Relator Fees and Settlements of Durable Medical Equipment ("DME") Cases

A whistleblower, a former billing supervisor for the company, received a **Relator Fee** of **$918,750** of the recovery from a **settlement** of **$5.25 million** in August of 2018, when Lincare, a nationwide provider of oxygen and home respiratory-therapy services, agreed to settle allegations that it offered illegal price reductions to Medicare beneficiaries, in violation of the AKS. *See* Press Release, U.S. Atty's Office for the S. Dist. of Ill., Durable Medical Equipment Provider Lincare Pays $5.25 Million to Resolve False Claims Act Allegations (Aug. 16, 2018), https://www.justice.gov/usao-sdil/pr/durable-medical-equipment-provider-lincare-pays-525-million-resolve-false-claims-act.

A **whistleblower**, a physician who worked for various durable medical equipment companies, received a **Relator Fee** of **$5.38 million from a $34.8 million settlement** in a case in March of 2016, when Respironics agreed to resolve allegations that it provided free call center services to durable medical equipment suppliers to induce the suppliers to purchase the company's sleep apnea masks. . *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Respironics to Pay $34.8 Million for Allegedly Causing False Claims to Medicare, Medicaid and Tricare Related to the Sale of Masks Designed to Treat Sleep Apnea (Mar. 23, 2016),https://www.justice.gov/opa/pr/respironics-pay-348-million-allegedly-causing-false-claims-medicare-medicaid-and-tricare.

Six co-conspirators connected with Jaspan Medical Systems (Jaspan), a California based DME supplier, were convicted of charges resulting from their involvement in a scheme to defraud Medicare, Medicaid and Tricare. The defendants—Jaspan manager Bryan Mitchell Bailey and sales staff Sandra and Calvin Bailey, Cindy Mallard, and Brenda and Dennis Sensing—were sentenced to a combined 20 years and 9 months in prison, and ordered to pay **$2.1 million** in **restitution**. The investigation found that the defendants marketed power wheelchairs to patients and represented them as paid fully by Medicare, and at no cost to the patients. An extensive network of illegally paid recruiters was used to find eligible patients. After finding the patients, the defendants falsified documents to make it appear that the patients qualified for the equipment. Bailey and his co-defendants also enlisted a local physician and nurse practitioner to order the equipment without the required physical examinations to determine if the equipment was medically necessary. Illegal

kickbacks were paid to the medical providers to facilitate this scheme. Many patients testified that they never used the power wheelchairs, and that the power wheelchairs were too large to be used in their homes. Most of the patients could walk, drive vehicles, and care for themselves without the need for a power wheelchair. *See* 2018 OIG Annual Report.

In of March 2017, Braden Partners, L.P., doing business as Pacific Pulmonary Services, agreed to pay **$11.4 million** to resolve allegations against it and its general partner, Teijin Pharma USA LLC, that they violated the civil FCA. California-based Pacific Pulmonary Services furnishes stationary and portable oxygen tanks and related supplies, and sleep therapy equipment, such as continuous positive airway pressure and bi-level positive airway pressure masks and related supplies, to patients' homes in California and other states. The United States alleged that beginning in about 2004, Pacific Pulmonary Services began submitting claims for home oxygen and oxygen equipment without obtaining a physician evaluation and authorization, as required by program rules. Further, beginning in 2006, certain of the company's patient care coordinators also allegedly agreed to make patient referrals to sleep testing clinics in exchange for those clinics' agreement to refer patients to Pacific Pulmonary Services for sleep therapy equipment in violation of the Anti-Kickback Statute. *See* 2018 OIG Annual Report.

In December 2014, a medical supplies company owner was sentenced in Baton Rouge, Louisiana to 156 months imprisonment for submitting hundreds of false and fraudulent claims to Medicare for medical devices over a two year period. For instance, he submitted claims for "brace kits," regardless of whether any of the Medicare beneficiaries named in the claims needed or had prescriptions for the items, submitted claims for custom-fabricated devices which were never provided, and submitted numerous claims for expensive replacement power wheelchairs that he falsely claimed had been damaged or destroyed by a hurricane. The owner was ordered to make **restitution to** the Medicare program in the amount of **$1.2 million,** to forfeit the proceeds of his criminal activity up to an additional $1.2 million, and to serve a two-year term of supervised release. *See* 2015 OIG Annual Report.

