and other relators raised various arguments in opposition to the intervention motion, the court found that these arguments set forth issues which the court could not currently resolve. For example, it was argued that the Relators waived any rights they might have in the Global Settlement when they settled and executed a release in their earlier case. According to the court, the record shows that the Relators waived some of their rights, but the scope of those waivers could not be determined from the record. In addition, the court could not determine whether there was an issue with respect to the public disclosure bar at § 3730(e)(4). The court held that since it could not be determined as a matter of law that the Relators have no interest in a portion of the Global Settlement, the Relators therefore have a "significantly protectable" interest and should be allowed to intervene as of right.

Government Compromise of *Qui Tam* Judgment

U.S. ex rel. Smith v. Gilbert Realty Co. et al., 9 F.Supp.2d 800 (E.D. Mich. Aug. 10, 1998)

The Government was harshly criticized by a Michigan district court for failing to notify a

relator before it negotiated a significantly reduced compromise payment on an FCA judgment that the relator had obtained without assistance from the Government. Calling the Government's actions an "egregious oversight" that "perpetrated a gross injustice," the court ordered the Government to pay the entire compromise payment to the relator and her counsel.

In October 1992, June Smith filed a *qui tam* action which the Government declined to join. In February 1994, a final judgment was entered against the defendants in the amount of $54,140 which included $13,250 in attorneys' fees payable to the relator's attorneys, Legal Services of Eastern Michigan. The relator was awarded 30 percent of the $39,890 awarded damages, or $11,967. Without notifying the relator, the United States subsequently filed a Satisfaction of Judgment against one of the defendants. The other defendant was insolvent. According to the Government's filing, the entire judgment plus interest had been paid by compromise in the amount of $18,000. The United States offered the relator 30 percent of that amount or $5,400. Because the relator had not been notified and had not given consent for the compromise, the relator filed a motion asking the court to order the Government to pay the relator its 30 percent share of the original damages judgment plus $13,250 for the attorneys' fee award.

The Government argued that it committed "harmless error" by failing to notify the relator of the compromise. The court disagreed stating:

> This court finds that by settling the judgment without notice to either the relator or her counsel,the United States has perpetrated a gross injustice on them. It was an egregious oversight on behalf of the United States to settle the judgment in that fashion. The rights of the relator and her attorney have been severely violated.

Noting that the Government could not provide any excuse for its action, the court found that "the United States violated both the letter and spirit" of the FCA. First, the Government violated the express language of the Act which requires notice and a hearing on any relator objections to a settlement. Second, the Government violated the Act's requirement that leave of the court be obtained for a late intervention, and that intervention not limit the status and rights of the relator. And finally, the court concluded that the Government's actions violated the spirit of the FCA, stating:

> The relator, without any assistance from the government, obtained a judgment against the defendants. It would defeat the purpose of the Act if the government could undo that judgment by settling with one of the defendants. It would deter persons from pursuing such actions in the future.

As a conciliatory measure, the Government agreed to pay the $18,000 compromise settlement to the relator and her attorneys for them to divide as they saw fit. The court modified this approach by ordering that the Government instead pay the relator her full original share plus interest, or $14,119.41, with the remaining $3,880.59 to be paid to her attorneys. Noting that the payment to the attorneys, Legal Services of Eastern Michigan, was significantly less than the amount Legal Services is entitled to under the judgment, Legal Services argued that the Government should pay the difference as a sanction. The court deferred ruling on the sanction request to allow the relator to file a supplemental brief on the issue if she wished.

Settlement Proceeds/Relator's Share/Attorneys' Fees

U.S. ex rel. Thornton v. Science Applications International Corp. et al., Order, No. 3:94-CV-0749-T (N.D. Tex. Sept. 17, 1998)

Claims against the Government waived by the defendants as part of a *qui tam* settlement are "proceeds" of which the relator is entitled to a share under the FCA § 3730(d), ruled a Texas district court. The court then granted the relator between 20 and 25 percent of the total settlement proceeds, taking into account, inter alia, the hardships suffered by the relator. In addition, the relator's attorney's motion for fees and expenses was denied for lack of standing.

Peter Thornton's April 1994 *qui tam* action alleged that his former employer, Science Applications International Corporation (SAIC), and two subcontractors committed various FCA violations in connection with an Army Corps of Engineers contract for the installation of a security system at the Bureau of Engraving's Western Currency Production Facility in Fort Worth, Texas. In April 1995,the Government intervened, and in August 1997 the Government and defendants reached a settlement, which the court approved despite Thornton's objection.

The settlement included three components: (1) a $230,000 cash payment to the Government,(2) the defendants' waiver of certain claims against the Army Corps of Engineers, and (3) government access to the source code for the software provided by SAIC to the Government under a security system contract. The Government argued that the relator was entitled only to a share of the cash, whereas the relator argued that he was entitled to a share of all three settlement components. The district court thus had to determine what constitutes "proceeds" under FCA § 3730(d) (the relator's share provision).

Claims Released by Defendants Constitute Settlement "Proceeds"

Noting that the FCA does not define "proceeds," the court looked to the plain meaning of the word — citing the *Black's Law Dictionary* definition and Supreme Court precedent — and concluded that the claims released by the defendants were part of the settlement proceeds. Moreover, the court found this conclusion to be supported by the settlement agreement itself and certain representations the parties made to the court.

The court rejected the Government's argument that the released claims could not be considered part of the proceeds because of their unknown value. While the defendants represented that the value of the claims was $1.6 million, the Government dismissed this figure as only what the defendants were claiming against the Government and not necessarily the actual value of the claims. The court responded that, for reasons discussed below, it did not need to know the exact value of the claims to consider them part of the proceeds in this case.

Collateral Settlement Issue Incidental to *Qui Tam* Action Not Part of Proceeds

The court rejected Thornton's argument that the value of the software source code should also be considered part of the proceeds. According to the Government,the security system contract already called for SAIC to turn over the source code to the Government, and the source code provision in the settlement agreement was included only to avoid future confusion. The court thus concluded that the source code provision represented a "collateral issue" that was "only incidental to the *qui tam* action" and, as such, should not be included in determining the relator's share.

Court Grants Relator 20 to 25 Percent Share

Turning to the determination of the relator's share percentage within the 15 to 25 percent statutory range, the court noted that "the statute gives no guidance on the appropriate percentage other than it must relate to the person's contribution" and "there is little case law that exists to guide the Court in determining the appropriate percentage." Citing the "helpful information" provided by Thornton to the Government and the "great deal of time and effort" devoted by Thornton in investigating and documenting the alleged fraud, and emphasizing the "considerable personal and professional hardship" suffered by Thornton, the court concluded that he was entitled to between 20 and 25 percent of the proceeds.

Relator To Receive All Cash Government Received in Settlement

As for the actual dollar amount to be received by Thornton, the court was faced with the Government's contention that value of the defendants' abandoned claims was not necessarily $1.6 million (the Government did not suggest what the value was), and that the Government could not comply with a court order awarding the relator more than the amount of cash proceeds because Congress had not appropriated funds for that purpose. So, the court ruled that Thornton was entitled to the full $230,000 in cash that the Government received in the settlement. The court reasoned that, even if the released claims were in fact worth only half of what the defendants claimed (i.e., only $800,000), $230,000 represented a share of just over 22 percent of the proceeds.

Relator's Attorney Lacks Standing to Seek Fees Under FCA

The court denied the relator's attorney's motion for fees and expenses for lack of standing, ruling that the relator — not his attorney — has standing to seek attorneys' fees under the FCA. According to the court, the 9th Circuit in U.S. ex rel. Virani v. Jerry Lewis Truck Parts & Equip., Inc., 89 F.3d 574 (9th Cir. 1996), 7 TAF QR 12 (Oct.1996), was correct in stating: "[T]he attorney remains at the mercy of the client, who can either demand attorneys' fees from the defendant, or not, as he chooses. If the client chooses not to ask for the fees, the attorney has no standing to request them." Here, even though (as the court pointed out) it could have been to Thornton's benefit to request attorneys' fees given the terms of his fee agreement with his attorney, Thornton chose not to do so.

Section 3730(h) Retaliation Claims

U.S. ex rel. Yesudian v. Howard University et al., 153 F.3d 731 (D.C. Cir. Sept. 1, 1998)

Providing a substantial amount of analysis, the D.C. Circuit reversed a Rule 50 judgment as a matter of law against a plaintiff on his Section 3730(h) retaliation claim. Unlike the lower court, which had reversed a jury verdict for the plaintiff, the appellate court found that a reasonable jury could have concluded that the plaintiff had engaged in activity protected by § 3730(h) and that the defendant knew of that protected activity.

In May 1992, Howard University terminated Dr. Daniel Yesudian, who had worked at the University for over twenty years, the last nine in the Purchasing Department. From 1984 through 1992, Yesudian had repeatedly complained to upper-level University officials about various financial improprieties by the Purchasing Department and its director, Joseph Parker. Yesudian alleged, among other things, that Parker falsified time and attendance records,

accepted bribes from vendors, and permitted payments to vendors who did not in fact provide services to the University. Parker was fully aware of the charges Yesudian had made against him, and Parker's alleged retaliation culminated in Yesudian's termination.

A jury returned a verdict for Yesudian on his § 3730(h) retaliation claim against Parker, as well as his breach of contract claim against the University. (The jury found against Yesudian on his *qui tam* claim, as well as his retaliation claims against the University and various University officials other than Parker.) Overturning the jury, the district court granted Parker's Rule 50 motion for judgment as a matter of law, ruling that there was no evidence from which the jury could reasonably have found either that Yesudian engaged in protected conduct or that the defendant knew Yesudian was engaged in protected conduct — both required elements of a § 3730(h) claim.

Submission of False Claim to Grantee Only, and Not to Federal Government, Covered by FCA

The D.C. Circuit first addressed Parker's argument — which actually had not been relied upon by the district court — that Yesudian could not establish that he was engaged in protected conduct because a viable *qui tam* action requires that the alleged false claims be presented to the Federal Government and not merely to a grantee of federal funds (such as Howard University). Yesudian, on the other hand, argued that submission of false claims to a grantee alone is covered by the False Claims Act.

Although resolution of this issue was unnecessary to deciding the § 3730(h) issues on appeal (and, as it noted, Yesudian had not appealed the judgment against his *qui tam* claim), the D.C. Circuit carried out a somewhat in depth analysis that focused on the 1986 FCA Amendments' new definition of "claim" and relevant legislative history. Emphasizing that in this case the grantee university receives over 80 percent of its funding from the Federal Government, the court concluded that its analysis "suggests that a *qui tam* suit brought against defendant Parker for submitting a false claim to Howard University could prevail even without evidence that the claim was resubmitted to the federal government."

