Recently Unsealed Whistleblower Cases

Mintz Levin Health Care *Qui Tam* Update

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BY HOPE S. FOSTER, KEVIN M. MCGINTY, JORDAN T. COHEN, AND LAUREN M. MOLDAWER

Trends & Analysis

- We have identified 36 health care–related *qui tam* cases that have been unsealed since the cases covered in our last *Qui Tam Update*. Of these cases, eight were filed within the last year. A number of the cases unsealed during May and June were filed several years ago. For example, one of the cases that was unsealed in May, which we highlight below, was filed in 2006. A second case that was also unsealed in May has been pending since November 2009. Seven of the unsealed cases were initially filed in 2011, three were filed in 2012, and the rest were filed in 2013 and 2014.
- These 36 cases were filed in federal district courts in 18 states. Eight of these cases were brought in or transferred to a federal court in Georgia, with the majority filed in the Northern District of Georgia. Additionally, five of the cases were brought in a court in California, and three were filed in a New York district court.
- The federal government has intervened in full in six cases and partially intervened in another six cases. The federal government declined to intervene in 19 cases. The government's decision on whether to intervene is still pending or its decision is unknown in four cases. One case was settled and voluntarily dismissed prior to government action on intervention (however, the government consented to the dismissal).
- There have been nine settlements associated with the 36 identified cases. The aggregate settlement amount of these cases is approximately $51 million, with an average settlement amount of $5.7 million per case.
- Subject matter of claims:
  - Half (18) of the 36 recently unsealed cases involve both state and federal claims.
  - Claims for relief under state or federal anti-whistleblower retaliation provisions appear in 9 of the recently unsealed cases.
  - Three of the recently unsealed cases involve the same defendant, Family Dermatology. We highlight these cases below.
  - The majority of the False Claims Act allegations assert that providers billed for unnecessary services, "upcoded" for more expensive procedures, or submitted claims to Medicare for 100% of the charges for services provided by mid-level practitioners even though a physician was not physically present when the practitioners performed their services.
  - There are several False Claims Act cases stemming from alleged Stark Law violations involving inappropriate compensation arrangements or management agreements.
  - Several of the unsealed cases contend that various defendant pharmaceutical manufacturers' violated the False Claims Act by entering into: (i) arrangements with pharmacy benefit managers for preferred placement on the formulary or (ii) arrangements with other manufacturers to delay generics from entering the market.
- The relators in 53% of the unsealed cases are current or former employees of the defendants, including former executives. One of the relators is an LLC specifically formed to combat false claims billed to the federal health care programs (EMR Quality, LLC), a device that some relators are using with increasing frequency, and another of the relators is thought to be a serial relator (Christopher Piacentile).

Recently Unsealed Cases

United States Of America ex rel. Dan Bisk, State Of New York ex rel. Dan Bisk v. Westchester Medical Center, No. 1:06cv15296 (S.D.N.Y)

Complaint Filed: December 19, 2006

Complaint Unsealed: May 14, 2015

Intervention Status: The United States partially intervened on May 14, 2015.

Claims: False claims to Medicare in violation of the Civil False Claims Act, 31 U.S.C. § 3729 et seq. ("FCA") premised on false certification of compliance with the Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b) ("AKS"), and the Physician Self-Referral Law, 42 U.S.C. § 1395nn ("Stark Law"). The relator also sought relief for retaliation claims under the FCA. The relator also brought claims under the New York False Claims Act § 187 *et seq.*

Name of Relator[s]: Dan Bisk

Defendant's Business: The Hospital defendant provides medical care through its tertiary and quarternary care hospital located in Valhalla, New York. The private practice defendants provide medical services to patients in the Valhalla area.

Relators' Relationship to Defendant: Former compliance officer of Westchester Medical Center.


Hope S. Foster, *Member*


Kevin M. McGinty, *Member*


Jordan T. Cohen, *Associate*


Lauren M. Moldawer, *Associate*

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Relators' Counsel: Sadowski Fisher PLLC

Summary of Case:

A former compliance officer of Westchester Medical Center ("WMC") alleged that WMC had, in violation of state and federal law, engaged in a number of schemes that violated the False Claims Act, some of which rewarded physicians for their referrals. Thus, the relator alleged that WMC: (i) provided private practices with the use of WMC space for free or at a substantially reduced lease amounts; (ii) provided WMC's personnel to private practice physicians, without charge, for use in their private practices; (iii) improperly discounted the cost charged to referring physicians for medical malpractice insurance coverage; (iv) provided remuneration to physicians disguised as recruitment payments; (v) compensated referring physicians under service agreements that were either unsigned or in excess of fair market value; and (vi) knowingly submitted false cost reports to Medicare.