In February 2015 and May 2015, two individuals pled guilty to health care fraud conspiracy for their roles in a $13 million long-running scheme to submit false claims for durable medical equipment to a government-sponsored organization for managed care in New York. The scheme involved

the defendants using information for approved, in-network equipment providers to obtain approvals that were then used to secure payments on behalf of sham companies that the defendants set up. Companies believed to have been involved in the scheme submitted fraudulent claims to the managed care organization in amounts over **$13 million** since 2008. InSeptember 2015, one of the defendants was sentenced to 21 months in jail and ordered to pay over $337,000 in forfeiture and the same amount in restitution. *See* 2015 OIG Annual Report.

In March 2015, an owner of Colonial Medical Supply, a durable medical equipment company in Los Angeles, was convicted after a jury trial for his role in a **$3.3 million** Medicare fraud scheme. The evidence at trial established that the defendant paid cash kickbacks to medical clinics for fraudulent prescriptions for durable medical equipment, such as expensive power wheel chairs, which the patients did not need. The defendant then used these prescriptions to bill Medicare for the medically unnecessary equipment. In May 2015, the defendant was sentenced to 84 months' imprisonment. *See* 2015 OIG Annual Report.

In March 2015, an owner of Ezcor-9000, Inc., a durable medical equipment company in Valencia, California, was convicted after an eight-day jury trial for her role in a **$3.5 million** Medicare fraud scheme. The evidence at trial established that the defendant paid illegal kickbacks to patient recruiters in exchange for patient referrals. The evidence also showed that the defendant paid kickbacks to physicians for fraudulent prescriptions—primarily for medically unnecessary, but expensive, power wheelchairs—that she then used to support her fraudulent bills to Medicare. In June 2015, the defendant was sentenced to 97 months in prison. *See* 2015 OIG Annual Report.

In May 2015, DME suppliers Orbit Medical Inc. and its partial successor, Rehab Medical Inc., agreed to pay **$7.5 million** to settle civil FCA allegations that Orbit submitted false claims to federal health care programs for power wheelchairs and accessories. The settlement resolved allegations that Orbit sales representatives knowingly altered physician prescriptions and supporting documentation to get Orbit's power wheelchair and accessory claims paid by Medicare, the Federal Employees Health Benefits Plan and the Defense Health Agency. In particular, the government alleged that Orbit sales representatives changed or added dates to physician prescriptions and chart notes to falsely document that the prescription was sent to the supplier within 45 days of the face-to-face beneficiary exam; changed the physician

prescription, chart notes, and other documentation to falsely establish medical necessity for the power wheelchair or accessory; and added facsimile stamps to supporting documentation to make it appear as though the physician's office had sent the documents to Orbit. *See* 2015 OIG Annual Report.

In May 2015, a registered nurse and owner of a DME company in Los Angeles, California was sentenced to 4 years in prison and ordered to pay **$4.3 million** in joint and several **restitution** after being convicted of health care fraud and laundering of monetary instruments. According to the investigation, the nurse/owner and her co-conspirators used cash and checks to pay illegal kickbacks to recruit Medicare beneficiaries for power wheelchairs and other DME, to which the beneficiaries did not have a legitimate medical need. She and her co-conspirators also paid illegal kickbacks to a physician in exchange for writing false prescriptions and documents for the DME, which was then used to fraudulently bill Medicare. *See* 2015 OIG Annual Report.

In October 2013, a Los Angeles-area church pastor was sentenced to 87 months in prison for conspiring to defraud Medicare. The defendant owned and operated the DME company Bonfee, Inc. His daughter owned and operated the DME company Ibon, Inc. According to the indictment, two other co-conspirators acted as marketers who solicited and obtained Medicare beneficiaries' information by offering them medically unnecessary medical equipment. The information was used by a physician and others to create fraudulent prescriptions and medical documents. The two DME owners then used the information to submit or cause the submission of more than **$11 million** in false claims to Medicare for power wheelchairs and other medical equipment that had not been provided or were medically unnecessary. Four of the conspirators previously pleaded guilty and were sentenced to a combined 14 years and nine months of incarceration and were ordered to pay joint and several restitution of $6.3 million. The fifth was convicted at trial and is awaiting sentencing. *See* 2014 OIG Annual Report.

