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Mintz Levin Health Care *Qui Tam* Update

Recent Developments & Unsealed Cases

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Trends & Analysis

In the period covered by this issue, we have identified 68 whistleblower cases related to health care that were unsealed. In this *Qui Tam Update*, we analyze the trends and take an in-depth look at three cases of note, including a case that yielded a $35 million dollar settlement – the largest-ever False Claims Act recovery in the State of Arizona – an amount that might have been higher had the defendant not previously self-disclosed overpayments by federal and state health care programs.

- We have identified 68 health care–related *qui tam* cases unsealed since the cases covered in our last *Qui Tam Update*. Of those, 53 were filed from 2012 to the present. The remaining cases, filed before 2012, date back as far as July 2007.
- These 68 cases were filed in 26 states. As we commonly observe, several of the recently unsealed cases were filed in historically active jurisdictions for false claims act cases, including the District of Massachusetts, the Eastern District of New York, and the Southern District of Ohio.
- Among the 68 recently unsealed cases, the unsealed filings disclosed that the government declined to intervene in 43% of the cases. The government intervened — sometimes in part — in 31% of the cases, and the government's intervention was unclear from the unsealed filings in 26% of the cases.
- Subject matter of claims:
    - More than 50% of the recently unsealed cases involved both state and federal claims.
    - Claims for relief under state or federal anti-whistleblower retaliation provisions appeared in almost 25% of the recently unsealed cases.
- Identity of relators:
    - Almost 70% of the relators were current or former employees of the defendants.
    - In at least 8 of the 68 cases, the relators were former business partners who had a contractual relationship with the defendants.

Recently Unsealed Cases

United States ex rel. Bloink v. Carondelet Health Network, No. 4:11-cv-00721 (D. Ariz.)

Complaint Filed: November 15, 2011

Complaint Unsealed: August 18, 2014

Intervention Status: After repeatedly requesting extensions of the period in which to make a decision on intervention, the United States ultimately intervened on August 12, 2014. The parties contemporaneously moved jointly for dismissal of the action pursuant to a stipulation of settlement.

Claims: Falsely billing the Medicare Program, the Federal Employees Health Benefit Program, and the Arizona Medicaid Program for inpatient rehabilitation facility (IRF) services that were not properly

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reimbursable because patients were not appropriate for inpatient rehabilitation facility services, in violation of the Civil False Claims Act (FCA), 31 U.S.C. § 3729.

Name of Relator: Jacqueline Bloink

Defendants' Business: Carondelet Health Network is an Arizona nonprofit corporation doing business as Carondelet St. Mary's Hospital and Carondelet St. Joseph's Hospital, both located in Tucson, Arizona. The specific services at issue in the case were Carondelet's IRF services.

Relator's Relationship to Defendant: The relator is a Certified Professional Coder-Instructor and Certified Medical Reimbursement Specialist. She was employed by Carondelet as a Corporate Responsibility Coordinator from June 2010 to June 29, 2011.

Relator's Counsel: Kline & Specter (Philadelphia, PA) and Joseph Trautwein & Associates, LLC (Erdenheim, PA)

Summary of Case: In order for IRF services to be considered reasonable and necessary and, therefore, reimbursable under federal health care programs, a patient's need for this intensive level of rehabilitation services requires careful evaluation and documentation. Such documentation includes preadmission screening to substantiate the need for IRF services, as well as documentation of the intensity of services provided, typically demonstrated by providing 15 hours of therapy in a seven-day consecutive period. The relator alleged that in the course of Carondelet's 2010 and 2011 audits, the latter of which she conducted, Carondelet discovered that a significant percentage of the sampled patient charts lacked preadmission screening documentation to support IRF services. Further, a significant percentage of sampled charts indicated that patients did not receive 15 hours of therapy over a period of seven consecutive days. As a result, according to the relator's allegations, Carondelet was routinely billing federal health care programs for costly IRF services provided to patients who were not appropriate for that level of care.

