Qui tam 'jackpot' spurs false claims suits

By BURT SCHORR

A private False Claims Act suit against DME/oxygen suppliers accused of cheating Medicare through kickbacks to more than three dozen Florida physicians, physician groups and hospitals is the latest use of the whistleblower statute against Medicare providers and suppliers.

The *qui tam* charges against Clearwater-based Lincare Holdings Inc., seven other DME/oxygen companies and the accused physicians are leveled in a private suit by Kirk Corsello, a former Lincare center manager in Orlando. Corsello contends Lincare fired him for insubordination after he threatened to expose the alleged kickbacks and other fraudulent activities.

Although the Justice Department so far has declined to intervene in the Orlando case, it retains the option of doing so at a later date, notes a federal prosecutor who has looked into the Corsello charges. Federal investigators also are checking reports that some of the Orlando defendants were involved in fraudulent claims elsewhere in the country, according to Corsello's attorney, Mike Bothwell of Roswell, Ga.

Lincare, a $440 million-a-year supplier of home-delivered oxygen and other respiratory therapy services in Florida and 40 other states, says the allegations—unsealed earlier this month by a federal judge in Atlanta—are without merit and that it will defend itself vigorously against them.

Without linking the individual accused companies to specific actions, Corsello's 20-page complaint charges that "certain of the DME defendants camouflaged" kickbacks with:

- "'Consulting arrangements' or other programs intended to pay referring defendant physicians for duties already owed to shared patients by virtue of the physician-patient relationship."
- Lease arrangements that might involve the renting of "unnecessary space" from the doctor in question or the leasing of space to the doctor. "In either case, the lease was secondary to the purpose of hiding the kickback."
- "Extremely reduced prices" on DME equipment and monitoring devices, such as oximeters, supplied to the physicians or to their patients.
- Provision of services, including pulmonary function testing, pulse

see QUI TAM page 14

Qui tam 'jackpot' spurs increase in false claims suits

QUI TAM from page 1

oximetry testing, spirometry and heart monitoring," for which the referring physicians then billed Medicare.

If successful, Corsello could get up to a 30 percent share of whatever the accused suppliers and providers might be forced to repay on fraudulent claims, which can run into the millions.

Statistics favor federal participation

Under the False Claims Act, the government is entitled to three times the amount of such claims paid by Medicare, Medicaid or the CHAMPUS program for military retirees and dependents. In addition, the law allows penalties of up to $10,000 for each fraudulent claim as well as payment of the plaintiff's legal costs.

Last year, Apria Healthcare Group, one of the Orlando defendants, settled a False Claims Act suit another Bothwell client had brought by agreeing to pay $1.65 million and develop a new compliance plan. A whistleblower suit also led to Justice Department charges in September that a network of 25 Tampa-area medical supply companies overbilled Medicare and Medicaid by at least $7 million over the past five years.

And yet another private False Claims Act suit triggered the massive federal investigation of Columbia/HCA Health Corp. and Quorum Health Group, which still is continuing.

If statistics are any guide, the odds of whistleblowers winning a judgment or out-of-court settlement increase greatly when the Justice Department elects to intervene in their cases with its own attorneys and investigators.

Of the 2,422 private False Claims Act suits filed from fiscal 1986 through August 1998, Justice has elected to play a role in 337, of which three-quarters so far have concluded in a settlement or a judgment against the defendant. Only seven have been dismissed with no recovery, the Washington-based False Claims Act Legal Center reports, based on its analysis of Justice Dept. data.

Among the 1,229 *qui tam* cases declined by Justice, however, fewer than 5 percent have ended with settlements or judgments and 70 percent have been dismissed with no recovery. The remainder of the 2,422 cases filed were still under investigation by Justice.

But the relative percentages could change as manpower limitations prevent Justice from intervening in more strong cases against defendants it otherwise would have joined.

'No downside' encourages suits

Reflecting Washington's increased public concern about Medicare and Medicaid fraud, Congress has greatly increased funding for local U.S. attorneys, the FBI and the HHS Office of Inspector General to bring such cases, notes Kenneth Nolan, a Hollywood, Fla. attorney who represents qui tam plaintiffs. "But they may not be able to keep up with the number of cases being filed and may have to decline meritorious, high-dollar cases," Nolan said.

"There's a whole lot of small fraud out there that's flying under the government's radar," agrees Philadelphia attorney David Laigaie whose law firm, Miller, Alfano & Raspanti, also represents *qui tam* plaintiffs.

Encouraging whistleblower suits is the fact that there's generally no downside to such private suits, says Kathleen McGwan, a Washington attorney with Reed Smith Shaw & McClay who represents health care providers accused of False Claims Act violations.

Plaintiffs who win, "hit the jackpot," McGwann notes, while those who lose typically suffer no financial loss because attorneys usually take such cases on a contingency basis.

Qui tam is part of a Latin phrase describing an English Common Law provision that allows private suits in behalf of the king. During the Civil War, Congress adapted it to a federal statute that allowed private plaintiffs to share in recoveries of federal dollars from military contractors and others found to have defrauded the government.

Since 1986, when False Claims Act revisions made it more worthwhile for individuals to file in behalf of the government, the number of qui tam whistleblower suits has ballooned—from 33 in fiscal 1987 to 534 in fiscal 1997 and 417 through Aug. 31 of this year.

Because the False Claims Act's treble damages are more severe than under Medicare's antifraud statutes, Justice also has made increasing use of the statute to bolster its own Medicare fraud actions. In one such case against First American Health Care of Georgia and its purchaser, Integrated Health Services, the two companies agreed to pay the government $255 million to settle the False Claims charges against them.

Overall recoveries from defendants in suits that began as private actions—the large majority involving Medicare or Medicaid claims—have totaled more than $2.2 billion, of which approximately $300 million went to the whistle-blower plaintiffs, Justice says. Significantly, more than 98 percent of those payments were in cases where Justice elected to intervene as a co-plaintiff.

That's clear from a new Justice Dept. report that judgments and settlements of whistleblowers' health care fraud suits resulted in provider payments of $618 million in fiscal 1997, or more than four times the prior year's total. The number of such health-related qui tam suits also is on the rise, with 289 filed against providers in fiscal 1997, or nearly 50 percent more than in fiscal 1996, the report states. ■

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