Mintz Levin Health Care *Qui Tam* Update

Recently Unsealed Whistleblower Cases

OCTOBER 2015

BY HOPE FOSTER, KEVIN MCGINTY, SEAN GRAMMEL, AND SARAH BETH SMITH

RELATED PRACTICES
- Health Law
- Health Care Enforcement Defense
- Litigation
- Class Action
- Fraud & Abuse, Compliance & Regulatory Counseling
- Medicare, Medicaid & Commercial Payor Coverage & Payment
- Privacy & Security – HIPAA Compliance
- Mintz Levin Center for Health Law & Policy

RELATED INDUSTRIES
- Health Care
- Insurance

RELATED BLOGS
- Health Law & Policy Matters

Trends & Analysis

- We have identified 15 health care–related *qui tam* cases that were unsealed since our last *Qui Tam Update*. Of those, 12 were filed from 2012 to the present. All but two cases had been pending more than a year before unsealing. The remaining three cases were filed in April 2008, May 2010, and March 2011.
- These 15 cases were filed in federal district courts in 11 states. Three of the unsealed cases were filed in the Middle District of Florida. The courts in the Northern District of Georgia and the District of New Jersey both unsealed two cases.
- Unsealed filings show that the government affirmatively declined intervention in 7 of the 15 recently unsealed cases. The government intervened — sometimes in part — in 5 of the cases. Two cases were dismissed before the government intervened, and the government's intervention status was unclear from the unsealed filings in the remaining case.
- Subject matter of claims:
    - Nine of the 15 recently unsealed cases involved both state and federal claims.
    - Four of the recently unsealed cases included allegations of illegal kickbacks. Three of these cases also alleged violations of the Stark Law.
    - Claims for relief under state or federal anti-whistleblower retaliation provisions appeared in 4 of the recently unsealed cases.
- Over 85% of the relators were current or former employees of the defendants.

Featured Unsealed Cases

Miller v. Neuropsychiatric Institute, LLC, No. 8:14-cv-1110 (M.D. Fla.)

Complaint Filed: May 9, 2014

Complaint Unsealed: July 29, 2015

Intervention Status: Both the federal government and the State of Florida gave notice on July 27, 2015 that they are declining to intervene at this time. No further action on intervention has occurred.

Claims: The relator asserted that the defendant failed to provide the mental health services for which it charged the government and thus submitted false claims in violation of the federal False Claims Act (FCA), 31 U.S.C. § 3729, and the Florida False Claims Act, Fla. Stat. § 68.082. Additionally, the relator alleged violations of the Social Security Act of 1935, 42 U.S.C. § 408, because the defendant's fraudulent activity caused false statements to be submitted to the federal government regarding

patients' rights to Social Security, Medicare, and Supplemental Security Income benefits.

Name of Relator: Nancy Miller

Defendant's Business: The Neuropsychiatric Institute ("NPI") is an interdisciplinary mental health practice that provides psychological testing for patients for the purpose of testing for schools, Social Security benefits, and legal matters including personal injury lawsuits, immigration, and diagnostic clarifications.

Relator's Relationship to Defendant: Current employee, as of the date of filing

Relator's Counsel: The Feldman Law Group, PA (Tampa, FL)

Summary of Case: According to relator's complaint, NPI performs psychological tests on patients and provides medical opinions or interpretations of those tests. The relator alleges that these tests are supposed to be performed and interpreted by employees with doctoral level degrees, but instead are actually performed and interpreted by non-doctoral level psychologist technicians, who should only be responsible for collecting data.

NPI purportedly uses the psychologist technicians to perform medical services that only a licensed doctor or psychologist is authorized to perform but then bills Medicare or Medicaid for those services by fraudulently representing that they were in fact performed by a doctor or psychologist. The relator contends that the psychologist technicians take the place of doctors or psychologists at every stage of treatment, from choosing which tests to perform on the patients, to actually performing those tests, writing up the reports, and then reviewing the test results with the patients. The two psychologists who work at NPI allegedly see only their own patients, a small percentage of NPI's total patient population.

The relator contends that this scheme also amounts to immigration fraud. NPI allegedly engages in a scheme whereby it falsely certifies that individuals who are undergoing naturalization are mentally disabled and therefore are not required to take the English language and civics portions of the U.S. citizenship exam. NPI purportedly falsifies medical histories and test results at a specified fee and then rubber-stamps Form N-648, which exempts individuals from the English language and civics examinations.

Current Status: The case is currently pending.

Reasons to Watch: The allegations in the Complaint evince an expanded reading of the False Claims Act. Rather than solely focusing on the false submissions to Medicare and Medicaid, the relator alleges that these fraudulent mental health services caused further false claims to be made, which constituted immigration fraud and Social Security benefits fraud. By falsifying immigration forms, individuals were exempted from requirements of the naturalization process. As the relator alleges, this led to fraud on the Social Security system. NPI's alleged scheme resulted in false submissions related to Social Security benefits, Medicare, and Supplemental Security Income. The relator alleged two independent violations of the Social Security Act of 1935, in addition to claims under the federal and state False Claims Acts.

United States ex. rel. Yvette Odumosu v. Pediatric Services of America Healthcare, No. 1:11-cv-1007 (N.D. Ga.) ("*Odumosu*")

United States ex. rel. Sheila McCray v. Pediatric Services of America, Inc., No. CV413-127 (S.D. Ga.) ("*McCray*")

Complaints Filed: March 30, 2011 (*Odumosu*); May 24, 2013 (*McCray*)

Complaint Unsealed: August 3, 2015

Intervention Status: Both the federal government and the State of Georgia intervened in part and declined to intervene in part on July 30, 2015.