Section 3730(h) Plaintiff Need Not Have Winning *Qui Tam* Action

In any event, continued the court, the protected conduct element of § 3730(h) "does not require the plaintiff to have developed a winning *qui tam* action before he is retaliated against." Instead,"it is sufficient that a plaintiff be investigating matters that 'reasonably could lead' to a viable False Claims Act case." The court clarified that "an employee's investigation of nothing more than his employer's noncompliance with federal or state regulations" is not enough, but rather the § 3730(h) plaintiff's investigation "must concern 'false or fraudulent' claims." In this case, found that court, "[t]here was more than enough evidence for a reasonable juror to conclude that Yesudian was engaged in such an investigation."

The court pointed out that, even if resubmission of a false claim to the Government were required for an FCA action, given Yesudian's knowledge of the 80 percent federal funding figure at the time of the retaliation, it would have been reasonable to conclude that there was a "distinct possibility" he would ultimately find evidence of resubmission. According to the court, "[t]he fact that Yesudian may have failed to find such evidence in the end means only that — if such evidence were necessary to prove a [FCA] case — he ultimately would not be entitled to recover on his *qui tam* claim. . . . But there is no requirement that to be protected, a [§ 3730(h)] plaintiff must have gathered all of the evidence by the time of the retaliation."

Plaintiff Need Not Have Known About the FCA

Furthermore, stated the court, it was not necessary for Yesudian to have known that the investigation he was pursuing could lead to an FCA suit, for "[a]n initial investigation may well further an action under the Act, even though the employee does not know it at the time of the investigation." If the rule were otherwise, "only lawyers — or those versed in the law — would be protected by the statute."

Initiation of Government Investigation Not Required

The appellate court also rejected the lower court's contention that Yesudian's conduct was unprotected because he had not initiated a government investigation prior to being terminated. According to the court, nothing in the FCA suggests that communication with the Government, or anyone else outside of the employing institution, is required for § 3730(h) protection. To the contrary, it would not "be in the interest of law abiding employers for the statute to force employees to report their concerns outside the corporation in order to gain whistleblower protection."

In short, the D.C. Circuit concluded that a reasonable jury "could readily have found" that Yesudian had engaged in activity protected by § 3730(h). It then turned to the district court's ruling that there was no evidence to support that the defendant knew Yesudian was engaged in protected activity.

Defendant Was Put On Notice of Protected Activity, Unlike in Other Cases Cited

Explaining that "the kind of knowledge the defendant must have mirrors the kind of activity in which the plaintiff must be engaged," the appellate court rejected the lower court's contentions that a § 3730(h) plaintiff must have suggested to his employer that he was contemplating an FCA action or told or threatened his employer that he would report his allegations to the Government. According to the appellate court, "[m]erely grumbling to the employer about job dissatisfaction or regulatory violations does not satisfy the requirement — just as it does not constitute protected activity in the first place. Threatening to file a *qui tam* suit or to make a report to the government, on the other hand, clearly is one way to make an employer aware. But it is not the only way." Here, found the court, the steps taken by Yesudian were in fact sufficient for a reasonable jury to conclude that Parker was on notice that Yesudian was engaged in protected activity.

The court distinguished the case at hand from three in which § 3730(h) claims were dismissed — U.S. ex rel. Hopper v. Anton, 91 F.3d 1261 (9th Cir. 1996),7 TAF QR 8 (Oct. 1996), U.S. ex rel. Ramseyer v. Century Healthcare Corp., 90 F.3d 1514 (10th Cir. 1996), 7 TAF QR 1 (Oct. 1996), and Robertson v. Bell Helicopter Textron, Inc., 32 F.3d 948 (5th Cir. 1994). According to the court, in those other cases the plaintiffs had not made allegations of fraud (as opposed to, e.g., mere regulatory noncompliance) and/or their intracorporate complaints were indistinguishable from their regular job duties (e.g., as a contract administrator in the case of Robertson). Here, on the other hand, "the nature of Yesudian's charges could not have been mistaken for mere regulatory noncompliance," and "his investigation and complaints regarding falsification, bribery, and corruption could not have been mistaken for routine actions in accordance with his employment obligations."

Dissent Argues that Defendant Was Not Put On Sufficient Notice

A brief dissent to the two-judge majority opinion argued that, for an employer to have been

aware of the plaintiff's protected activity as required under § 3730(h), the plaintiff must "have put the employer on notice not only that he is investigating fraud but also that the fraud is against the federal government, so as to potentially support a *qui tam* suit or a direct suit by the government." Since Yesudian had not done so, the dissent concluded that the district court's Rule 50 judgment should have been affirmed.

Vessel v. DPS Associates of Charleston Incorporated et al., 148 F.3d 407 (4th Cir. July 8, 1998)

The coverage of Section 3730(h) does not extend to reach independent contractors, ruled the 4th Circuit. Accordingly, the appellate court upheld the lower court's dismissal of a landscaper's § 3730(h) claim against the real estate agency that had contracted with him because he was not an "employee" of the agency.

George Vessel's FCA action against Re/Max real estate agent Tom Gibbons, Re/Max real estate agency, and various other Re/Max agents involved the Government's Housing Assistance Program (HAP), under which the Army Corps of Engineers contracted with Re/Max to manage and market homes acquired by the Government from government employees who had been forced to sell because of military base closings. Vessel had discovered the alleged wrongdoing, and worked undercover for the FBI to expose it, while he was the owner and operator of a landscaping company that did work for Gibbons and Re/Max. After an FBI "sting" operation against Gibbons, Re/Max ceased giving Vessel work. Vessel subsequently gave up landscaping and became a private investigator.

The Government intervened in Vessel's *qui tam* suit and reached a settlement with the defendants. Vessel's related § 3730(h) claim went to trial, and the district court directed a verdict against Vessel, finding that he was not an "employee" of Re/Max and thus not covered under the plain language of § 3730(h), which begins, "Any employee who is discharged, demoted . . . ."

Independent Contractor is Not Employee and Thus Not Protected by § 3730(h)

On appeal, Vessel argued that § 3730(h) should not be read narrowly but instead to include protection of independent contractors. The 4th Circuit noted that the FCA does not define "employee," and other circuit courts have yet to address whether the FCA's protection of "employees" extends to independent contractors; however, all district courts addressing the question have held that it does not.

Applying common law agency principles to determine whether Vessel was an employee or independent contractor, the 4th Circuit found that Vessel indeed was not a Re/Max employee. Among other things, Vessel set his own schedule, owned his own tools, hired his own assistants, was not salaried, and did not receive employee benefits.

Turning to the statute's plain language — and stating that "[o]ther provisions of the False Claims Act, which permit anyone with knowledge of wrongdoing to bring a *qui tam* action . . . indicate that Congress was perfectly capable of extending the statute's coverage as broadly as it desired" — the court concluded that it must presume that Congress intended to limit § 3730(h) to employees. Moreover, according to the court, an examination of legislative history would not change this conclusion, and Vessel's public policy argument that an independent contractor should not lose its contract for exposing wrongdoing any more than an employee should, while "not wholly unpersuasive," could not override the statute's plain language.

U.S. ex rel. Ghaprial v. Quorum Health Resources, Inc. et al. (ED LA No. 97-1051)

In July 1998, a Louisiana district court denied the defendants' motion to dismiss Dr. Gameel Ghaprial's *qui tam* suit on constitutional and Rule 9(b) grounds. Explicitly disagreeing with the Texas court's ruling in U.S. ex rel. Riley v. St. Luke's Episcopal Hospital, 982 F. Supp. 1261 (S.D. Tex. 1997), 12 TAF QR 1 (Jan. 1998), the Louisiana court ruled that "the plaintiff/relator sues on behalf of and in the name of the government and invokes the standing of the government resulting from the fraud injury, and thus Article III's standing requirement is not violated." In addition, contrasting the case at hand with U.S. ex rel. Thompson v. Columbia/HCA Healthcare Corp. et al., 125 F.3d 899 (5th Cir. 1997), 12 TAF QR 5 (Jan.1998), the court found that Dr. Ghaprial had satisfied the Rule 9(b) particularity requirement.

U.S. ex rel. Weddington v. Scott and White Memorial Hospital et al. (WD TX Civil No. W-97-CA-208)

In July 1998, a Texas district court denied the defendants' motion to dismiss Ron Weddington's *qui tam* suit on constitutional grounds. In rejecting the defendant's argument that the *qui tam* provisions are unconstitutional, the court emphasized that the "sole authority" cited by the defendants was U.S. ex rel. Riley v. St. Luke's Episcopal Hospital, 982 F. Supp. 1261 (S.D. Tex. 1997),12 TAF QR 1 (Jan. 1998). Weddington's suit alleges the billing of unauthorized surgery and associated treatment costs to Medicare.

U.S. v. Krizek et al. (D DC No. Civ. A. 93-00054)

In July 1998, on remand from the D.C. Circuit's May 1997 decision, U.S. v. Krizek et al., 111 F.3d 934 (D.C. Cir. 1997), 10 QR 5 (July 1997), the D.C. district court found that the Government could prove only three False Claims Act violations, for which the defendant Dr. Krizek was liable in the amount of $10,000 each. U.S. v. Krizek et al., 7 F.Supp.2d 56 (D.D.C. July 15, 1998). Reversing the lower court's original finding of 11 violations, the appellate court had held that each false CPT code entry on a HCFA 1500 form did not constitute a separate false claim under the FCA, and that the parties should be permitted to present additional evidence regarding whether the defendants had submitted claims in excess of the 24-hour presumption set by the lower court. At the conclusion of its July decision — noting that when the case was originally filed in January 1993 the Government had sought $80 million in damages from Dr. Krizek, who is now retired, suffering from cancer, and "a broken man" — the district court stated: "The Government insists on pursuing a case that should long have been over. . . . While the Government's vigor in pursuing violators of the law is to be commended, there comes a point when a civilized society must say enough is enough. That point has been reached in this case."

U.S. v. Lippert (ED MO No. 97-2447)

In July 1998, the 8th Circuit affirmed a $352,823 district court judgment against defendant James Lippert for violation of the Anti-Kickback Act. U.S. v. Lippert, 148 F.3d 974 (8th Cir., July 2, 1998). The district court had granted summary judgment under both the Anti-Kickback Act and False Claims Act, offering the Government immediate judgment under the former for double the amount of the kickbacks, or $352,823, or under the latter for civil penalties totaling $50,000, but not both. (The court reasoned that recovery under both statutes would be duplicative.) The Government elected the former. On

appeal, Lippert — who had already served 18 months in prison and paid a $5,000 fine pursuant to a guilty plea to criminal violation of the Anti-Kickback Act (a plea which collaterally estopped him from contesting liability in the Government's subsequent civil action) — argued that the subsequent civil judgment violated his rights under the Double Jeopardy Clause and the Excessive Fines Clause. Relying on recent Supreme Court precedent applying the Double Jeopardy and the Excessive Fines Clauses to forfeitures and civil penalties, the 8th Circuit rejected Lippert's constitutional arguments.

