

**THE TOP 100 FALSE  
CLAIMS ACT SETTLEMENTS**

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## **INTRODUCTION**

The federal False Claims Act is a remarkable law.

It says to citizens of the U.S. – if you have information about corporations that are defrauding the federal government, come forward, tell federal prosecutors about it, and if federal prosecutors can verify your claim, they will join with you and sue the corporation to recover the amount of money that the corporation defrauded from the United States.

If you can prove your case, and the government recovers the defrauded money, then you, ordinary citizen, will get a cut of the recovery – anywhere from 15 to 30 percent.

This law grew out of the Civil War.

President Abraham Lincoln was upset with companies that sold faulty war supplies to the Union Army during the Civil War. These faulty supplies included broken rifles, rancid food, useless ammunition, and lame horses and mules.

In 1863, President Lincoln called on Congress to pass the False Claims Act. They did and he signed it into law.

Lincoln condemned the corporate criminals in his midst. He put it this way: "Worse than traitors in arms are the men who pretend loyalty to the flag, feast and fatten on the misfortunes of the nation while patriotic blood is crimsoning the plains of the south and their countrymen are moldering in the dust."

The 1863 False Claims Act provided both criminal and civil penalties, contained a qui tam provision, and permitted a whistleblower to collect 50 percent of the damages.

Under pressure from contractors, Congress in 1943 amended the False Claims Act to make it virtually impossible for a whistleblower to successfully recover under the law.

But in 1986, facing media reports of defense contractor rip-offs of the Pentagon, a coalition of Democrats and Republicans again amended the law, this time to make it easier to bring qui tam lawsuits under the False Claims Act.

Qui tam is a shorthand version of the Latin phrase: "Qui tam pro domino rege quam pro se ipso," which means: "He who sues on behalf of the King, as well as for Himself"

The qui tam provisions of the law allow citizens to sue on behalf of the federal government against corporations who defraud the government.

The 1986 amendments made a number of important changes to the law, including requiring the government prove a false claim by a preponderance of evidence instead of higher

standards that had been imposed by courts, providing for treble damages, enhancing the qui tam relator's role in the litigation and enlarging his or her share to between 15-25 percent where the government participates in the litigation or 25-30 percent where the government declines to participate in the litigation, and protecting the relators from retaliation by their employers.

Ever since the 1986 amendments to the False Claims Act were passed into law, cases and recoveries to the federal Treasury have grown remarkably.

The government has recovered \$12 billion since the 1986 amendments were passed.

This report documents the 100 top settlements under the False Claims Act.

The top 100 recoveries brought in a total of \$8.2 billion – more than 65 percent of the \$12 billion recovered in total under the False Claims Act since it was amended in 1986.

Eight of the top ten settlements involved criminal plea agreements by the companies.

The top 100 settlements ranged from a \$731 million settlement in December 2000 with the Tennessee-based health care giant HCA to a \$13 million settlement with each of three companies tied for the 100<sup>th</sup> spot – Kerr-McGee, FMC and First Health Services.

In each of the top 100 cases, whistleblowers raked in more than \$1 million.

Fifty-six of the top 100 false claims settlements were with health care corporations, while 23 were defense contractors.

The top two settlements were with HCA, the Tennessee based health care corporation – for \$731 million in December 2000 and for \$631 million in June 2003.

Rounding out the top five settlements were TAP Pharmaceuticals for \$559 million in October 2001, Abbott Labs for \$400 million in July 2003, and Fresenius Medical Care for \$385 million in January 2000.

The federal government has the authority to prohibit corporations convicted of serious crimes from doing business with the federal government.

This debarment or exclusion authority is considered the equivalent of the death penalty, because for major health care corporations and defense corporations which rely on federal contracts, denying them federal contracts would effectively put them out of business.

The federal government rarely exercises this authority – although it should more often to deter an ongoing pattern of criminal fraud.

