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Health Care Qui Tam Update and Recently Unsealed Whistleblower Cases

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Trends & Analysis

- We have identified 67 health care–related qui tam cases that have been unsealed since the cases covered in our last *Qui Tam Update*. Of those cases, 29 were filed before January 1, 2014, with seven in 2013, seven in 2012, seven in 2011, and the remaining eight cases between January 2008 and November 2010.

- These 67 cases were filed in federal district courts in 23 states. Twenty-five of the unsealed cases were filed by the same relator (Frank Coyle) in the Middle District of Alabama. The *Coyle* cases are discussed in more detail below. Seven of the unsealed cases were filed in the Middle District of Florida.

- Unsealed filings show that the government affirmatively declined intervention in 21 of those 67 recently unsealed cases. The government intervened — sometimes in part — in 12 of the cases, and the government's intervention status could not be determined based on the unsealed filings in the remaining 34 cases.

- Subject matter of claims:

    - Nineteen of the 67 recently unsealed cases involved both state and federal claims.

    - Claims for relief under state or federal anti-whistleblower retaliation provisions appeared in 11 of the recently unsealed cases.

- The relators in 85% of the unsealed cases were current or former employees of the defendants, including former executives.

Recently Unsealed Cases

United States ex rel. Ava Dock v. Research Foundation of the State University of New York, No. 1:10cv385 (N.D.N.Y.)

Complaint Filed: April 1, 2010

Complaint Unsealed: December 15, 2014

Intervention Status: The United States intervened on December 15, 2014, for the purpose of settlement.

Claims: False claims — submission of false claims (31 USC §3729(a)(1) and (2)) and conspiracy to submit false claims (31 USC §3729(a)(3)).

Name of Relators: Ava Dock, Patricia Monks, Patrick Campion, Carol Mousseau, and James Ryan

Defendant's Business: The Research Foundation is a nonprofit educational corporation which helps support research for the State University of New York and runs multiple programs.

Relators' Relationship to Defendant: Former employees

Relators' Counsel: Stockli Greene Slevin & Peters and Law Office of Dennis B. Schlenker

Summary of Case: The defendant was contracted by New York State to conduct audits of its State Children's Health Insurance Program and Medicaid program (together referred to as Medicaid), specifically the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) audit programs, to measure the state's error rate in authorizing Medicaid payments. The audits were overseen by the New York State Department of Health (NYSDOH). The PERM and MEQC audits are congressionally mandated to assure proper management of federally funded programs like Medicaid, and NYSDOH must implement them to receive federal

matching funds. NYSDOH receives up to $22 billion in federal funding annually.

The relators alleged that the defendant, in conspiracy with certain NYSDOH officials, made false and fraudulent claims for federal funds they were not entitled to when they manipulated the PERM and MEQC audit data to misrepresent the state's error rate in authorizing Medicaid payments. The state risks losing federal matching funds if the audits find an excessive error rate in payment authorizations. The relators allege that defendant's management instructed them to manipulate the audits in various ways to reduce the actual error rate being found, including altering data by replacing records for ineligible patients with records for eligible patients, and lifting security restrictions in the audit databases so managers and other employees could alter the entries.

Current Status: Settlement and dismissal entered December 15, 2014. All claims by the United States were dismissed (claims for the conduct covered by the Settlement Agreement were dismissed with prejudice). All claims by the relators were dismissed with prejudice (except claims for attorneys' fees and costs).

Reasons to Watch: The defendant was hired by the state to detect, avoid, or mitigate fraud and abuse in the state's Medicaid system through the audit process, but was then actually accused of committing fraud in conspiracy with state officials so that NYSDOH would receive federal funds to which it was not entitled. The complaint alleged that the defendant altered the audit records to show an error rate below the 3% threshold, even though the results were actually showing the error rate to be more than 20%. Although this complaint was filed in 2010, an article from the *Albany Times Union* suggests that the case dates back to 2009 and a related criminal investigation may have begun in 2008. Ultimately, the investigation lasted almost seven years, and the defendant paid $3.75 million to resolve the false claims act case against it. States rely heavily on the large dollar amounts spent by the federal government on state health care programs, and the federal government continues to focus on protecting those funds from misuse or waste. In its press release the Department of Justice stated, "We will continue to pursue vigorously entities that deliver substandard work on taxpayer-funded projects and violate the public trust by falsifying information to receive federal funds." The relators will receive $825,000 in this case, which is 22% of the settlement proceeds.

United States of America ex rel. Joel Dobson v. Nason Medical Center LLC, No. 2:11cv93 (D.S.C.) *("Dobson").*

United States of America ex rel. David Abrams v. Nason Medical Center LLC, No. 2:12cv464 (D.S.C.) *("Abrams").*

Complaint Filed: January 12, 2011 (Dobson); February 17, 2012 (Abrams)

Complaint Unsealed: January 9, 2015

Intervention Status: The United States intervened on December 31, 2014.

Claims: False claims, false statements, and conspiracy (31 U.S.C. §§ 3729(a)(1)(A),

(B), (C), and (G)); retaliation (Dobson only) (31 U.S.C. § 3730(h)).

Name of Relators: Joel Dobson and David Abrams

Defendants' Business: The defendants operated emergency and urgent care facilities in Charleston, South Carolina.