GOVERNMENT PURSUES GROUNDBREAKING REHABILITATION HOSPITAL FRAUD CASE

In the Matter of Rel Gray, M.D.; Joe Mitchell Smith, M.D.; North Louisiana Rehabilitation Center, Inc.; Continental Medical Systems, Inc.; Horizon/CMS Healthcare Corporation; and Edward T. Stinson

By Sabrina A. Skeldon[1]
Assistant United States Attorney
Western District of Louisiana

A 1992 complaint made to Blue Cross and Blue Shield of Arkansas by a former rehabilitation patient started an HHS investigation of North Louisiana Rehabilitation Hospital ("NLRH" and/or the "Hospital"), a 90 bed rehabilitation facility located in Ruston, Louisiana. That investigation, which spanned several years, ultimately resulted in the felony mail fraud conviction of one of NLRH's doctors and a civil recovery of $4.46 million for Medicare Part A and Part B overbillings. Of that amount, $4,212,920 was paid by Horizon/CMS and $250,000 was paid by Joe Mitchell Smith, M.D., the Medical Director of NLRH, individually. Additionally, NLRH and Horizon/CMS were required by the HHS-OIG to enter into a three year Corporate Integrity Agreement.

The $4.46 million recovery is the largest healthcare fraud recovery in the state of Louisiana,and represents a groundbreaking development into fraud issues surrounding "medical necessity."

NLRH settled claims under the False Claims Act, 31 U.S.C. Section 3729, et seq., and under common law arising from its fraudulent practices which promoted inappropriate admissions and re-admissions of patients, and unduly delayed the discharge of patients. Additionally, the Hospital and its key personnel facilitated a fraudulent Medicare billing scheme of a physician employed by NLRH, Rel Gray, M.D., during 1989-1992. In order to facilitate and conceal the fraudulent scheme, the Hospital permitted the alteration of 600 closed files, after the fact, to reflect that Gray was a second attending physician, so as to protect his Medicare billings from the scrutiny of auditors.

1 The opinions expressed herein do not represent the position of the United States Department of Justice and are solely those of the author.

MEDICARE PART A OVERBILLINGS

Medicare Part A covered services include providers such as hospitals, and skilled nursing facilities. Under Section 1156 of the Social Security Act, 42 U.S.C. Section 1320c-5, healthcare providers governed by Medicare Part A must ensure that services are provided economically, and only to the extent they are medically necessary. 42 C.F.R. 413.30(a)(2). Pursuant to the HCFA Medicare Hospital Insurance Manual, Pub. 10, rehabilitative care on an inpatient basis is determined to be reasonable and necessary when a patient requires a more coordinated intensive program of multiple services than is ordinarily available in a hospital.

Under Medicare, 42 C.F.R. 412.23(b), the following criteria govern inpatient hospital stays for rehabilitative care:

- A patient's condition must require the 24 hour availability of a physician with special training or experience in the field of rehabilitation.

- The patient requires the 24 hour availability of a registered nurse with specialized training or experience in rehabilitation.

- An initial inpatient assessment requiring a 3-10 day hospitalization is available to determine a patient's potential for benefiting from an intensive coordinated rehabilitative program. Hospitalization after the initial assessment is authorized only if the rehabilitative team concludes that a significant practical improvement can be achieved by the patient in a reasonable amount of time.

- Once admitted to the rehabilitation hospital, the patient's records must reflect evidence of a coordinated program, i.e., documentation that periodic team conferences were held with regularity at least every two weeks to evaluate the patient's progress, or problems impeding progress, to consider resolutions to such problems, and to reassess the validity of the rehabilitative goals initially established.

- The threshold for establishing the need for inpatient hospital rehabilitative services is that the patient must require and receive at least 3 hours a day of physical and/or occupational therapy, in addition to any other required therapies or services. This requirement may vary depending on the individual patient's needs.

- Medicare reimbursement ceases when it is clear that the patient is unlikely to make further progress toward the established rehabilitation goal, or such progress can be achieved in a less intensive setting.

In evaluating whether the government overpaid NLRH in Medicare Part A charges during 1990-1992, the government employed a physiatrist and a statistician to analyze the

paid claims and construct a damage model. The experts drew a random statistical sampling of patient admissions and extrapolated an estimation of patient days that should be disallowed based upon the sample. In evaluating the admissions the physiatrist used the criteria set out in 42 C.F.R. Part 412. The HHS audit and random statistical sampling performed by the government's experts identified that NLRH engaged in fraudulent admissions practices in violation of Medicare Part A. Specifically, the audit found:

- The hospital had completely inadequate pre-admission evaluation practices in place during 1990-1992 to validate the rehabilitation potential of patients prior to the event leading to their hospitalization. The deficiencies in the pre-admission screening frequently led to the admission of: patients still requiring acute care; patients in poor physical condition; and/or patients who lacked cognitive functions. This resulted in the admission of patients who were unable to participate in physical or occupational therapy at the intensity level appropriate for such a facility. The physiatrist concluded that no pre-screening occurred in 30.2% of the patient admissions at NLRH during 1991-1992. By failing to properly screen cases, NLRH incurred unnecessary costs per case that should not have been reimbursed by Medicare.

- NLRH took patients for admission at very low functional levels, and often with little or no determination of the patient's ability to tolerate or benefit from intensive rehabilitation programs. This resulted overall in longer lengths of stay, as well as patients who failed to show significant improvement, resulting in inappropriate Medicare charges.

- Lengths of inpatient stays were inappropriately extended where no benefit was realized by the patient (i.e., instances where patients had already achieved functional levels; patients who refused to participate in therapy; patients who lacked the cognitive skills necessary to participate in an intensive rehabilitation program). Oftentimes NLRH attempted to medically manage patients with acute complications before finally transferring the patient to an acute care facility. The statistically valid random sample suggested that numerous patients should have been discharged after the initial 3-10 day inpatient hospitalization assessment as failed rehabilitation trials.

The findings of the government statistician reflected that 18.6% of the Medicare admissions to NLRH during 1991-1992 were appropriate, and that the percentage of patients who had at least one admission which should not have been made to NLRH was 22.5% during that same time frame. These percentages were arrived at by dividing the total number of inpatient days for Medicare patients by the number of disallowed days. The amount of overpayment due HHS for excessive Part A reimbursement was derived as follows: for each patient, the overpayment owed was found by multiplying the paid amount by the ratio of days disallowed by the government expert to the length of stay. The average amount owed per patient was obtained by averaging the owed amounts for each patient in the random sample. The paid amount was derived from what was historically paid per diem during 1991-1992. The results were extrapolated over the 1,078 patients in the data

base for NLRH's fiscal intermediary, Mutual of Omaha, for the years 1991-1992 by multiplying the average by 1,078, yielding the overpayment. Because the random statistical sampling was small in size, the rate of error was high; therefore, the calculated overpayment was adjusted downwards to take into account the possible standard deviation. Roughly $4 million of the amount recovered was attributable to Medicare Part A overpayments.

MEDICARE PART A FRAUD - VIOLATION OF THE 75% RULE

NLRH and other similar providers receive reimbursement from Medicare Part A based on expenses submitted on a cost report, Form HCFA 2550, subject to the Tax Equity and Fiscal Responsibility Act (TEFRA) limits. NLRH's cost reports are submitted annually to Mutual of Omaha. The intent of compensating the provider in this way is to encourage providers to operate in a more cost efficient manner.

Under Medicare guidelines, certain facilities such as psychiatric hospitals and rehabilitation facilities can qualify for exemption from the prospective payment system ("PPS") if they meet certain criteria. PPS exemption permits those facilities that often treat long term care patients to be reimbursed on a basis other than by DRG diagnosis code. 42 C.F.R. Section 413.40; HCFA Pub 15-1, Section 3001.2. Rehabilitation facilities that are PPS exempt are reimbursed based on their reasonable costs, subject to a rate of increase ceiling on inpatient operating costs. The ceiling is based on target amount per discharge. A rehabilitation hospital's target amount for a cost reporting period is equal to the hospital's allowable inpatient operating costs (excluding capital and medical education costs) per discharge for its base year, increased by applicable update factors. The base year for a PPS exempt hospital is the first twelve month reporting period that begins at least one year after the hospital accepts its first patient. HCFA Pub. 15-1, Section 300, et. seq.

To establish the PPS exempt hospital's first year target amount, its fiscal intermediary, in this instance Mutual of Omaha, determines the allowable inpatient operating costs per discharge for the hospital's base period. This amount is then updated by the applicable percentage increase (a statutory amount), yielding the hospital's per discharge target amount for the first cost reporting period. The target amount is then multiplied by the total number of Medicare discharges for the period to arrive at the "ceiling," which is the upper limit on net operating costs for that hospital during the cost reporting period. HCFA Pub. 15-1, Section 3002.[2]

[2] A PPS exempt hospital may request an adjustment to the payment allowed under the rate of increase ceiling, if the hospital's costs exceed the ceiling and there are differences in inpatient costs incurred during the cost reporting period in question that make comparison to the base year inappropriate. HCFA Pub. 15-1, Section 3004-1. Distortions in inpatient operating costs resulting in noncomparability of the cost reporting periods are generally the result of one of two things: (i) an increase in the average length of stay of Medicare patients; and/or (ii) changes in the volume and/or intensity of direct patient care services. Since the rate of increase ceiling is based on an average cost per discharge, the impact of the increase in the average length of stay of Medicare patients is measured by converting the target amount from a per discharge limit to a limit based on a per diem rate. HCFA Pub. 15-1, Section 3004-1.

The TEFRA cost reimbursement system can be subject to fraud when Part A providers, in this instance NLRH, permit unnecessary admissions and/or unnecessarily increase the length of stay of their patients. Under Medicare guidelines, a rehabilitation facility can only qualify for exemption from PPS if 75% of its admissions/discharges for a twelve month cost reporting period fall within ten (10) diagnostic categories identified in 42 C.F.R. Section 412.23(2) for rehabilitation hospitals and/or units. If it is found that in a given twelve month cost reporting period, a hospital miscoded the principal diagnosis of its patients to permit it to come within the 75% rule, when in fact its actual patient population was composed of only 67% of patients whose principal diagnosis came within the ten (10) diagnosis categories, that hospital would no longer be PPS exempt. The effect of a judicial determination that a hospital is not PPS exempt would cause its Medicare billings to be reimbursed on a DRG basis, not a TEFRA cost basis. NLRH was facing a challenge from the government on this issue. Such an adjustment to its reimbursement system would have required NLRH to disgorge the difference between the billing systems as an overpayment to the government. An analysis of the patient charts reflected a trend that the principal diagnosis for which the patients were treated was not the same diagnosis code for which the hospital documented the services rendered to the Medicare beneficiary. Numerous instances were noted where the treatment administered to the patient at NLRH would not meet the criterion for the 75% rule for rehabilitation facilities. For example, one patient, an 84 year old woman, was admitted from a nursing home where she had lived for approximately one year prior to her admission to NLRH. The principal diagnosis for the patient was stroke, however the primary focus of her treatment was for wound care of a right leg ulcer. No functional progress was made by the patient during her stay at NLRH, though the leg ulcer did decrease in size. Had her principal diagnosis been noted as "leg ulcer," the diagnosis would have fallen outside the 75% rule of Medicare guidelines and the admission itself may have even been questioned, as wound care can be managed in less intensive settings. The pattern of treating patients under the non-rehabilitative diagnosis (i.e., a diagnosis not covered by 42 C.F.R. Section 412.23(2)), while submitting claims under one of the 10 diagnoses recognized by 42 C.F.R.412.23(2), permitted the hospital to conceal any problem it had in maintaining its patient population at the 75% rule level,and permitted it to maintain its reimbursement as a PPS exempt provider. This issue was one of the claims settled in the NLRH matter, and one of considerable concern to the provider.[3]

MEDICARE PART B OVERBILLINGS

From December 21, 1989 through April 1992, Dr. Rel Gray, a physician on staff at NLRH, engaged in a pattern and practice of submitting claims for reimbursement to Blue Cross for medical services which were not medically necessary, were not performed or were otherwise not reimbursable under the Medicare Program. Between December 1989 through April 1992, Gray served as Program Director for NLRH. Additionally, as of

3 The arguments put forth by the government in this case were highly original. This would have been a case of first impression.