## **THE TOP 100 FALSE CLAIMS ACT SETTLEMENTS: IN BRIEF**

**The Top 100 False Claims Act Settlements (Ranked by Amount of Settlement)  
Published by Corporate Crime Reporter, December 30, 2003**

<i>Company Name</i>	<i>Settlement Amount</i>	<i>Date</i>	<i>Relators Share (if known)</i>
(* indicates related criminal conviction)			
1) HCA *	731,400,000	December 2000	
2) HCA *	631,000,000	June 2003	151,591,500
3) TAP Pharmaceuticals Products Inc. *	559,483,560	October 2001	95,000,000
4) Abbott Labs *	400,000,000	July 2003	
5) Fresenius Medical Care of North America *	385,000,000	January 2000	65,000,000
6) SmithKline Beecham Clinical Labs	325,000,000	February 1997	
7) National Medical Enterprises *	324,200,000	June 1994	65,000,000
8) AstraZeneca *	266,127,844	June 2003	47,500,000
9) Bayer Corp. *	257,200,000	April 2003	34,000,000
10) First American Health Care Of Georgia	225,000,000	October 1996	
11) Laboratory Corporation of America *	182,000,000	November 1996	
12) Beverly Enterprises Inc. *	170,000,000	February 2000	28,900,000
13) United Technologies	150,000,000	March 1994	
14) Blue Cross Blue Shield Illinois *	140,000,000	July 1998	29,200,000
15) Northrop Grumman	111,200,000	June 2003	27,200,000
16) Shell Oil Company	110,000,000	January 2001	
17) Vencor Inc./Ventas Inc.	104,500,000	March 2001	
18) National Health Labs	100,000,000	December 1992	
19) Quorum Health Group Inc.	95,500,000	October 2000	
20) Chevron	95,000,000	January 2000	14,500,000
21) Lucas Industries *	88,000,000	September 1995	19,360,000
22) GlaxoSmithKline	87,600,922	April 2003	
23) PacifiCare Health Systems	87,300,000	April 2002	3,500,000
24) Teledyne	85,000,000	April 1994	
25) Damon Clinical Laboratories*	83,700,000	October 1996	
26) Litton	82,000,000	July 1994	

27) (tie) Northrop Grumman	80,000,000	July 2003	
27) (tie) FMC	80,000,000	October 2000	
29) General American Life Insurance Co.	76,000,000	June 2002	14,400,000
30) Boeing Company	75,000,000	April 1994	
31) State of California Los Angeles County	73,300,000	June 2002	1,300,000
32) Philips Electronics *	65,300,000	February 1996	
33) General Electric *	59,500,000	July 1993	
34) Shell Oil Company	56,000,000	September 2000	
35) Singer	55,500,000	July 1992	
36) Hercules	55,000,000	May 1998	
37) (tie) Tenet Healthcare Corporation	54,000,000	August 2003	10,500,000
37) (tie) Boeing Company	54,000,000	August 2000	
39) Gambro Healthcare Inc.	53,100,000	July 2000	5,945,959
40) (tie) Pfizer Inc.	49,000,000	October 2002	
40) (tie) Shell Oil Company	49,000,000	August 2003	
40) (tie) New York State and City of New York	49,000,000	November 1998	4,900,000
43) Texaco Inc.	43,000,000	September 2000	9,800,000
44) Olsten Corporation *	41,000,000	July 1999	
45) MetPath/MetWest (Corning Labs)	39,800,000	September 1993	
46) Basin Electric Power Cooperative	39,100,000	March 1999	5,976,000
47) Highmark Inc.	38,500,000	September 1998	
48) Salomon Smith Barney	38,000,000	April 2000	8,750,000
49) Lockheed Martin	37,900,000	July 2003	
50) Jacobs Engineering Group	35,000,000	March 2000	
51) NEC	34,000,000	May 1991	5,400,000
52) BP Amoco	32,000,000	April 2000	
53) Community Health Systems Inc.	31,000,000	May 2000	
54) Lifescan (Johnson & Johnson) *	30,600,000	December 2000	
55) (tie) Contech Construction	30,000,000	January 2001	
55) (tie) University of Pennsylvania	30,000,000	December 1995	4,000,000
57) Lifemark Hospital (Tenet)	29,000,000	July 2002	
58) Blue Cross Blue Shield Michigan	27,600,000	January 1995	5,520,000
59) Teledyne	27,500,000	April 1994	5,400,000