On May 14, 2015, the United States filed a complaint-in-intervention, partially intervening in the case. While the relator's complaint described WMC's financial arrangements with a number of different entities, the government's complaint focused on WMC's relationship with Cardiology Consultants of Westchester County, P.C. ("CCW"). CCW operated as a private practice and also operated as the academic and clinical cardiology division of WMC. CCW was a significant source of revenue for WMC, responsible for approximately 80% of cardiac referrals to WMC. In its complaint, the government alleged the following:

Violation of Stark and AKS Through "Seed Monies" and Use of Fellows. Through an affiliate, WMC entered into a management agreement with CCW ("Management Agreement") to provide seed monies to help CCW establish and develop medical office space in Kingston, New York. WMC's affiliate advanced CCW approximately $450,000 to pay for certain practice costs, with CCW agreeing to repay the loan at a rate of 8.5% interest. Later, while in the process of terminating the Management Agreement, WMC received a memorandum from CCW requesting that WMC postpone or eliminate certain interest payments, reduce the interest rate, and extend the repayment period. According to the memorandum, these adjustments would be made in recognition of CCW's efforts in developing clinical volume at the Kingston location and the resulting referrals to WMC. Subsequent to these adjustments, the parties terminated the agreement and entered into a promissory note pursuant to which CCW agreed to repay the advances at a rate of 4.75%. In addition, before CCW's initial repayment, WMC and CCW entered into a consulting agreement under which WMC agreed to pay CCW $50,000 per year. Thereafter, although WMC made the payments required by the agreement, it admitted that it was unable to find evidence that CCW had performed the consulting services covered by the agreement.

Additionally, WMC had historically charged various physician practices for a portion of the salaries and expenses relating to residents and fellows who trained at WMC. These fellows would perform certain services within CCW's private offices as part of their clinical rotation. CCW historically paid WMC hundreds of thousands of dollars for the salaries and expenses relating to these fellows. Beginning in 2003, CCW stopped paying WMC for these fellows. WMC admitted that it simply wrote-off these amounts.

The government alleged that the use of seed monies and of the fellows violated the AKS by inducing the CCW physicians to make referrals to WMC. It also asserted that the CCW physicians who referred to WMC had a financial relationship with WMC, and that the seed money and fellow arrangements were evidence that the financial relationship violated the Stark Law by taking into account the volume or value of referrals to WMC. These violations, the government argued, caused WMC to present false claims for payment under the FCA.

False Claims Related to WMC's Cost Reports.

For a number of years, WMC submitted annual Medicare cost reports to the Health Care Financing Administration ("HCFA") (and later to the Centers for Medicare and Medicaid Services ("CMS")), reflecting certain costs, referred to as Direct Graduate Medical Education ("DGME") and Indirect Medical Education ("IME") costs, associated with its residency and fellowship programs. WMC failed to carve out costs for time spent by residents and fellows at other hospitals or at non-hospital settings. By failing to properly exclude these costs from its cost reports, the government argued that WMC improperly inflated Medicare reimbursement for DGME and IME, and as a result, violated, *inter alia*, the FCA.

Current Status: On May 14, 2015, the case was settled for $18,800,000, with the relator's estate receiving a $3,713,000 share. The relator, Dan Bisk, died in 2009 from injuries sustained in the crash of a small airplane on which he was a passenger. All other claims were dismissed, including claims made under New York State law.

Reasons to Watch: While this case provides a number of examples of non-compliant arrangements, it also underscores the crucial need for hospitals to maintain a culture of compliance. The relator's complaint paints a damaging picture of WMC's handling of repeated warnings by relator. Individuals at all levels of WMC's leadership, including the CEO, were allegedly complicit in marginalizing the relator's standing within the — eventually terminating him, and denying him his severance. The case is also a reminder of the care that hospitals should take in preparing the cost reports associated with their residency and fellowship programs.

Recently Unsealed Cases

United States ex rel. Ross v. Family Dermatology of Penn., P.C., No. 1:11-cv-2413 (N.D. Ga.)

United States ex rel. Baucom v. Family Dermatology of Penn., P.C., No. 1:11-cv-4260 (N.D. Ga.)

United States ex rel. Milstein v. Family Dermatology, P.C., No. 1:13-cv-01027 (N.D. Ga.)

Complaints Filed:

- *Ross:* July 21, 2011, with First Amended Complaint filed on April 24, 2013;
- *Bourcom:* December 8, 2011;

- *Milstein:* March 28, 2013, with First Amended Complaint filed on October 1, 2013.

Complaints Unsealed: April 2, 2015 (all three cases)

Intervention Status: The United States elected to intervene in all three cases on April 21, 2015; the same day it filed its notice of settlement.

Claims: *Ross:* Violations of the Stark Law, 42 U.S.C. § 1395nn, the Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), and the False Claims Act, 31 U.S.C. § 3729 et seq., including the submission of false claims and false statements.

Baucom: Violations of the False Claims Act, 31 U.S.C. § 3729 et seq., including the submission of false claims and false statements, as well as reverse false claims, and the Georgia State False Medicaid Claims Act (Ga. Code Ann. §§ 49-4-168 *et seq.*), including the submission of false claims.

Milstein: Violations of the Stark Law, 42 U.S.C. § 1395nn, and the False Claims Act, 31 U.S.C. § 3729 et seq., including the submission of false claims and false statements.