December 1, 1989, NLRH and Gray entered into a Medical Coverage Agreement, whereby Gray was hired to provide general medical consultation coverage on patients admitted to the hospital. Under the terms of the Medical Coverage Agreement, Gray was to perform a complete history and physical on all unassigned patients within 24 hours of admission. Additionally, Gray was to provide backup coverage for attending physicians who were unavailable. Gray was responsible for his own Medicare billings and for collecting from patients, patients' insurers, and other third-party payors. The majority of Gray's reimbursements for services rendered at NLRH came from Medicare.

Beginning in December 1989, and continuing until approximately September 1990, Gray contacted or attempted to contact each and every resident patient at NLRH for the purpose of establishing a basis for submitting fraudulent claims to Medicare through Blue Cross. Few formal requests for consultation were made. Gray initiated the patient visits on his own. Even when consultations were requested, few complete histories and physical examinations were ever performed. Gray knowingly provided fraudulent billing information,including improper and inaccurate Medicare billing codes,and lists of patients allegedly examined to his office billing staff with instructions that the claims be forwarded to Blue Cross for services rendered by Gray to Medicare patients at NLRH. Summaries of the total amount billed by Gray to Medicare reflected that during the years 1990-1991 it was not uncommon for Gray to see and bill for treating between 30-50 patients during the four hours a day he spent at NLRH. The NLRH nursing staff independently corroborated that Gray did not render services for the amounts billed to the Medicare patients. NLRH was not ignorant of Gray's attempt to expand his role from consultant to second attending physician. In a Memorandum for the Utilization Coordinator of NLRH to the Medical Records Director, the hospital was monitoring the pattern and number of patients seen by Gray. Commencing in May 1990, the hospital began actively assisting Gray in arriving at an informal arrangement and then a formal arrangement whereby Gray could expand his role from consultant to attending physician. The government created a spreadsheet of 150 patients admitted to NLRH between 1990 and1992 which identified the variety of ways Gray was fraudulently documented in patient files. The spreadsheet reflected that in some instances,the attestation of the file was altered to change Gray from being documented as a consultant to a medical attending physician. In other instances, NLRH staff after the fact altered the patient medical record cover sheet to reflect that Gray was a medical attending physician. Finally, in some instances a special "medical management" form created by the hospital's Executive Committee to accommodate Gray was used that reflected that Gray was a second attending physician. All of these methods of falsifying Gray's status, and permitting him to bill Medicare as an attending physician, violate Medicare criteria. For Gray to have been reimbursed as a consultant, the only capacity in which he was employed by the hospital, Gray would have had to meet the following criteria:

- A written consult order had to be prepared and approved in advance of the consultation.
- The written consult order was required to be specific as to the nature of the problem

the consultant was to address, and authorized by the treating physician.
- The consultant was required to prepare a written report of his findings and conclusions upon completing his evaluation of the patient.
- The consultant was not authorized to bill Medicare for consultations more frequent than every 60 days, without a showing of medical necessity.

The summary reflected the following violations of Medicare regulations:

- Consult orders were seldom written, or were backdated.
- The consult orders consisted of a request to "follow the patient." There were no specific orders which identified the specific problems Gray was to address.
- Written consult reports were seldom, if ever, submitted to the treating physicians. The consultations were more frequent than every 60 days, without any showing of medical necessity.

Under Medicare guidelines, the spreadsheet amply supported that Gray's billings as a consultant were not reimbursable under Medicare. Additionally, under Medicare regulations and guidelines, Dr. Gray was only authorized to visit patients as a second attending physician if the chart clearly demonstrated medical necessity, and/or the patient's problems were ones that required a specialist.[4] The frequency with which Gray visited patients, together with his failure to document the medical necessity of the visit, subjected his billings to the scrutiny of auditors.

As a result of a complaint made to the Medicare Integrity Unit by the husband of a former NLRH patient relating to overbillings by Dr. Gray, HHS-OIG began a criminal investigation. In late 1995, Rel Gray was indicted on nine counts of mail fraud. In April 1996, Gray entered into a plea agreement whereby he pleaded guilty to one felony count of mail fraud.

Blue Cross audited the Medicare Part B billings of Rel Gray, M.D. at NLRH during 1990-1992, and computed that the government was owed by Rel Gray $222,543 as an overpayment for non-rendered services, and $187,654 for services that were not medically necessary. The total allowed billings paid by Blue Cross and Blue Shield to Gray during 1990-1992 was $826,584. The total overpayment calculated by the auditor totaled $410,197, representing one-half of Gray's total billings.

4 The status of second attending physician was allowed under Gray's medical management contract in only limited circumstances: as backup coverage on weekends, when Gray was on call, or the treating physician was on vacation. None of these circumstances occurred with enough frequency to justify the pattern of billing uncovered by the government. Moreover, Dr. Gray's only area of specialization was in pediatrics,hardly useful in the care of patients in need of rehabilitation or physical therapy.

ALLEGATION: UPCODING NURSING HOME SERVICES, UNPERFORMED SERVICES,AND INADEQUATE CARE

U.S. ex rel. Martin v. The Deaconess Associations, Inc., Deaconess Hospital of Cincinnati et al. (SD OH No. C-1-96-1164)

In June 1998, a *qui tam* suit was unsealed alleging that Deaconess Hospital and affiliated entities and physicians defrauded Medicare and Medicaid. Allegations center on upcoding "gang visits" of nursing home residents, a practice involving quick checks on large numbers of patients in a single day. The suit also alleges billing for services not performed and inadequate patient care. According to the complaint, the defendants falsified medical records and charged for procedures not personally performed by the billing physicians. Nurses allegedly routinely signed physician names to records as well as adjusted medication doses, including controlled substances, without prior physician orders. The suit was brought by Mary Martin, a geriatric nurse who formerly worked for defendant Extend Care Physician Services, Inc. DOJ declined to intervene in the action. The relator is represented by Phyllis Brown of Copeland & Brown Co., L.P.A. (Cincinnati, OH).

ALLEGATION: UNNECESSARY PSYCHOLOGICAL TESTING OF NURSING HOME RESIDENTS

U.S. v. Donaldson and Kaplan et al. (ND IL No. 98C3881)

In June 1998, DOJ announced that it filed a False Claims Act suit against James Donaldson and Joel Kaplan alleging false Medicare claims for psychological testing of unresponsive and comatose nursing home residents in Chicago. According to the suit, approximately 375 fraudulent claims were filed involving more than 200 residents. In connection with the unnecessary tests, a federal grand jury has also returned an eight count indictment against Donaldson and Kaplan.

According to DOJ, Donaldson was the executive director of Olivet Comprehensive Human Services, and Kaplan served as clinical director. Wedgewood Nursing Pavilion, Ltd. retained Olivet to perform psychological testing and evaluations of its residents. However, because the residents tested were severely cognitively impaired, the defendants knew that the tests were not medically necessary, and it took substantially less than the stated billable time to perform and document the tests. As part of the scheme, the defendants allegedly obtained information about the Medicare status of patients and did not consult with attending physicians or psychiatrists regarding medical necessity. The defendants further employed non-licensed testers and instructed them to conduct a second test six months later even though the residents' conditions had not changed. The matter was investigated by the HHS OIG and FBI. Handling the case are Assistant U.S. Attorneys Brenda Atkinson and Joseph Ferguson.

ALLEGATION: SOCIAL SECURITY FRAUD

U.S. v. Chiavaroli (D MA No. __)

In June 1998, DOJ announced that it filed a False Claims Act suit against Susan Chiavaroli, the administratrix of the estate of Richard Armstrong, alleging Social Security fraud. According to the lawsuit, Armstrong concealed his financial resources when he filed an application in 1993 for Supplemental Security Income benefits. (In order to be eligible for SSI benefits, an applicant must be disabled and his monthly income and other financial resources cannot exceed a specific amount.) In subsequent Social Security forms for determining continuing eligibility, Armstrong again alleged-

ly claimed that he did not own any promissory notes when that was not the case. The investigation was conducted by the Social Security Administration OIG. Handling the matter is Assistant U.S. Attorney George Henderson, II.

ALLEGATION: FRAUDULENT COST PRICING PROPOSALS

U.S. ex rel. Campbell v. Brown and Root Services Corporation (ED CA No. CIV-97-1541WBSPAN)

In July 1998, a *qui tam* suit was reportedly unsealed alleging that the construction firm Brown and Root Services Corp. submitted inflated bills to the Army Corps of Engineers for maintenance and repair of military buildings at the Presidio of Monterey and Presidio of Monterey Annex in California. The suit was filed in August 1997 by former Brown & Root project manager Dammen Grant Campbell. DOJ has declined to intervene.

According to the complaint, Brown and Root entered into an agreement with the Army Corps of Engineers and the Presidio Public Works Department whereby Brown and Root was permitted to perform site inspections,normally conducted by the Corps of Engineers, to determine the work to be performed at the sites. The complaint alleges that through the course of its inspections, Brown and Root developed a scheme which enabled it to determine the exact dollar amount budgeted by the Army for particular projects and then inflate its contract cost pricing proposals to match that amount, even when it would ordinarily not cost the company that much to complete the work. Brown and Root allegedly included the costs of unnecessary work in its cost pricing in order to inflate its proposals. The relator is represented by Daniel Schrader of Fischer, Norris & Schrader (Monterey, CA).

ALLEGATION: DEFECTIVE MISSILE SERVICE TRAILERS

U.S. ex rel. Klump v. Ellis & Watts Co. (SD OH No. __)

In July 1998, it was reported that DOJ intervened in a *qui tam* suit alleging that Ellis & Watts Co., a Batavia, Ohio military contractor, supplied defective trailers to the Navy and Air Force. The lawsuit alleges that Ellis & Watts did not meet contract and testing requirements on trailers used to service Minuteman missile warheads and carry electronic equipment. The company provided the Air Force with 33 of the trailers, which contain an octagonal hatch that opens when the trailer is positioned over a Minuteman missile silo, allowing work on warheads. Alleged problems include bent hinges and poor seals on doors, roof leaks, electrical wiring defects, unlabeled wiring, and corroded security systems. The suit further alleges that the company refitted an old trailer shell from its scrap yard and sold it to the Navy as new. The company reportedly tried to cover up the problems by submitting falsified documents to the Government. The *qui tam* suit, filed in 1995, was brought by former Ellis & Watts employee Michael Klump, a sheet metal worker. The Government reportedly spent more than $13.3 million for the trailers and an additional $2.2 million to repair the trailers so they would meet contract specifications.