Relators' Relationship to Defendants: Former and current employees

Relators' Counsel: Joseph P. Griffith Law Firm

Summary of Case: The first relator, Dobson, asserted that the defendants violated the Anti-Kickback Statute and False Claims Act by engaging in fraudulent billing practices for claims submitted to Medicare, Medicaid, and TRICARE and by providing illegal bonus incentives for physicians. The defendants allegedly paid physicians and physician assistants productivity bonuses based on their total charges, which included the value and volume of ordered ancillary services, like CT scans and X-rays. Dobson also contended that the defendants fraudulently billed for services that had been provided and/or ordered by physician assistants as though the services had been provided by a physician; unlicensed and non-employed physician assistants also allegedly provided some services for which claims for reimbursement were submitted to the federal government. Physicians employed by the defendants allegedly signed medical records and physician orders for patients treated by physician assistants, but the patients had never seen by the signing physician. Dobson further charged that the defendants upcoded or otherwise fraudulently billed for drugs, tests, and other services, such as morphine drugs, noninvasive vascular ultrasounds, EKGs, CT scans, and X-rays. Many of the billed services were allegedly performed by unlicensed technologists or were not performed at all.

The second relator, Abrams, alleged that the defendants engaged in fraudulent billing practices when submitting claims to Medicare, Medicaid, and TRICARE. Abrams charged that the defendants fraudulently billed for medically unnecessary or unreasonable lab tests such as urinalysis, urine pregnancy tests, strep tests, flu swabs, and BNP tests. The defendants allegedly upcoded or miscoded ICD-9 codes to report patient symptoms, which were in actuality false, to justify these lab tests. In addition, the defendants allegedly had triage technicians or medical assistants order lab tests before the physician saw the patient. While physicians were supposed to review and approve the lab tests and ICD-9 codes, Abrams asserted that they rarely did. The United States chose to intervene in both cases, and the parties subsequently agreed to a settlement and dismissal of the FCA claims. The defendants agreed to pay $1.02 million and to enter into a five-year Corporate Integrity Agreement ("CIA"). The CIA requires the defendants to remove all imaging equipment except X-rays and to stop providing emergency services. The defendants can now only provide urgent care center services. The defendants must also work with an independent monitor chosen by the OIG to ensure that they comply with federal law and the CIA.

Current Status: Settlement announced on January 14, 2015.

Reasons to Watch: As we've noted previously, this case is another example of a settlement agreement being filed promptly after the unsealing of a qui tam

complaint. The Department of Justice also referred to patient safety concerns in its press release; the overuse of CT scans and other services that exposed patients to unnecessary tests and radiation likely played a role in the demanding terms of the CIA. The OIG will select the independent monitor under the CIA, which is unusual. However, while the allegations are serious and the CIA is fairly intensive, the amount of the settlement is relatively small. Subsequent court documents alleged that the defendant is in financial distress and that the business partners are fighting with one another over the financial management of the company. The substance of those filing suggests that the relatively small settlement amount was determined on an ability to pay basis, as appears to be the case in a growing number of recent FCA settlements.

United States ex rel. Coyle v. [A Number of Hospitals], Various docket numbers, (M.D. Ala.)

Complaint Filed: Between September 2013 and October 2014

Complaint Unsealed: January 26, 2015

Intervention Status: After the relators' numerous complaints, filed in district courts across the country, were transferred to the Middle District of Alabama, the cases were dismissed at the relators' request, with the consent of the government, apparently before the decision to intervene occurred.

Claims: Failure to comply with the Stark Law's "whole hospital" investment exception, as amended by the Affordable Care Act. Specifically, the relators alleged that the various hospital defendants had failed to disclose in their advertisements and on their websites that they were partially owned by physicians. This allegedly resulted in the submission of claims for payment that were false, in violation of the Civil False Claims Act (FCA), 31 U.S.C. § 3729, as the hospitals had certified that they were in compliance with the Stark Law.

Name of Relators: Frank Coyle and Randy Bruce

Defendants' Business: The defendants in these 20-plus cases are various physician-owned hospitals located in cities and towns across the country.

Relators' Relationship to Defendants: Frank Coyle was, until shortly after the cases were unsealed, the general counsel of IASIS Healthcare. (IASIS Healthcare is a competitor of the defendants in some parts of the country.) Randy Bruce also had formerly worked in the counsel's office at IASIS.

Relators' Counsel: Scott A. Powell and Don McKenna of Hare, Wynn, Newell & Newton, LLP (Birmingham, AL)

Summary of Case: In over 20 nearly identical complaints, the relators (who were themselves executives at a health care services company), filed suit in a number of federal district courts against hospitals which were alleged to have failed to disclose their physician owned status in violation of the Stark Law. Relators based their complaints on their review of the defendants' advertisements, television

commercials, and websites, and, finding no disclosure that they were partially owned by physicians, brought essentially the same case against each, alleging a prima facie violation of the Stark Law.

Current Status: On January 26, 2015, the court dismissed the cases without prejudice at the relators' request, at the same time denying the relators' request that their identities remain sealed upon dismissal.

Reasons to Watch: These cases are noteworthy for the manner in which they were dismissed. While the motion papers remain sealed, the unsealed order granting dismissal reveals that the relators had moved to dismiss without prejudice while simultaneously moving "that their identities remain sealed upon dismissal because they are still working in the healthcare industry and revelation of their identities would cause substantial harm to their careers." The Middle District of Alabama rejected the relators' attempt to cloak their identities after dismissal, agreeing with the government's position that "the seal is for the limited purpose of protecting the government's investigative process," meaning that the case should be unsealed once the government determines whether it will intervene. The court noted the presumptive right of public access to court documents and held that, notwithstanding the professional concerns voiced by the relators, the countervailing public right of access weighed in favor of unsealing. Perhaps unsurprisingly, a few weeks after the court entered the order and the relators' identities were revealed, IASIS announced Frank Coyle's departure from the company, which may have received heightened attention by virtue of his failed attempts to keep his identity as a relator secret. The result of these cases may well dissuade future health care executives who are fearful of having it known that they have filed qui tam cases from becoming relators, and at the very least the order demonstrates to would-be relators that the prospect of sharing in any recovery under the False Claims Act is not necessarily a risk-free proposition.

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