60) (tie) National Healthcare	27,000,000	December 2000	
60) (tie) Rockwell International	27,000,000	July 1995	4,050,000
			4,200,000
62) New York State	26,970,000	December 1994	
63) Conoco Inc	26,000,000	March 2000	
64) (tie) Perkin-Elmer	25,000,000	October 1993	7,370,000
64) (tie) Continental Grain *	25,000,000	November 1996	
64) (tie) Koch Industries	25,000,000	May 2001	
67) Lovelace Health Systems	24,500,000	December 2002	
68) North Carolina	23,800,000	September 2003	
69) Toshiba Corporation	23,000,000	October 2000	
70) Olympus America Inc.	22,800,000	September 1997	
71) University of California	22,500,000	February 2001	
72) RR Donnelley	22,000,000	August 1999	
73) Paine Webber Inc..	21,600,000	April 2000	
74) Unocal	21,500,000	December 2001	3,775,000
75) American Medical Response Inc.	20,000,000	June 2002	
76) Dana Corp.	19,500,000	September 1995	
77) Dey Inc. (Merck)	18,500,000	June 2003	
78) Quorum Health Group	18,000,000	October 2000	
79) Baptist Medical Center	17,500,000	September 1997	
80) University of Texas	17,200,000	June 1998	
81) (tie) 139 Hospitals Owned by Tenet Healthcare Corp	17,000,000	June 2002	
81) (tie) Rotech Medical Corp.	17,000,000	February 2002	
83) (tie) Curative Health Care	16,500,000	January 2002	
83) (tie) Fresenius Medical	16,500,000	May 1999	
85) Allina Health Systems	16,000,000	January 2002	
86) McLeod Regional Medical Center	15,909,470	November 2002	
87) (tie) W.R. Grace & Co.	15,500,000	August 2000	
87) (tie) Emergency Physicians Billing Services Inc.	15,500,000	October 1999	
89) Ventura County, California	15,300,000	November 1999	
90) BT Alex Brown	15,177,572	November 1999	
91) Superior Home Health Care of Chattanooga Inc.	15,250,000	March 2002	
92) (tie) Lifescan (Johnson & Johnson)	15,000,000	November 2001	
92) (tie) Motorola	15,000,000	February 1992	
92) (tie) American Management			

Systems Inc.	15,000,000	June 2003
92) (tie) Gottlieb Financial Services Inc.	15,000,000	July 1999
96) Pratt & Whitney	14,800,000	May 1997
97) Humana Inc.	14,500,000	June 2000
98) Bayer Corporation	14,000,000	January 2001
99) Quest Diagnostics	13,100,000	January 2001
100) (tie) Kerr-McGee	13,000,000	October 2000
100) (tie) FMC	13,000,000	October 1996
100) (tie) First Health Services	13,000,000	April 2003

## THE TOP 100 FALSE CLAIMS ACT SETTLEMENTS: THE CASE HISTORIES

### 1) HCA (\$731,400,000) \*

In December 2000, HCA The Healthcare Company (formerly known as Columbia HCA), the largest for profit hospital chain in the United States, agreed to plead guilty to criminal conduct and pay more than \$840 million in criminal fines, civil penalties and damages for alleged unlawful billing practices.

Under the agreement, HCA will pay a total of \$745 million to resolve five allegations regarding the manner in which it bills the U.S. government and the states for health care costs.

The agreement does not resolve allegations that HCA unlawfully charged for the costs of running its hospitals on cost reports submitted to the government, and that it paid kickbacks to physicians to get Medicare and Medicaid patients referred to its facilities.

Of the \$745 million, the settlement requires HCA to pay:

- \* more than \$95 million to resolve civil claims arising from the company's outpatient laboratory billing practices, which included billing to Medicare, Medicaid, the Defense Department's TRICARE health care program, and the Federal Employees' Health Benefits Program, for lab tests that were not medically necessary, not ordered by physicians, as well as other billing violations;

- \* more than \$403 million to resolve civil claims arising from "upcoding," where false diagnosis codes were assigned to patient records in order to increase reimbursement to the hospitals by Medicare, Medicaid, TRICARE and the Federal Employees' Health Benefits Program. The guilty plea includes one count relating to this upcoding practice;

- \* \$50 million to resolve civil claims that the company illegally claimed non reimbursable marketing and advertising costs it disguised as community education. Medicare reimburses providers for "community education" - costs to educate the community at large about public health issues - but not for advertising and marketing a hospital's services;

- \* \$90 million to resolve civil claims that HCA illegally charged Medicare for non reimbursable costs incurred in the purchase of home health agencies owned by the Olsten Corporation, as well as other agencies in Florida, Georgia and Alabama.

According to the government, HCA devised an elaborate scheme to hide these costs in reimbursable "management fees" paid to third parties.

In 1999, a subsidiary of Olsten Corporation, Kimberly Quality Care, entered into criminal plea agreements in three districts and paid more than \$10 million in criminal fines.

Olsten paid nearly \$41 million as part of a civil settlement arising from its collusion with HCA for that conduct. HCA has now agreed to pay \$90 million to settle this issue, and \$106 million to resolve civil claims for billing Medicare, Medicaid and TRICARE for home health visits for patients who did not qualify to receive them or were not performed and for committing other billing violations.