ALLEGATION: NEGLECT OF NURSING HOME RESIDENTS

U.S. ex rel. McKenzie and Swan v. Crestwood Hospitals, Inc. et al. (ED CA No. __)

In July 1998, a *qui tam* suit was unsealed alleging that ten California nursing homes owned by Crestwood Hospitals, Inc. violated the False Claims Act by neglecting nursing home residents, falsifying patient records in order to

conceal their noncompliance with federal laws and regulations, and submitting bills to Medicare and Medicaid knowing that they failed to satisfy federally-mandated conditions for participation. Also named in the suit were several companies hired by Crestwood to manage the nursing homes. According to the complaint, the nursing homes refused to provide individualized care plans for residents, to properly care for residents' personal hygiene, to provide adequate water, to provide proper wound care, to appropriately medicate residents, or to provide a safe environment, all in violation of federal law. In addition, the suit alleges that the nursing homes falsified patient records and falsified documentation provided to the Government in order to conceal its violations of the law and maintain certification to participate in federally funded health care programs. DOJ has declined to intervene in this *qui tam* action, which was filed by Marilou McKenzie and Ila Swan. Representing the relators is Von Packard of Packard, Packard & Johnson (Palo Alto, CA).

ALLEGATION: FRAUDULENT USE OF NONPROFIT MAILING RATE

U.S. ex rel. Relator v. Vantage Travel Service, Inc. et al. (D MA No. __)

In July 1998, DOJ intervened in a *qui tam* suit alleging that Vantage Travel Service, Inc. of Brookline, Massachusetts and its chief executive officer Henry R. Lewis defrauded the U.S. Postal Service by fraudulently using nonprofit mailing privileges. Vantage, a for profit company, ran fundraisers by mail for its nonprofit clients. According to DOJ, Vantage entered into joint venture agreements, also known as cooperative mailings, with its nonprofit clients through which it shared the risks and benefits of the mail programs it ran. Under federal law, only nonprofit organizations or their agents are allowed to mail at the nonprofit postage rate, about half the standard bulk rate, and nonprofits may not mail at the nonprofit rate if the mailing is part of a cooperative mailing whereby the benefits and risks are shared with a for profit company. DOJ alleges that Vantage was notified in 1990 that the mailings it conducted on behalf of its nonprofit clients were cooperative and did not satisfy the requirements for the nonprofit rate. Vantage allegedly revised its contracts and certified to the Government that the mailings were not cooperative, but later amended its contracts by means of secret side agreements with its clients. These secret agreements retermed the mailings as cooperative and Vantage continued to improperly use the nonprofit rate while certifying otherwise to the Government. The Government alleges that Vantage defrauded the Postal Service out of approximately $1.4 million. The matter was investigated by the U.S. Postal Inspection Service. The Government is being represented by Assistant U.S. Attorney John Capin.

ALLEGATION: DEFECTIVE NAVY WEAPONS SYSTEMS

U.S. ex rel. Shukla v. United Defense et al. (D MN No. __)

In July 1998, a *qui tam* suit was unsealed alleging that United Defense falsified testing of parts and components in weapons systems it sold to the Navy. Also named in the suit are FMC Corp., Harsco Corp., and the Carlyle Group, which bought United Defense in 1997. United Defense allegedly incorrectly performed or did not perform quality assurance tests and inspections, but certified to the Government that the tests had been done properly. In addition, the suit alleges that parts and components manufactured by the company were substandard, deficient, or not in com-

pliance with contract specifications. The lawsuit was filed by Har Shukla , a quality engineer at United Defense's Fridley, Minnesota facility. DOJ has declined to intervene in the matter. The relator is being represented by Dale Nathan of Nathan & Associates (Eagan, MN) and Mike McCarthy of Maslon Edelman Borman & Brand, LLP (Minneapolis, MN).

ALLEGATION: BILLING FOR UNNECESSARY ONCOLOGY SERVICES/BILLING FOR ONCOLOGY SERVICES NEVER PERFORMED

U.S. ex rel. Rahman v. Oncology Associates, P.C. et al. (D MD No. Y-95-2241)

In August 1998, DOJ intervened in a *qui tam* suit alleging that more than 80 businesses owned or controlled by Douglas Colkitt, M.D., including cancer clinics, medical billing companies, and equipment and real estate leasing companies, submitted or conspired to submit false claims to Medicare and CHAMPUS for radiation oncology services. The suit was filed in 1995 by Syed Rahman, M.D., a former radiation oncologist at one of Colkitt's cancer centers. The suit alleges that Colkitt's companies submitted claims for services not rendered or for medically unnecessary services, billed for a higher level of services than actually performed, and double billed for services. Colkitt's companies allegedly followed "standing orders" and billing practices made applicable to all the cancer centers which directed the clinics to bill Medicare and CHAMPUS regardless of the services rendered or their medical necessity. Among the many allegations included in the complaint are that the clinics billed for multiple treatment plans when only one treatment plan was prepared by the treating physician, billed for physics consults which were never performed, billed for excessive physics consultations, and double billed for basic dosimetry calculations. The HHS OIG and DCIS investigated the matter. Representing the Government are Assistant U.S. Attorney Kathleen McDermott and Polly Dammann and Marlene Gibbons of the DOJ Civil Division.

ALLEGATION: NONCONFORMING PARTS SUPPLIED TO MILITARY AIRCRAFT

U.S. ex rel. Lundgren and VanVoorhis v. Lucas Western Inc. (D UT No. __)

In August 1998, a *qui tam* suit was reportedly unsealed alleging that former defense contractor Lucas Western Inc. installed nonconforming parts in military aircraft at its Park City, Utah plant. The lawsuit alleges that Lucas Western falsified testing documents and certifications of the gearboxes that transfer power from the engine to other critical flight components in the military aircraft. The suit was filed in 1996 by Glayde Lundgren, a former Park City plant machinist and assembly test liaison responsible for verifying certifications and inspections of new production gearboxes, and Alan VanVoorhis, formerly in charge of supplying parts to refurbish components and gearboxes at Park City. DOJ has declined to intervene in the suit.

ALLEGATION: FALSE PRESCRIPTION DRUG CLAIMS

U.S. ex rel. Mueller v. Walgreen Corporation (MD FL No. 96-84-CIV-T-23E)

In August 1998, a *qui tam* suit was unsealed alleging that Walgreens drugstores, owned by the Walgreens Corporation, billed Medicaid at full price for prescriptions provided to Medicaid beneficiaries that were only partially filled. According to the complaint, when a Walgreens pharmacy would get low on its prescription

inventory, it would give customers what it had in stock and then ask them to come back for the rest. Even when Medicaid program beneficiaries did not come back, the store allegedly billed Medicaid for the full amount and then resold the remaining medication, retaining the excess profit. Walgreens had no system in place to refund the prescription overpayments to the Medicaid program. The suit was filed in 1996 by pharmacist Louis Mueller. In February 1998, DOJ and the State of Florida intervened in a another *qui tam* suit filed by Mr. Mueller alleging a similar scheme by the Eckerd Drugstore chain. The relator is being represented by Gary Takacs of James, Hoyer, Newcomer, Forizs, Smiljanich, P.A. (Tampa, FL).

ALLEGATION: SUBSTANDARD LIVING CONDITIONS IN HUD SECTION 8 HOUSING

U.S. v. Hardaway Management Co., Inc. et al. (SD MS No. 1:98cv351ER)

U.S. v. Intervest Corporation et al. (SD MS No. 3:98cv531BN)

U.S. v. Southland Management Corporation et al. (SD MS No. 3:98cv530LW)

In August 1998, DOJ, in conjunction with the U.S. Department of Housing and Urban Development, filed three False Claims Act suits seeking a total of $15 million in damages and penalties against private owners of three apartment complexes that receive rental assistance subsidies from HUD. The suits allege that the owners, who receive assistance under HUD's Section 8 rental assistance subsidy program, falsely certified to HUD that their apartment complexes provided tenants the safe, decent, and sanitary living conditions required by federal law. The law requires that Section 8 housing be free from roach or rat infestations and have adequate cooling and heating facilities, a firm roof structure, adequate physical security, smoke detectors, safe walkways, and other basic housing needs. The three apartment complexes named in the lawsuits are the Metro Manor Apartments and Jackson Apartments in Jackson, Mississippi, and the Americana Apartments in Gulfport, Mississippi.

According to the complaints, the apartment owners and their management companies knew from inspection documentation and information that their apartment units did not meet HUD's minimum housing standards. However, they certified monthly to HUD that the apartment complexes met legal housing quality standards so that they could continue to receive Section 8 benefits. Private sector owners of Section 8 HUD-subsidized properties receive financial benefits through HUD rental payments, HUD mortgage insurance and the resulting mortgage interest savings, HUD grants, HUD tenant referrals, income tax benefits, transaction fees, and management fees. Representing the Government in this matter are U.S. Attorney Brad Pigott and Assistant U.S. Attorney John Meynardie.

ALLEGATION: FRAUDULENT ENDORSEMENT OF DIET DRUGS

U.S. ex rel. Trevena v. Wyeth-Ayerst Laboratories et al. (MD FL No. __)

In August 1998, it was reported that a *qui tam* suit was unsealed alleging that Wyeth-Ayerst Laboratories, a Philadelphia-based manufacturer of the diet drugs dexfenfluramine and fenfluramine, defrauded the Government by secretly paying a nutritionist to testify favorably for its diet drugs before a Food and Drug Administration advisory board. The drugs are

part of the now banned combination of diet drugs popularly known as fen-phen. The suit alleges that Medicare and Medicaid will possibly incur billions of dollars in medical costs from people who get ill from taking the drugs. Dexfenfluramine and fenfluramine have been found to cause illnesses such as heart valve problems. According to the lawsuit, Wyeth-Ayerst paid nutritionist Judith S. Stern to help it circumvent FDA rules which would have prevented it from marketing fenfluramine in combination with phentermine to form fen-phen. The nutritionist reportedly did not reveal to the FDA that she was being paid by Wyeth-Ayerst. The suit was filed by Advantage Weight Control, Inc. founder John Trevena, whose company physicians prescribed fen-phen. DOJ has declined to intervene.

ALLEGATION: NEGLECT OF NURSING HOME RESIDENTS

U.S. v. Greenbelt Nursing & Rehabilitation Center (D MD No. __)

In September 1998, DOJ intervened in a *qui tam* suit alleging that the Greenbelt Nursing and Rehabilitation Center, a long-term care facility, falsely certified compliance with federal laws regarding nursing home standards of care in order to continue participating in state and federally funded health care programs. According to the complaint, the Maryland Licensing and Certification Administration, the state agency responsible for ensuring that long term care nursing home facilities meet federal and state program participation requirements, and HCFA found continuing, systemic substandard care in the course of several administrative investigations of the nursing home. The quality of care deficiencies alleged include failure of medical staff to intervene in the changing medical condition of residents, failure to notify physicians of timely medical issues, failure of the physicians or the facility Medical Director to respond to nursing staff requests for physician and other medical assistance, failure to administer and monitor medications properly, failure to assess nutritional needs of residents, and failure to provide appropriate wound care.

