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Don't Ignore Small And Midsize Health FCA Settlements

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Law360, New York (August 26, 2015, 1:56 PM ET) -- On Aug. 14, 2015, the medical director of a Brooklyn health clinic was sentenced to two years in prison and was ordered to pay a total of $13 million in restitution and forfeiture for his role in a scheme to defraud government health care programs. According to the U.S. Department of Justice, Dr. Okon Umana oversaw Cropsey Medical Care's submission of $13 million in fraudulent claims to Medicare and Medicaid. Among other things, Cropsey billed the government under Dr. Umana's provider number for services performed by physician assistants and certified the medical necessity of procedures that were, in fact, not medically necessary. Dr. Umana was the ninth individual to plead guilty for participating in the scheme.

Health care and pharmaceutical fraud cases brought under the federal False Claims Act, its state counterparts and various criminal statutes generate the most press when they involve large, publicly traded companies. This is due in part to the name recognition of the perpetrators and the often staggering size of the settlements and penalties involved. Such cases have led to nine of the 10 largest civil FCA awards in history, with the largest being a $2 billion settlement of civil claims against GlaxoSmithKline PLC, which also incurred $1 billion in related criminal penalties. Despite these massive sanctions and settlements, many of which have occurred within the past 15 years, fraud cases against large pharmaceutical and health care companies remain relatively common. Within the third quarter of 2015 alone, the DOJ has announced that AstraZeneca LP and Cephalon Inc. agreed to pay a total of $54 million for underpaying Medicaid drug rebates, and Amgen Inc. agreed to pay $71 million to 48 states to settle claims that it engaged in the off-label promotion of two of its drugs.

While large pharmaceutical and health care fraud cases will inevitably continue to dominate the news, the reality is that federal and state regulators aggressively pursue civil and criminal penalties against companies of all sizes, as well as individuals, for health care fraud. In 2007 the federal government established a Medicare Fraud Strike Force comprised of members of the DOJ and U.S. Department of Health and Human Services' Office of the Inspector General, which in its eight years of existence has initiated more than 3,000 criminal actions and indictments and has recovered more than $1.6 billion.

In 2009, the DOJ and HHS announced the creation of the Health Care Fraud Prevention and Enforcement Action Team initiative to further coordinate government efforts, including those of the strike force, to target fraud against health care programs. The coordinated efforts of the strike force have resulted in massive crackdowns, including against small and independent health care providers. Most notable among these was the June 18, 2015, announcement of charges against 243 individuals for fraudulent billing to government health

care programs totaling approximately $712 million. In addition to large sweeps, the DOJ and HHS announce enforcement actions, charges and sentencing against small providers on a regular basis. Recent examples include:

- On Aug. 7, 2015, the owner of Miami-based Biomax Pharmacy Inc. pleaded guilty to one count of health care fraud for her role in the submission of $1.6 million in false claims for prescription reimbursement from Medicare.

- On Aug. 3, 2015, a federal judge in California sentenced a Los Angeles pharmacy owner to 18 months in prison and ordered payment $644,060 in restitution for submitting fraudulent claims for prescription reimbursement to Medicare, and for paying illegal kickbacks to Medicare recipients to incentivize them to fill their prescriptions at his pharmacy.

- On July 27, 2015, two home health care agency owners were convicted as part of a $33 million Medicare fraud scheme that involved paying cash kickbacks to recruiters — and indirectly to patients — to induce them to use their health care agencies, and paying physicians to refer patients for services that were not medically necessary.

- On July 24, 2015, the owner of two home health care companies in Detroit was sentenced to 80 months in prison and ordered to pay $14.1 million in restitution for his role in a health care and tax fraud scheme that included illegal kickbacks and false claims for reimbursement for services, which resulted in payments from Medicare of $12.6 million.

While the dollar figures involved in fraudulent schemes committed by small and midsize providers pale in comparison to those against companies such as GlaxoSmithKline and the Hospital Corporation of America, they are nonetheless substantial and can result in significant awards through the *qui tam* provisions of the FCA.

Under the FCA, an individual, known as a relator, may sue on behalf of the government for alleged fraud committed against the government. The government may choose to intervene in the suit or decline and allow the relator to pursue the government's claim on his or her own. A relator whose suit leads to a settlement or favorable judgment may receive between 15 and 30 percent of the total amount the government recovers from the defendant(s). Note that regardless of whether an individual files a *qui tam* suit, the anti-retaliation provisions of the FCA protect an employee who takes efforts in furtherance of a *qui tam* action or attempts to stop one or more violations of the FCA, including by conducting an investigation or reporting the matter internally.

Even in relatively small FCA cases, the incentives available to whistleblowers who provide key information and assistance may lead to sizable awards. For example, a physician whose *qui tam* suit implicated two southwest Missouri health care companies in a fraudulent scheme to pay kickbacks for referrals will receive $825,000 of the federal government's $5.5 million settlement of the case, which was announced in July 2015.

The previous month, on June 1, 2015, Friendship Home Healthcare agreed to pay $6.5 million to settle claims that it used forged signatures of the company's director of nursing in submitting claims to federal and Tennessee health care programs, and that it billed for services provided by an individual with an invalid nursing license. As a result of the

settlement, the relator, a licensed practical nurse who worked for the company, may receive up to $1.95 million. On June 18, 2015, Hebrew Homes Health Network Inc. and its president, William Zubkoff, agreed to a $17 million settlement related to a kickback scheme in which the company hired physicians into "ghost positions," pretending to pay them for duties they did not perform, when in fact the payments were for referrals. As a result of the settlement, the former chief financial officer of the company, which runs a small network of rehabilitation and skilled nursing facilities in southern Florida, will receive $4.25 million. Examples of similar settlements abound.

The clear message from the federal government and state attorneys general is that stopping fraud on government health care programs is — and will remain — a top priority, whether the company at issue has a national presence or operates within a single county. Individuals with inside information will continue to be central to these enforcement efforts, and those willing to come forward and blow the whistle stand to receive significant awards for their contributions.

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