Many of the civil issues resolved as part of the agreement arose from lawsuits filed by relators, commonly known as "whistleblowers," under the False Claims Act.

This law allows whistleblowers who qualify under the statute to receive up to 25 percent of the settlement recovery in cases the government pursues.

In addition to the civil settlement, two subsidiaries of Tennessee based HCA, Columbia Homecare Group Inc. and Columbia Management Companies Inc. entered into a criminal plea agreement in which they agreed to pay \$95,336,432 in criminal fines and plead guilty to several charges involving a wide range of criminal conduct which occurred at HCA's hospitals nationwide.

("HCA To Pay \$840 Million," 15 *Corporate Crime Reporter* 1(5), January 1, 2001)



## **2) HCA (\$631,000,000) \***

In June 2003, HCA Inc. (formerly known as Columbia/HCA and HCA – The Healthcare Company) will pay the United States \$631 million in civil penalties and damages arising from false claims the government alleged it submitted to Medicare and other federal health programs.

The settlement resolves HCA's civil liability for false claims resulting from a variety of allegedly unlawful practices, including cost report fraud and the payment of kickbacks to physicians.

Previously, on December 14, 2000, HCA subsidiaries pled guilty to substantial criminal conduct and paid more than \$840 million in criminal fines, civil restitution and penalties.

Combined with a separate administrative settlement with the Centers for Medicare & Medicaid Services (CMS), under which HCA will pay an additional \$250 million to resolve overpayment claims arising from certain of its cost reporting practices, the government will have recovered \$1.7 billion from HCA, by far the largest recovery ever reached by the government in a health care fraud investigation.

"Health care providers and professionals hold a public trust, and when that trust is violated by fraud and abuse of program funds, and by the payment of kickbacks to the physicians on whom patients and the programs rely for uncompromised medical judgment, health care for all Americans suffers," Robert D. McCallum, Jr., Assistant Attorney General for the Civil Division said. "This settlement brings to a close the largest multi-agency investigation of a health care provider that the United States government has ever undertaken and demonstrates the Department of Justice's ongoing resolve and commitment to pursue all types of fraud on American taxpayers, and health care program beneficiaries."

This latest settlement resolves fraud allegations against HCA and HCA hospitals in nine False Claims Act qui tam or whistleblower lawsuits pending in federal court in the District of Columbia.

Under the federal False Claims Act, private individuals may file suit on behalf of the United States and, if the case is successful, may recover a share of the proceeds for their efforts.

Under the settlement, the whistleblowers will receive a combined share of \$151,591,500, the highest combined qui tam award ever paid out by the government.

("HCA Investigation Nets Record \$1.7 Billion," *17 Corporate Crime Reporter* 26(4), June 30, 2003)

## **3) TAP Pharmaceutical Products Inc. (\$559,483,560) \***

In October 2001, TAP Pharmaceutical Products Inc., a major American pharmaceutical manufacturer, agreed to pay \$875 million to resolve criminal charges and civil liabilities in connection with its fraudulent drug pricing and marketing conduct with regard to Lupron, a drug sold by TAP primarily for treatment of advanced prostate cancer in men.

TAP will plead guilty to a conspiracy to violate the Prescription Drug Marketing Act and will pay a \$290 million criminal fine, the largest criminal fine ever in a health care fraud prosecution.

TAP's criminal conduct caused losses of \$145 million.

Thomas Watkins, president of TAP, said that while the company "fundamentally disagrees" with many of the government's allegations, "we resolved this matter to make clear our commitment to proper and ethical business practices, and to avoid protracted legal battles and ensure uninterrupted availability of Lupron for many thousands of patients who rely on it."

"We admit that TAP provided free samples of Lupron to a number of physicians,

primarily in the early to mid 1990s, with the knowledge that those physicians would seek and receive reimbursement," Watkins said in a statement. "The billing for free samples is wrong, and it should never have happened."

TAP also agreed to settle its federal civil False Claims Act liabilities and to pay the U.S. Government \$559,483,560 for filing false and fraudulent claims with the Medicare and Medicaid programs as a result of TAP's fraudulent drug pricing schemes and sales and marketing misconduct.

TAP will settle its civil liabilities to the fifty states and the District of Columbia and to pay them \$25,516,440 for filing false and fraudulent claims with the states, as a result of TAP's drug pricing and marketing misconduct, and from TAP's failure to provide the state Medicaid programs TAP's best price for those drugs as required by law.