According to DOJ, the Government has reached a consent preliminary injunction with Greenbelt, subject to approval by the U.S. District Court, which provides protection for the nursing home residents beyond the minimum legal requirements. The terms of the injunction require the appointment of a temporary manager, the appointment of an independent monitor, and the hiring of a certified nurse practitioner. The Government's investigation of Greenbelt is ongoing and is being conducted by the HHS OIG and the FBI, with assistance from the MDLC. Representing the Government are Assistant U.S. Attorneys Kathleen McDermott and Perry Sekus.

ALLEGATION: DURABLE MEDICAL EQUIPMENT SUPPLIER FRAUD

U.S. ex rel. Flewelling v. Goldstar Healthcare Inc. (MD FL No. 97-2005-CIV-T-17E)

In September 1998, it was reported that DOJ and the State of Florida intervened in a *qui tam* suit alleging that 25 durable medical equipment companies paid kickbacks to medical personnel and committed numerous other instances of Medicare and Medicaid fraud. In addition to paying kickbacks to medical and other personnel in exchange for their cooperation, the companies reportedly failed to deliver purchased durable medical equipment, billed Medicare and Medicaid for higher priced items than delivered, failed to make legitimate attempts to collect the

20 percent Medicare copayment for the equipment, used "shell" companies to disguise the DME companies' true control and ownership, altered certificates of medical necessity signed by physicians, forged doctors' signatures,used maildrops as operating business locations, used multiple bank accounts to launder proceeds, and sold Medicare beneficiary claims numbers for later submission to federally funded health care programs. The durable medical equipment included electric scooters, powerlift seats, pressure mattresses, and hospital beds. The scheme allegedly was carried out by means of door to door sales in low income and elderly neighborhoods throughout Florida. The suit was filed by Gary Flewelling, a former sales representative for Goldstar Medical Services, Inc., a durable medical equipment company. The Government has allegedly been defrauded out of $7.3 million. The Government is being represented by Assistant U.S. Attorney Jay Trezevant.

ALLEGATION: FALSE BILLING FOR LABORATORY TESTS

U.S. v. Medical Pathology Laboratory Ltd. et al. (SD MS No. 3:98CV578)

In September 1998, it was reported that DOJ has filed a False Claims Act suit against Medical Pathology Laboratory Ltd. of Meridian, Mississippi alleging that over a ten year period the clinical laboratory double billed Medicare for thousands of lab tests and submitted thousands of fraudulent claims to Medicare for lab tests that were not performed. The allegations involve cultures done on tissue and fluid samples to determine whether bacteria were present. According to the lawsuit, the laboratory billed Medicare for 5,000 positive cultures when the cultures were negative and no tests had been run, and billed Medicare twice for the same culture under two different billing codes as many as 10,000 times. Representing the Government is Assistant U.S. Attorney Cliff Johnson.

ALLEGATION: BANNED CHEMICALS IN PAINT SOLD TO GOVERNMENT

U.S. ex rel. Tipton v. Niles Chemical Paint Company (D WA No. __)

In September 1998, it was reported that a *qui tam* suit was unsealed alleging that the Niles Chemical Paint Company of Niles, Michigan manufactured and sold to the U.S. Forest Service paint it knew to contain chemicals banned by the U.S. Government. The paint reportedly contained the banned chemical toluene, a solvent which is alleged to cause reproductive toxicity and other health problems. The suit alleges that the paint company falsely certified to the Government that its paint was toluene free, thereby fraudulently inducing the U.S. Forest Service to buy large quantities of it. The paint was used in National Forests throughout the Pacific Northwest, the Lake Tahoe basin, the Southeast, and elsewhere to designate the trees picked by the U.S. Forest Service for logging. The suit was filed by Carla Tipton, who works at the Wallowa and Whitman national forests in Oregon.

U.S. ex rel. Geldart v. Frequency Electronics, Inc. et al. (ED NY 93-CV-4750)

U.S. v. Frequency Electronics, Inc. et al. (ED NY 93-CV-5200)

In June 1998, Frequency Electronics, Inc. (FEI) agreed to pay the Government $5 million to settle a *qui tam* suit alleging that it used false cost data in connection with various defense contracts. FEI is a supplier of time and frequency control products for the military and aerospace markets. According to the suit, filed in 1993 by former company employee Howard Geldart, FEI inflated manufacturing costs and received improper payments on the AMRAAM air-to-air missile program. According to DOJ, the company has also agreed to pay the Government $1.5 million to settle a False Claims Act suit alleging inflated costs associated with terminated "Fox contracts" for space satellites. On the criminal side, FEI has pleaded guilty to falsifying costs, paid a fine of $400,000, and reimbursed the Government $1.1 million for the costs of its investigation. Investigating the cases were the FBI, DCIS, DCAA, NCIS, and the Air Force Office of Special Investigations. The relator's share was 17 percent or $850,000. The relator's counsel was Guy Heinemann (New York, NY). The Government was represented by Assistant U.S. Attorneys Michael Cornacchia and Charles Kleinberg.

U.S. ex rel. Heyrman v. Fulton DeKalb Hospital Authority d/b/a Grady Memorial Hospital (ND GA No. __)

In July 1998, DOJ announced that Grady Memorial Hospital in Atlanta agreed to pay the Government $4.3 million to settle a *qui tam* suit alleging that the hospital submitted false prescription claims for Medicaid patients between 1984 and 1994. The suit was filed in 1996 by Craig Heyrman, a former pharmacy reimbursement manager at the hospital. According to the suit, Grady improperly charged two fees for Medicaid prescriptions — its "usual and customary" dispensing fee and the statutory Medicaid dispensing fee. The case was investigated by the HHS OIG, FBI, and Georgia Department of Medical Assistance. The relator's share was $778,855. The relator was represented by Matthew Billups (Atlanta, GA).

U.S. ex rel. Knoob v. Health Care Service Corporation (SD IL No. 95-4071-JLF)

In July 1998, Health Care Service Corporation (HCSC), the Medicare contractor for Illinois and Michigan, agreed to pay the Government $140 million to settle a *qui tam* suit alleging that it shredded claims and otherwise concealed evidence of poor performance in processing Medicare claims. The lawsuit was filed in 1995 by former HCSC supervisor Evelyn Knoob. According to the suit, HCSC had for years altered documents, failed to process claims in accordance with HCFA guidelines, and not handled beneficiary and physician inquiries in a timely manner. In connection with its misconduct, HCSC has pleaded guilty to eight felony counts and agreed to pay $4 million in criminal fines while admitting to obstructing federal auditors. Prior to this plea, two HCSC managers pleaded guilty, and five others were indicted.

Also known as Blue Cross Blue Shield of Illinois, HCSC is one of the nation's largest Medicare carriers. According to DOJ, the contractor manipulated work samples, falsified reports used by HCFA to evaluate how well HCSC was performing its duties, and falsely claimed superior performance. As part of the

settlement, HCSC has agreed to enter into a corporate integrity agreement with the HHS OIG and HCFA. The case was investigated by the FBI, HHS OIG, and Postal Inspection Service. The relator's share at the time of settlement was 15 percent or $21 million, with any additional award to be determined through non-binding mediation before a federal magistrate. The relator was represented by Ronald Osman and Timothy Keller of Ronald E. Osman and Associates, Ltd. (Marion, IL). Representing the Government were U.S. Attorney W. Charles Grace, Assistant U.S. Attorney Laura Jones, and Patricia Hanower and Stephanie Jackson of the DOJ Civil Division. Handling the criminal matter were U.S. Attorney Grace, Assistant U.S. Attorneys Thomas Daly, Michael Quinley, and the late Robert Coleman, and Michael Ruggio of the DOJ Criminal Division.

U.S. ex rel. Thistlethwaite v. Dowty Woodville Polymer Limited et al. (SD NY 94 Civ. 3521)

In July 1998, DOJ announced that British aerospace manufacturer Dowty Woodville Polymer Limited agreed to pay the Government $12.35 million to settle a *qui tam* suit alleging that the company and two of its officers overcharged the Air Force for military parts. According to DOJ, Dowty Woodville inflated labor and material costs relating to the production of wing seals for F-111 and B1-B aircraft. The company allegedly overstated costs in its contract proposals and withheld data in violation of the Truth in Negotiations Act. Jeffrey Thistlethwaite, a former manager at Dowty Woodville, filed the suit in 1994. Investigating the case were DCIS, DCAA, and the Air Force Office of Special Investigations. The relator's counsel was Tom Engel of Engel & McCarney (New York, NY). Assistant U.S. Attorneys Gideon Schor, Jonathan Willens, and Amy Benjamin represented the Government.

U.S. v. Yedidsion, M.D. (CD CA No. CV98-0239)

In July 1998, DOJ announced that Dr. David Yedidsion agreed to pay the Government $1.5 million to settle a False Claims Act suit alleging that he billed Medicare for home visits to patients who were deceased or in nursing homes. Yedidsion also allegedly billed for patients who lived out of state, were incarcerated, or resided in facilities that had banned him. In settling the suit, Yedidsion admitted to billing for services not provided and for more expensive services than those that were rendered. Yedidsion further acknowledged committing fraud against the Small Business Administration in connection with a disaster loan application following the Northridge earthquake. The doctor previously pleaded guilty to mail fraud and making false statements. The investigation was conducted by the HHS OIG, Postal Inspection Service, and Small Business Administration. Assistant U.S. Attorney Wendy Weiss handled the civil case and Assistant U.S. Attorney Maurice Suh the criminal action.

U.S. ex rel. Kneepkens v. Quest Diagnostics, Inc. et al. (D MA No. 97-10400-GAO)

In July 1998, Quest Diagnostics, Inc. agreed to pay the Government $15 million to settle a *qui tam* suit alleging fraudulent billing for unnecessary lab tests. The suit will proceed against two dialysis companies also named as defendants, Transitional Hospitals Corporation, Inc., formerly known as Community Psychiatric Centers, Inc. (CPC), and CPC spin off Dialysis Holdings, Inc., formerly known as Vivra Inc. (Vivra).

According to DOJ, Quest, at the time known as Damon Clinical Laboratories, and CPC/Vivra entered into a joint venture arrangement to operate a clinical laboratory in Smyrna, Georgia. CPC/Vivra referred most of its end stage renal disease dialysis patients to the laboratory for testing. The settlement resolves allegations that the lab unbundled an automated panel of blood tests into two separate panels in order to obtain Medicare reimbursement to which it was not entitled for the second panel. Damon and CPC/Vivra also allegedly billed Medicare for medically unnecessary non-routine tests added to routine groups of tests provided to the kidney disease patients.