Current Status: On August 12, 2014, the United States and the relator jointly moved to dismiss the action in accordance with the terms of a settlement agreement filed concurrently with the motion. Under the settlement agreement, Carondelet will pay $35 million in settlement, with the Relator receiving $5,950,000.

Reasons to Watch: Carondelet's $35 million settlement is the largest-ever False Claims Act recovery in the State of Arizona, according to John Leonardo, United States Attorney for the District of Arizona. This settlement resolves allegations pertaining to services billed from April 7, 2004 through December 31, 2011. Interestingly, as the government stated in its Notice of Election to Intervene, Carondelet had actually self-disclosed to the government — shortly before learning of the government investigation — that it had become aware of certain inpatient rehabilitation overpayments and had tendered a substantial repayment. Nevertheless, the government stated that it "had concerns about the nature of Carondelet's disclosure, including concerns that the disclosure and the repayment Carondelet tendered were not timely, complete, or adequate." But "[d]espite these concerns, the United States considered Carondelet's efforts in this regard as one of several factors in reaching the settlement amount and the proposed resolution of the case" — implicitly suggesting that the government might have sought a substantially higher settlement amount had Carondelet not self-disclosed.

United States ex rel. Jahn v. Agility Health, Inc., No. 1:12-cv-00449 (W.D. Mich.)

Complaint Filed: May 7, 2012

Complaint Unsealed: August 26, 2014

Intervention Status: Unclear; the Complaint is the only entry on the docket to have been unsealed.

Claims: Submitting false or fraudulent claims for payment for services in violation of the FCA, 31 U.S.C. § 3729, as well as the analogous false claims law of Michigan by, among other things, upcoding and overbilling for services provided at skilled nursing facilities (SNFs).

Name of Relators: Philip L. Jahn, Julaine M. Foster, and Md Nouruddin Choudhury

Defendants' Business: Agility Health operates a network of over 155 services sites in 20 states, at which it provides rehabilitative services including physical and occupational contract therapy services.

Relators' Relationship to Defendants: The relators are two physical therapy assistants and a contract physical therapist employed to provide services at one of Agility Health's service locations.

Relators' Counsel: Levy Phillips & Konigsberg, LLP (New York, NY) and Drew, Cooper & Anding, P.C. (Grand Rapids, MI).

Summary of Case: Medicare pays for services provided at SNFs based, in part, on the evaluation and classification of beneficiaries into resource utilization groups (RUGs). Each of the eight RUGs has a different

per diem reimbursement rate. Beneficiaries requiring more intensive services are assigned to higher RUGs, with a correspondingly higher payment rate to reflect the level of services received. The relators allege that Agility Health has routinely engaged in the fraudulent manipulation of RUG levels such that patients are placed in the highest RUG categories and remain there for the full payable period under Medicare Part A. The relators allege that Agility Health uses staffers — instead of doctors, nurses, or certified therapists — to evaluate and classify patients to the appropriate RUG level, which is designed to result in increased utilization of higher RUG levels. The relators further allege that Agility Health routinely bills for group therapy sessions as individual sessions and uses physical therapy assistants to supervise two or more patients performing the same exercise but bills for multiple individual therapy sessions.

Current Status: The Complaint has been unsealed and the case is currently pending.

Reasons to Watch: As we have previously remarked in this space, the United States has demonstrated its close monitoring of, and ongoing interest in, the billing practices of SNFs. As we have observed before, SNFs provide fertile ground for false claims litigation because most patients in SNFs are beneficiaries of either Medicare or Medicaid, and therefore the majority of services rendered are potentially subject to a false claims action. The Department of Justice continues to hold SNFs accountable for "the provision of excessive and medically unnecessary therapy services."

United States ex rel. Nichols v. The Sleep Medicine Center, No. 3:12-cv-01080 (M.D. Fl.)

Complaint Filed: October 3, 2012

Complaint Unsealed: September 11, 2014

Intervention Status: The United States intervened in this case on September 11, 2014. The government reached a settlement with and dismissed its claims against the Sleep Medicine Center and two of the individual physician defendants (Dr. Hubert Zachary and Dr. George Restea), but will continue to pursue the claims against remaining defendants, Dr. John DeCerce and Dr. George Young.