Claims: The relator charged that the defendant failed to disclose and return overpayments received from federal health care programs, failed to document monthly supervisory visits by registered nurses on claims submitted to the Georgia Pediatric Program, and erroneously billed federal health care

programs for providing services to patients over periods of time that exceeded the time periods during which such services were actually provided. Thus, the defendant allegedly submitted false claims in violation of the FCA, 31 U.S.C. §§ 3729-33, and the Georgia Medicaid False Claims Act, Ga. Code § 49-4-168.1. The *Odumosu* complaint advances retaliation claims under state and federal law. *McCray* alleges that false claims were also submitted in violation of several state laws: the California False Claims Act, Cal. Gov. Code § 12650, *et. seq.,* the Colorado Medicaid False Claims Act, Colo. Rev. Stat. § 25.5-4-303.5, *et. seq.,* the Connecticut False Claims Act for Medical Assistance Programs, Conn. Gen. Stat. § 17b-301(a), *et. seq.,* the Florida False Claims Act, Fla. Stat. Ann. § 68.081, *et. seq.,* the Illinois Whistleblower Reward and Protection Act, 740 ILCS 175/1, *et. seq.,* the Louisiana False Claims Act/Medical Assistance Program Integrity Law, La. Rev. Stat. § 46.437.1, *et. seq.,* the Massachusetts False Claims Act, Mass. Gen. Laws § 5A, *et. seq.,* the New Jersey False Claims Act, N.J. Stat. § 2A:32C-1, *et. seq.,* the New York False Claims Act, N.Y. Fin. Law § 187, *et. seq.,* the North Carolina False Claims Act, N.C. Gen. Stat. § 108A-70-10, *et. seq.,* the Texas Medicaid Fraud Prevention Action, Tex. Hum. Res. Code § 36.001, *et. seq.,* the Virginia Fraud Against Taxpayers Act, Va. Stat. § 8.01-216.1, and the Washington State Medicaid Fraud False Claims Act, Wash. Rev. Code § 74.66.05, *et. seq.*

Name of Relators: Yvette Odumosu and Sheila McCray

Defendant's Business: Pediatric Services of America ("PSA") provides home health care and related services for medically fragile children.

Relator's Relationship to Defendant: Former employees

Relator's Counsel: Law Offices of Michika Reynolds-Quillin (*Odumosu*); Gamble Law LLC (*McCray*)

Summary of Case: Relator Odumosu was employed as the Director of Clinical Nursing at one of PSA's facilities. Odumosu alleged that PSA submitted claims without physicians reviewing plans of treatment every 60 days and recertifying that services are needed, as required by Georgia regulations. Additionally, PSA allegedly paid employees for 8-hour shifts when they only worked 5 hours so that bills could be inflated. PSA also purportedly photocopied parental and physician signatures on documents and added copies of the signatures to documents, which resulted in multiple reimbursements without confirmation by the parent or physician that services were actually provided as claimed. Odumosu asserted that she brought PSA's billing practices to the attention of two corporate officers in September 2010, but employees continued to engage in these billing practices. The director of the facility where Odumosu worked also advised employees not to deem patients' caregivers competent in providing services themselves to the patients in an effort not to reduce the number of hours of services provided by PSA.

Relator McCray was employed as an Accounts Receivable Specialist for PSA until April 2012. As charged in the complaint, she was hired to work alongside a reimbursement manager to resolve credits and issue refunds to payers. McCray allegedly discovered millions of dollars of private and government overpayments intentionally held by PSA shortly after she started working there. She alleged that PSA created a hidden reserve fund for these credits. McCray also contended that she discussed this issue with the Chief Corporate Development Officer and Head of Accounts Receivable, but he informed her that they should wait to see if Medicare or Medicaid caught the overpayments before repaying the money. In addition, he allegedly advised McCray to stop repaying overpayments that were older than 12 months because PSA had to refund both the overpayment and the charges for the services provided. For these older claims, PSA allegedly began to hide the overpayments by restricting access to reports on the overpayments and changing some overpayments to make it appear that they were only 30 to 120 days old, when they were in fact much older.

Current Status: Settlement announced on August 4, 2015.

Reasons to Watch: As noted in the DOJ press release, this is the first FCA settlement in which a provider has allegedly failed to investigate credit balances and determine whether those balances resulted from overpayments from federal health care programs. The settlement agreement requires PSA to pay $6.88 million — of which $1.1 million goes to the relators — and enter into a corporate integrity agreement with the Office of the Inspector General.

For more information, including details relating to the above cases, please contact **Hope S. Foster** at **202.661.8758** or HSFoster@mintz.com.

About Our Health Care Enforcement Defense Practice

Mintz Levin's Health Care Enforcement Defense Practice includes health law, employment, and white collar defense attorneys with experience in government investigations and health care regulatory compliance matters. We regularly help clients conduct internal investigations designed to detect and correct problems before the government becomes involved. We have represented clients in federal and state government investigations and litigation across the country in matters initiated by the Criminal and Civil Divisions at the Department of Justice, United States Attorneys, the Office of Inspector General for the Department of Health and Human Services, the Drug Enforcement Administration, State Attorneys General, Medicare and Medicaid contractors, and the 50 Medicaid Fraud Control Units. We have helped clients avoid potentially ruinous civil fines, incarceration, other criminal and administrative penalties, and exclusion by combining our regulatory knowledge with our investigative, employment-related, and litigation capabilities.