The suit was brought by Gareld Kneepkens, the former general manager of the joint venture laboratory. The matter was investigated by the HHS OIG, the FBI, and the Defense Criminal Investigative Service. The relator's share was $1.5 million, which was 19 percent of the portion of the settlement which resolved the allegations in his *qui tam* suit. The relator was represented by William Hardy of Kleinfeld, Kaplan & Becker (Washington, D.C.). The Government was represented by Assistant U.S. Attorney Susan Winkler and Laurence Freedman of the DOJ Civil Division.

Ohio National Project

In July 1998, it was reported that 25 Ohio hospitals agreed to pay the Government a total of $9.4 million in order to resolve allegations that they violated the False Claims Act by overbilling Medicare and Medicaid for outpatient laboratory testing. The settlements resulted from an ongoing national health care fraud initiative known as the Ohio National Project, also known as the Ohio Hospital Project and Operation Bad Bundle, through which the Government focuses on unbundled outpatient laboratory tests by hospitals and independent laboratories. Unbundling occurs when hospitals or laboratories increase their reimbursements by billing the Government for separate tests which should be billed under one lower rate as an automated panel of tests, or "bundle." The settlements reportedly ranged from $3 million to $22,500 per hospital. The Ohio National Project has already resulted in settlements with 63 additional hospitals for a total of more than $27 million. The investigation was conducted by the HHS OIG, FBI, and Ohio Auditor Jim Petro.

U.S. ex rel. Mettevelis and Rowan v. Charter Hospital St. Louis, Inc. et al. (MD FL No. 94-1170-CV-ORL-22)

In August 1998, Charter Behavioral Health Systems, Inc.and Charter Hospital of St. Louis, Inc. — d/b/a Charter Hospital Orlando-South — agreed to pay the Government $4.75 million to settle a *qui tam* suit alleging that the hospital fraudulently admitted and extended the length of stay of hundreds of elderly Medicare beneficiaries. Charter Hospital is an acute inpatient psychiatric hospital. According to the lawsuit, Charter admitted elderly patients suffering from debilitating organic brain disorders such as Alzheimer's disease for medically unnecessary and inappropriate "psychiatric treatment." Charter then falsified patient medical records in order to obtain reimbursement from Medicare, Medicaid, and CHAMPUS.

The suit was filed in 1994 by Francine Mettevelis and Rhea Rowan, two former Charter employees. According to DOJ, Charter has also agreed to a five year corporate integrity agreement and will not bill the Medicare program for any services for 15 months. The case was investigated by DCIS. The relators'

share was 19 percent or $903,899. The relators were represented by Donald Petersen (Orlando, FL). The Government was represented by Assistant U.S. Attorney Karen Gable and T. Reed Stephens, Elizabeth Hack, and Robert MacAuliffe of the DOJ Civil Division.

U.S. ex rel. Hicks and Hicks v. Pennsylvania Blue Shield, (MD PA Nos. 4:96 CV-611 and 4:96 CV-1303)

U.S. ex rel. Bultena v. Medical Services Association of Pennsylvania (MD PA No. 96-CV-4430)

U.S. ex rel. Howell v. Pennsylvania Blue Shield (MD PA No. 97-CV-0518)

In August 1998, Highmark Inc., the corporate successor to Pennsylvania Blue Shield, agreed to pay the Government $38.5 million to settle four *qui tam* suits alleging that Pennsylvania Blue Shield submitted false claims under its contract as a Medicare carrier. According to DOJ, Pennsylvania Blue Shield was responsible for accurately processing millions of claims by health care providers for billions of dollars worth of medical services under the Medicare program. The four *qui tam* suits were brought by Linda and Brent Hicks, who jointly filed two separate suits, Lynn Bultena, and Susan Howell. All are current or former Pennsylvania Blue Shield employees.

The settlement marks the end of a two year government investigation into the civil misconduct alleged in the lawsuits. From 1989 through 1996, Pennsylvania Blue Shield allegedly failed to properly process Medicare secondary payer claims, failed to implement Medicare requirements for the screening of end stage renal disease lab claims, failed to recover overpayments resulting from computer system errors, and inappropriately used manual computer overrides to bypass computer payment safeguards. In addition, Pennsylvania Blue Shield allegedly obstructed government audits of its performance. In a related criminal investigation, DOJ reports that a former corporate vice president at Pennsylvania Blue Shield has been charged with conspiring to make false statements to federal regulators in the course of federal audits of the company's performance under its Medicare contract. Under the terms of the civil settlement, Highmark agreed to cooperate fully with the ongoing criminal investigation.

The HHS OIG and the FBI investigated the matter. The relators' shares were as follows: Linda and Brent Hicks will receive $2,520,000; Lynn Bultena will receive $2,880,000; and Susan Howell will receive $560,000. Linda and Brent Hicks were represented by Rita Grant Ndirika of Gardner, Carton & Douglas (Washington, D.C.) and James West (Harrisburg, PA). Ms. Butena was represented by Michael Salmanson of Salmanson & Palcao (Philadelphia, PA). Ms. Howell was represented by Norman Greenspan of Blank, Rome, Comisky & McCauley (Philadelphia, PA). Stanley Alderson of the DOJ Civil Division and Assistant U.S. Attorneys Anne Fiorenza and Martin Carlson represented the Government.

U.S. ex rel. Lucey, M.D. v. Embriano, M.D. (D CT No. 3:96CV01128)

In August 1998, Connecticut ophthalmologist Peter Embriano agreed to pay the Government $700,000 to settle a *qui tam* suit alleging false Medicare billing. According to the suit, which was filed by Dr. Kimberly Lucey, Dr. Embriano billed for the performance of laser surgery when he actually did not have the equipment required for such surgery; in fact, he used a non-laser light and called it laser surgery in order to bill Medicare. The suit also alleged that Dr. Embriano billed Medicare for endothelial cell count tests which were not performed or were improperly performed. In addition to the settlement payment, Dr.

Embriano was excluded from participation in any federal health care program for a period of five years. Also, he reportedly was charged with mail fraud, filing a false tax return, and submitting false claims to Medicare in a related criminal indictment. The relator's share was 15 percent or $105,000. The relator was represented by David Hetzel and Ronald Zdnjeski of LeBoeuf, Lamb, Greene & MacRae (Hartford, CT). Assistant U.S. Attorney John Hughes represented the Government.

U.S. ex rel. Einer v. OrthoLogic Corporation (ED CA No. S-96-2166)

In August 1998, OrthoLogic Corp. agreed to pay the Government $1 million to resolve a *qui tam* suit alleging that the company billed Medicare, TRICARE, and Medicaid for non-FDA approved devices. Affected state governments will be paid a portion of the $1 million. The suit was filed by Lee Einer, a former OrthoLogic Senior Appeals Specialist, who alleged that the company billed federal and state health care programs for a reconfigured bone-growth stimulator device without obtaining new FDA approval for the modified device. The FDA advised the company that the modification could affect the safety and effectiveness of the device and ordered OrthoLogic to submit a supplemental application for approval, which it never did. Under Medicare regulations, with certain exceptions not applicable to this case, only medical devices approved for marketing by the FDA are considered "reasonable and necessary."

According to DOJ, this is the first case in which the False Claims Act has been applied against a medical device manufacturer for submitting claims for reimbursement to the Government based on the sale of medical devices not approved by the FDA. Under the settlement agreement, OrthoLogic agreed to implement a corporate integrity program. The matter was investigated by the HHS OIG. The relator's share was 17.5 percent or $175,000. Assistant U.S. Attorney Michael Hirst represented the Government.

U.S. v. City of Philadelphia et al. (ED PA No. __)

In August 1998, the City of Philadelphia and Episcopal Long Term Care agreed to pay the Federal Government $50,000 to resolve a False Claims Act suit alleging neglect of residents at the Philadelphia Nursing Home, which is owned by the City and operated by Episcopal. The lawsuit was also brought pursuant to the Civil Rights of Institutionalized Persons Act of 1980 (CRIPA). The suit referenced numerous instances of inadequate care to residents, including the nursing home's failure to provide adequate medical care, adequate wound care, adequate nutrition, adequate physical therapy, adequate psychiatric care, and safe living conditions as required by federal and state law. It was further alleged that there were insufficient numbers of adequately trained staff at the home, that residents' medications were not properly administered, and that staff inappropriately used restraints on residents.

Among the numerous areas covered by the settlement agreement were resident safety, resident hygiene, psychiatric care, nursing care, nutrition, and staff training. In addition, the settlement required that Philadelphia Nursing Home work with a federal monitor to implement the agreed upon procedures and that it create a $15,000 fund for a special project that will improve the quality of life for the residents. This case marked the first time that the DOJ Civil Rights Division joined with a U.S. Attorney's Office to address quality of care concerns, and the first time that the CRIPA was used in conjunction with the False Claims Act to improve nursing home conditions. The HHS OIG investigated the matter. The Government was represented by Assistant U.S. Attorneys James Sheehan and David Hoffman, and Robinsue Frohboese and Richard Farano of the DOJ Civil Division.

U.S. ex rel. Buffington and Trimmer v. Telephonics Corporation (ED VA No. 98-22-A)

In August 1998, Telephonics Corporation, a manufacturer of electronics information and communication systems for aircraft, agreed to pay the Government $1.085 million to settle a *qui tam* suit alleging that Telephonics fraudulently charged the Government for commission payments made to a foreign national under the Foreign Military Financing (FMF) Program. The FMF Program is a United States financial assistance program in which countries allied with the U.S. can purchase military hardware manufactured in the U.S.

In 1993, the Government of Israel contracted with American Eurocopter Corporation, a U.S. contractor, to purchase four AS 565 MA Panther Helicopters. Under the FMF Program, the U.S. agreed to pay for a portion of American Eurocopter's contract with Israel. American Eurocopter formed a subcontract with Telephonics Corp. for the provision of certain helicopter parts. According to the lawsuit, hidden within the American Eurocopter subcontract were illegal commission amounts paid by Telephonics Corp. to an Israeli national. The suit alleged that the parties concealed these commissions from the Government when making the required certifications for FMF Program financing.

The suit was filed in March 1998 by James Buffington, Jr., and Jeffrey Wayne Trimmer, Sr., two former employees of American Eurocopter Corp. In 1997, American Eurocopter paid $12 million in criminal fines and $10 million in civil damages to settle fraud charges stemming from the incident. The relators' share was 15 percent. The relators were represented by William Hardy of Kleinfeld, Kaplan & Becker (Washington, D.C.). The Government was represented by Assistant U.S. Attorney Gerard Mene.

U.S. ex rel. Johnson, Jr., Martineck, Wright, Brock, Brian, and Project on Government Oversight v. Shell Oil Company et al. (ED TX No. 9:96CV66)

In August 1998, DOJ announced that Mobil Oil Corporation agreed to pay the Government $45 million to settle a *qui tam* suit alleging underpayment of oil royalties on oil extracted from federal and Indian lands. Portions of the settlement funds will go to the Navajo Nation and Jicarilla Apache tribes and to states in which the Federal Government has leases with Mobil. The *qui tam* suit was brought by the not-for-profit Project on Government Oversight and several individuals in the oil industry.