Claims: Falsely billing the Medicare Program and the Florida Medicaid Program for sleep study–related services, for tests that were not provided, and for services provided by unlicensed physicians, in violation of the FCA, 31 U.S.C. § 3729 and the Florida False Claims Act, Fla. Stat. § 68.081, *et seq.*; for providing kickbacks to physicians for referrals in violation of 42 U.S.C. § 1320a-7b; and for retaliating against the relator for engaging in activities protected under the FCA, in violation of 31 U.S.C. § 3730(h).

Name of Relator: Donna Nichols

Defendants' Business: The Sleep Medicine Center is a Florida corporation, and a Medicare- and Medicaid-certified provider of sleep studies, tests, analyses, and treatments. Dr. Hubert Zachary is the owner and manager of the Sleep Medicine Center and is not a Florida-licensed physician; Drs. Young, Restea, and DeCerce are all licensed Florida physicians affiliated with the Sleep Medicine Center.

Relator's Relationship to Defendants: The relator worked in an administrative role for the Sleep Medicine Center from February to June 2012.

Relator's Counsel: The Employment Law Group, P.C. (Washington, DC) and Shutts & Bowen LLP (Fort Lauderdale, FL)

Summary of Case: The Complaint alleges that defendants submitted false and fraudulent claims to the Medicare and Florida Medicaid programs for services purportedly provided at the Sleep Medicine Center, a sleep-disorder clinic owned and managed by Dr. Hubert Zachary. According to the relator, the Sleep Medicine Center billed Medicare and Medicaid for services and treatments it could not have provided, because it did not have the necessary equipment. In some instances, the equipment needed for polysomnography studies was malfunctioning and would not capture or produce the data the physicians needed to analyze, but the defendants still billed Medicare and Medicaid for the studies, and Dr. Zachary allegedly invented test results to replace the missing sleep data. The relator also claims that the defendants regularly charged Medicare and Medicaid for EEG tests for every patient — even though the Sleep Medicine Center does not own or have access to the equipment required to perform EEG tests. The defendants also billed Medicare and Medicaid for full office visits with patients for basic phone interactions and when patients only came in to the office and collected equipment from administrative staff without seeing any medical practitioners. Because Dr. Zachary was not licensed in Florida, he employed Florida-licensed physicians — including Dr. Restea, Dr. DeCerce, and Dr. Young — to sign prescriptions, recommendations, and other documents requiring a physician license. The relator claims that these physicians rarely came to the Sleep Medicine Center, rarely saw patients, and rarely reviewed any of the documents that bore their signatures.

Current Status: Partially dismissed and partially pending. All FCA claims against the Sleep Medicine Center,

Dr. Restea and owner-manager Dr. Zachary were dismissed on September 9, 2014, in accordance with the terms of a settlement between the United States and these three defendants. The Sleep Medicine Center will pay $200,000 and Dr. Restea will pay nearly $100,000 to resolve the claims, and both the Sleep Medicine Center and Dr. Zachary will be excluded from federal health care program participation for eight years. The relator will receive more than $60,000 in connection with the settlement. The government will proceed with its claims against Dr. Young and Dr. DeCerce.

Reasons to Watch: Although the Complaint focuses on Dr. Zachary and his management and direction of the Sleep Medicine Center and the government has dismissed all FCA claims against those defendants, the government is still pursuing the remaining allegations against Dr. Young and Dr. DeCerce, who, as the DOJ contends in its **press release**, "merely lent their names [to the Sleep Medicine Center] in exchange for compensation." In that same announcement, the DOJ counted this $300,000 settlement as another victory for its HEAT partnership with HHS, emphasizing that more than $13 billion has been recovered relating to health care fraud and stating that "one of the most powerful tools in this effort is the False Claims Act."

For more information, including details relating to the above cases, please contact
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