In November 2013, the Richmond, Texas owner of a DME company was sentenced to four years in prison and ordered to pay nearly **$1.5 million** in **restitution** following his conviction for conspiracy to commit health care fraud and health care fraud aiding and abetting. Spectrum Foundation, Inc. (Spectrum) was a Texas business that purportedly provided Medicare and Medicaid beneficiaries with orthotics and other DME. According to the indictment, Spectrum's owner and his co-conspirators used Spectrum to

submit claims for DME that were medically unnecessary or were not provided at all and claims for DME that were intentionally miscoded. Spectrum then submitted claims to Medicare in excess of $3.4 million for these and other items, including 157 unpaid claims on behalf of deceased beneficiaries. The owner also owned and operated an ambulance transportation company and submitted or caused the submission of claims to Medicare for ambulance services that had not been provided or for instances when the beneficiaries had been transported in a standard minivan. *See* 2014 OIG Annual Report.

In February 2014, a Houston, Texas defendant was sentenced to **87 months in federal prison** for his role in a multi-state health care fraud scheme involving unnecessary motorized wheelchairs. The defendant was ordered to pay **restitution** in the amount of **$1.6 billion** to the Medicare and Medicaid programs and a fine of $12,500. According to the indictment, from May 2002 to June 2003, the defendant conspired with others to defraud Medicare and Medicaid through the mass marketing of motorized wheelchairs. As part of the scheme, the defendant and his co-conspirators recruited Medicare and Medicaid beneficiaries and would secure the beneficiaries protected health information. The defendant and his co-conspirators created false medical necessity certificates, drafted prescriptions from doctors who had never examined those beneficiaries, and then billed Medicare for motorized wheelchairs. He then delivered less expensive scooters to the beneficiaries instead, and in other instances, did not deliver anything even though Medicare had paid for a motorized wheelchair. *See* 2014 OIG Annual Report.

In April 2014, the owner and managing employee of Midvalley Medical Supply who also worked as an office manager under a different name at the Vermont Clinic in Los Angeles, was sentenced to six years and four months of incarceration and ordered to pay **$9.6 million** in joint and several restitution. According to the indictment, the managing employee, along with a physician's assistant at the Vermont Clinic and others, recruited and transported Medicare beneficiaries to the Vermont Clinic, often with the promise of free, medically unnecessary DME. Some of these beneficiaries lived hundreds of miles away. The beneficiaries were often prescribed DME and underwent medically unnecessary tests, including nerve conduction tests and ultrasounds. The managing employee then used the patient information obtained from beneficiaries at the Vermont Clinic to bill for medically unnecessary DME prescriptions through her DME company, Midvalley. In addition to her sentencing, the managing employee was excluded from participating in any federal health care programs for 30 years. The physician's

assistant pleaded guilty to charges of health care fraud and conspiracy to commit health care fraud and is awaiting sentencing. *See* 2014 OIG Annual Report.

In June 2014, following their convictions at trial, two Los Angeles area DME supply owners and a San Francisco based "recruiter" were sentenced to 144 months, 51 months, and one year and one day, respectively, for their roles in a **$3.2 million** health care fraud and kickback conspiracy. A San Francisco physician and another recruiter, both of whom pled guilty and testified at trial, were sentenced to 24 months in prison and three years' probation, respectively. The lead defendants were also ordered to forfeit $1,577,426 and pay restitution of the same amount to CMS. The investigation showed that from approximately December 2006 and continuing through July 2011, the owners submitted over 400 false and fraudulent power wheelchair claims to Medicare in the names of beneficiaries identified by recruiters using fraudulent prescriptions and medical records prepared by the physician. After the recruiters identified beneficiaries, the physician conducted sham examinations to obtain background information for the required Medicare paperwork and gave the information and bogus prescriptions to the owners. The owners paid the physician a $100 kickback for each power wheelchair prescription. *See* 2014 OIG Annual Report.