The Minerals Management Service of the U.S. Department of the Interior requires oil companies to report the amount and value of oil produced under federal and Indian leases each month. According to DOJ, Mobil was required to pay royalties based upon the value of the oil it reported, subject to audits. Mobil allegedly underreported the value of oil it produced in order to reduce the royalties it would have to pay the Government. The relators also have brought suit against 15 other oil companies. The matter was investigated by the Department of the Interior OIG and the Minerals Management Service. The relators' share was 18 percent or $8.1 million. Michael Havard of Provost & Umphrey Law Firm (Beaumont, TX) represented the relators.

U.S. ex rel. Seckler v. Healthy Buildings International (D DC No. 93-0710)

In August 1998, it was reported that Healthy Buildings International, an indoor air consulting firm headquartered in Fairfax, Virginia, agreed to pay the Government $65,000 to resolve a *qui tam* suit alleging that the company fraudulently misstated the extent of envi-

ronmental tobacco smoke in federal buildings. The suit was filed in 1993 by former company executive Jeffrey Seckler. The suit alleged that Healthy Buildings conspired with and was secretly funded by The Tobacco Institute to alter data in air quality tests performed in federal buildings and to mislead the Government about the harmful effects of secondhand tobacco smoke in order to stop smoking bans from being imposed on public buildings. The company was hired by numerous federal agencies to conduct air quality inspections of their buildings. Members of The Tobacco Institute include RJ Reynolds Tobacco Company and the Philip Morris Corporation. The relator's share was $19,175. Counsel for the relator was Alexander Pires, Jr. of Conlon, Franz, Phelan, Knapp & Pires (Washington, D.C.).

U.S. ex rel. Semtner v. Emergency Physicians Billing Service et al. (WD OK No. Civ-94-617-(C))

In September 1998, DOJ announced that Spectrum Emergency Care, an emergency room management company, and two of its subsidiaries agreed to pay the Government $3.1 million to settle a *qui tam* suit alleging that they improperly billed Medicare, Medicaid, TRICARE, and the Federal Employees Health Benefits Program through Emergency Physicians Billing Service, a third party billing service. The settlement was the third stemming from this *qui tam* suit, which named EPBS and several of its clients as defendants. The suit alleged that EPBS upcoded emergency department medical service codes. Upcoding occurs when providers bill for more expensive services and procedures than actually provided.

The suit was filed in 1994 by Teresa Semtner, a licensed practical nurse who worked as a billing coder for EPBS. According to DOJ, eleven states will collectively receive $381,584 of the settlement funds. In September, the Government went to trial against EPBS and its chairman, J.D. McKean, M.D., and is currently awaiting a decision from the U.S. District Court in Oklahoma City. The case was investigated by the HHS OIG, FBI, DCIS, Program Integrity Branch of the TRICARE Program, DOD, Office of Personnel Management OIG, and various State Attorney General Medicaid Fraud Control Units around the country. Semtner's estate will receive a relator's share of $552,781.

U.S. ex rel. Hill and Leavitt v. Paracelsus Healthcare Corporation (CD CA No. __)

In September 1998, DOJ announced that Paracelsus Healthcare Corporation agreed to pay the Government $7.3 million to settle a *qui tam* suit alleging that two of its hospitals in Orange County, California — Orange County Community Hospital (OCCH) and Bellwood General Hospital — paid kickbacks to physicians and improperly billed Medicare for psychiatric services. According to DOJ, Paracelsus allegedly made improper payments to management companies in connection with psychiatric programs at OCCH, and paid kickbacks to physicians and physician groups at Bellwood, an acute care facility.

In addition to paying the settlement amount, Paracelsus entered into a corporate integrity agreement with the HHS OIG. The lawsuit was filed in 1995 by relators Alan Leavitt, former Chief Executive Officer of OCCH, and Timothy Hill, former Administrator and Chief Executive Officer of Bellwood. The matter was investigated by the FBI and HHS OIG. Counsel for the relators was Michael Leslie of Caldwell, Leslie, Newcombe and Pettit (Los Angeles, California). Assistant U.S. Attorney Consuelo Woodhead

represented the Government.

U.S. ex rel. Jackson v. Yale University School of Medicine (D CT No. __)

In September 1998, it was reported that Yale University agreed to a $5.6 million settlement package, $700,000 of which settles a *qui tam* suit alleging the improper handling of credit balances resulting from medical services billings by Yale School of Medicine. Due to an increase in the volume of payments from insurers and HMO's, Yale reportedly became unable to determine which payer had properly paid for a patient's medical care and which deserved secondary payer reimbursement. Many checks from payers allegedly did not contain specific invoice, account, or patient numbers. As a result, the medical school posted these entries in its records as unidentified credit balances. In addition, Yale arbitrarily erased previous credit balances from its records when it started a new computer system in 1995. The complex settlement combines false claims issues with repayment of private-payer credit balances.

In addition to a $700,000 settlement payment to the Federal Government, Yale reportedly will refund $500,289 to the Government for Medicare and other federal health care programs, will make available $1.8 million to designated health care carriers, and will make available $2.5 million to individuals and other entities. If valid claims to these sums are not established, the amounts will be turned over to the Connecticut state treasurer as unclaimed property. Yale also agreed to a four year Corrective Action Plan. The settlement ends a three year government investigation into the medical school's billing practices. The settlement is reportedly the largest ever for a civil health care case in Connecticut. The HHS OIG, the FBI, and the DCIS conducted the investigation. The relator's share is 15 percent or $105,000 of the $700,000 portion resolving the *qui tam* allegations.

U.S. ex rel. Vukanovich and Light v. C.A.S.H., Inc. et al. (CD CA No. CV 96-0402-AAH)

In September 1998, Tenet Healthcare Corporation agreed to pay the Government $850,000 to settle a *qui tam* suit alleging that OrNda Healthcorp's revenue recovery firm submitted false claims for payment to the FEHBP and CHAMPUS. (Tenet acquired OrNda in 1997.) OrNda owned a group of hospitals which utilized the services of a contingent fee revenue recovery firm known as Comprehensive Auditing Services for Hospitals, or C.A.S.H. According to the lawsuit, OrNda, through C.A.S.H., knowingly billed FEHBP and CHAMPUS for services which were never provided or which had already been billed for and paid. C.A.S.H. allegedly selected to pad only smaller hospital bills in an attempt to avoid detection, and would pretend to act as the hospitals' own billing offices in order to conceal from the Government that it was a revenue recovery organization. The settlement covers 42 hospitals which used C.A.S.H.'s services, most of which are located in Southern California. The suit was filed in 1996 by Michael Vukanovich, a former C.A.S.H. employee, and Viva Light, R.N., an independent nurse-auditor. The matter was investigated by the DCIS and FBI. Mark Allen Kleiman (Santa Monica, CA) represented the relators. Assistant U.S. Attorney Consuelo Woodhead represented the Government.

U.S. ex rel. Tribble et al. v. Aerospatiale General Aviation (ED VA No. 98-471-A)

In September 1998, in a reversal of its July 17, 1998 decision, a Virginia district court awarded the Government $17,295,142 in a *qui tam* suit alleging that Aerospatiale General Aviation falsely certified that it used mostly U.S. parts and labor in planes sold to foreign governments under the Foreign Military Finance Program. Under the FMF program, the U.S. will reimburse foreign governments for the cost of purchasing U.S.-made military equipment, but only to the extent that the parts and labor come from U.S. sources.

In this case, the Government agreed to reimburse Israel for the U.S. portion of its contract to buy 22 military airplanes from AGA. Under the terms of Israel's agreement with the Government, AGA was required to submit a certification to the U.S. Defense Security Assistance Agency stating the total values of U.S. and non-U.S. parts and labor in the airplanes. AGA certified that the non-U.S. portion of the contract represented $1,823,588 out of a total contract price of $7,928,644. Although AGA was unable to provide supporting documentation to show how it arrived at that figure,in its initial July 17 decision the district court found that the Government's Certification Agreement with AGA did not require such documentation and therefore AGA could not be held liable under the False Claims Act.

However, in response to the Government's motion for reconsideration, the court looked beyond the certification itself to federal import/export, labor, and tax laws which require an employer to maintain detailed records for any American labor and for the importation of foreign military hardware. AGA, however, could not produce withholding tax, Medicare, social security, or any other type of employee data with regard to the work it had certified was American labor; it could not produce invoices or documentation for more than $343,342 of the amount it had certified was U.S. content; and neither AGA's president nor its employees knew on what informational basis the certification had been made. The court ruled that where the law requires that records be kept, and where such records are then requested but cannot be produced, a trier of fact may infer that a certification lacking such corroboration is false. The relators were represented by William Hardy of Kleinfeld, Kaplan & Becker (Washington, D.C.).

TAF NEWS

FCA Conference Materials

- As part of its information clearinghouse activities, TAF has materials available for distribution at conferences and other programs. Information can be tailored to a legal or general audience. Resource material,including statistical information,is also available for those writing articles on the FCA.

Qui Tam Practitioner Guide

- The *TAF Qui Tam Practitioner Guide: Evaluating and Filing a Case* can be ordered at no charge by phone,fax, or mail. This "how to" manual includes sections on evaluating the merits and viability of a case, pre-filing and practical considerations, and preparing and filing the complaint.

TAF on the Internet

- TAF's Internet presence, designed to educate the public and legal community about the False Claims Act and *qui tam*, has expanded to highlight the growing health care trend and recent legislative developments. TAF's site is located at http://www.taf.org.

Previous Publications

- Back issues of the *Quarterly Review* are available in hard copy as well as on TAF's Internet site.

Quarterly Review Submissions

- TAF seeks submissions for future issues of the *Quarterly Review* (e.g., opinion pieces, legal analysis, practice tips). We thank Sabrina Skeldon for her contibution in this issue. To discuss a potential article,please contact Associate Director Alan Shusterman.

Anniversary Reports and Video

- To mark the anniversary of the 1986 FCA Amendments, TAF has available a variety of resources including a Tenth Anniversary Report, an Assessment of Economic Impact, and an educational video highlighting the effectiveness of the Act. These materials are available at no charge.

Call for Experts and Investigators

- In response to inquiries, TAF is working to compile a list of experts and investigators across an array of substantive areas. Please contact Staff Attorney Amy Wilken with any suggestions you may have.

Qui Tam Attorney Network

- TAF is continuing to build and facilitate an information network for *qui tam* attorneys. For an Attorney Network Application or a description of activities, please contact TAF. Be sure to ask about TAFNET, our electronic mail system for Attorney Network members.

TAF Library

- TAF's FCA library is open to the public, by appointment, during regular business hours. To schedule a visit or to inquire about TAF's resources, please contact Staff Attorney Amy Wilken. Submissions of case materials such as complaints, disclosure statements, briefs, and settlement agreements are appreciated.

Acknowledgments

- TAF thanks the Department of Justice and *qui tam* counsel for providing source materials.