Name(s) of Relators: Dr. Scott Ross, Dr. Mark Baucom, and Dr. Harold Milstein

Defendant's Business: Family Dermatology P.C. ("Family Derm") is a multi-state dermatology practice with practices throughout the United States, owned and operated by individual defendant, Dr. Paula Nelson. Dr. Nelson also owns various other companies along with her husband, individual defendant Yinka Adesokan. For example, Dr. Nelson owns and is the medical director of Nelson Dermatopathology & Pathology Laboratory ("Nelson Dermatopathology"). Along with her husband, she also owns Database, Inc. ("Database"), which sells a comprehensive practice management and electronic medical record system to dermatology practices.

Relators' Relationship to Defendant:

Dr. Scott Ross is a physician who agreed to sell his dermatology practice to Family Derm and to provide dermatology services on a contract basis on behalf of Family Derm. Dr. Ross' refusal to refer all of his pathology services to Nelson Dermatopathology led to the termination of the sale of his practice, along with his independent contractor agreement.

Dr. Mark Baucom is a physician and owner of a dermatology surgery practice in Georgia who became aware of Family Derm's business model when one of Family Derm's owners contacted him about purchasing his practice and employing him as a dermatologist. Dr. Baucom declined to enter into an agreement with Family Derm.

Dr. Harold Milstein is a physician who sold his dermatology practice to Family Derm and worked as an independent contractor for Family Derm until June 30, 2013.

Relators' Counsel: Pietragallo, Gordon, Alfano, Bosick & Raspanti, LLP and Wilbanks & Bridges, LLP (*Ross*); Boone & Stone Trial Lawyers and Frank, Haron, Weiner, & Navarro (*Baucom*); The Cohen Law Group (*Milstein*)

Summary of Case:

While all three cases allege slightly different facts and circumstances, at the core of these cases is the allegation that Family Derm and Dr. Nelson violated the Stark Law, the Anti-Kickback Statute, and the False Claims Act by entering into "sweetheart arrangements" with independent contracted physicians after purchasing their practices. All three relators contended that Dr. Nelson and Family Derm would buy dermatology practices, enter into independent contractor agreements with the remaining physicians, and require each of the independent contractor physicians to refer their pathology specimens to Nelson Dermatopathology. According to Dr. Ross, Family Derm would terminate physicians who refused to comply with this requirement. The relators charged that by directing the physicians to make referrals to a laboratory that she owned, Dr. Nelson violated the Stark Law and knowingly submitted false claims to the Medicare program, in violation of the False Claims Act.

Each relator alleged various other violations of the Stark Law, the AKS, and the False Claims Act. For example, Relator Dr. Baucom claimed that compensation paid to the individual contracted physicians was based on the volume of pathology specimen referrals to Nelson Dermatopathology, which implicated the AKS.

Further, Dr. Ross and Dr. Baucom both asserted that Dr. Nelson and her husband, Mr. Adesokan, violated the Stark Law and the False Claims Act by forcing physicians who purchased Database to refer pathology specimens to Nelson Dermatopathology. Under this scheme, Dr. Ross claimed that physicians were offered Database at steeply discounted rates. Once their practices became dependent on the system a few months later, Mr. Adesokan would threaten to increase the price by as much as 85% unless the physicians referred their dermatopathology tests to Nelson Dermatopathology. Similarly, Dr. Baucom alleged that Database allowed Mr. Adesokan to identify the laboratory that physicians were using and that he would substantially increase the Database subscription rates for dermatologists who did not make sufficient referrals to Nelson Dermatopathology.

Dr. Ross claimed that Family Derm financially incentivized dermatologists to over-utilize dermatology services and stated that he had heard that at least one Family Derm practice performed biopsies on every single patient, regardless of medical necessity. Dr. Milstein also alleged that Family Derm billed Medicare 100% for services provided by mid-level practitioners when the supervising physician was not at the same location, and that Family Derm would bill Medicare under Dr. Nelson's NPI for services provided by physicians not enrolled in Medicare.

Current Status: On April 21, 2015, Family Derm and the United States reached a settlement agreement in all three cases, under which Family Derm will pay the United States $3,247,835 plus interest to settle the allegations.

The Department of Justice's press release regarding this settlement is available here.

Reasons to Watch: This trio of cases is of particular interest because they are evidence of the government's on-going commitment to scrutinize "sweetheart deals" between health care companies and the physicians associated with them to ensure that their decisions are based on sound medical practice rather than on financial incentives. As the health care industry continues to move toward more consolidation, physician practices, laboratories, and others should be aware that acquisition of physician practices should be guided by applicable Stark Law exceptions and AKS safe harbors. Also of note is that the relators in this case were all physicians who sold their practices to Family Derm or were approached regarding a sale, rather than a disgruntled employee, as is more normally the case, which suggests that as consolidation continues, mergers and acquisitions may give birth to relators.

About Our Health Care Enforcement Defense Practice

Mintz Levin's Health Care Enforcement Defense Practice is comprised of 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.

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