TAP entered into what prosecutors called a "sweeping" corporate integrity agreement which, among other things, significantly changes the manner in which TAP supervises its marketing and sales staff, and ensures that TAP will report to the Medicare and Medicaid programs the true average sale price for drugs reimbursed by those programs.

("TAP Pharmaceuticals Pleads Guilty to Health Care Crimes," 15 *Corporate Crime Reporter* 38(1), October 8, 2001)

#### **4) Abbott Labs (\$400,000,000) \***

A unit of Abbott Laboratories, Inc. pled guilty to obstructing a criminal investigation of health care offenses.

Pursuant to the plea agreement, the United States and CG Nutritionals, Inc. agreed to recommend a sentence of five years probation and a criminal fine of \$200 million.

Abbott will pay an additional \$400 million to resolve civil claims involving the Medicare and Medicaid programs.

The plea agreement requires Abbott and CG Nutritionals, Inc. to cooperate fully with the United States in connection with an ongoing investigations and prosecutions.

The action marks the first criminal conviction arising from "Operation Headwaters," in which federal agents created an entity known as Southern Medical Distributors.

While operating, Southern Medical Distributors acted as a distributor of medical supplies, and was approached by various manufacturers, including Ross Products, who offered inducements to undercover personnel to purchase the manufacturers' products.

CG Nutritionals, Inc. is a wholly-owned subsidiary of Abbott, and that Ross Products is a Division of Abbott.

Ross Products engaged in business that included the sale of durable medical equipment (DME), including enteral feeding products, and CG Nutritionals, Inc. sold and distributed these products.

Enteral products are health care products intended to assist patients who, because of disease or other disorder, are not able to ingest meals in the normal manner.

Enteral nutrition products introduce nutrition into the stomach and digestive system of such patients.

There are three basic components to the enteral nutritional system: the liquid food, the plastic tubing, and an electronic pump which pumps the liquid food at a regulated rate into the patient through the plastic tubing.

Ross Products counseled DME suppliers, including the FBI's undercover company, Southern Medical Distributors, and skilled nursing facilities to submit claims to the Medicare program for enteral pumps and the plastic tubing.

Ross Products sold providers a "bundled" pump and plastic tubing set as one product at one price.

The structure of the bundled transaction made it difficult for the Medicare program to

discern the true and reasonable charges associated with the equipment.

Ross Products has marketed its pumps and plastic tubing sets in essentially this manner from January 1, 1992, through December 1, 2001, often providing pumps as part of a bundled product, or at no additional charge to providers in exchange for an agreement from the provider to purchase a minimum number of plastic tubing sets and/or food per month.

Ross Products offered up-front payments to certain customers who entered into written contracts with Ross Products as an incentive to encourage their purchase of DME from Ross Products for ultimate use by Medicare beneficiaries.

Ross Products' sales representatives told Southern Medical Distributors that by calling the up-front payment a signing bonus or conversion bonus – it then would not have to be reported to the Government as a discount.

Therefore, Ross Products attempted to prevent or delay Medicare from determining the actual price on a per product basis that Ross Products charged Southern Medical Distributors.

Ross Products attempted to mislead Medicare regarding discounts and the per product cost of enteral products.

Certain Ross Products employees told Southern Medical Distributors that the letter could be used in the event of an audit to establish a per pump cost for enteral nutritional products.

The subject letter misstated the customer's costs of acquiring the feeding pumps and failed to disclose that in some instances, the customer received a pump at no charge.

These communications were made during the course of a criminal health care fraud investigation and were attempts to mislead duly authorized criminal investigators regarding the true nature of the underlying pump lease transaction.

(“Abbott Laboratories Unit Pleads Guilty to Felony Obstruction Charge, to Pay \$600 Million,”<sup>17</sup> *Corporate Crime Reporter* 30(1), July 28, 2003)

## **5) Fresenius Medical Care of North America (\$385,000,000) \***

In January 2000, Fresenius Medical Care North America, the world's largest provider of kidney dialysis products and services, agreed to pay the United States \$486 million to resolve a sweeping investigation of health care fraud at National Medical Care, Inc. (NMC), Fresenius' kidney dialysis subsidiary.

Three NMC subsidiaries will plead guilty to three separate conspiracies and to pay a record setting \$101 million in criminal fines.

Fresenius will also pay a record setting \$385 million to resolve related civil False Claim Act claims, which were brought to the government's attention under the whistleblower provisions of the False Claims Act.

Under the terms of the civil settlements, whistleblowers will collect \$65.8 million of the \$385 million civil recovery.

Fresenius has also entered into a corporate integrity agreement with the Office of the Inspector General (OIG) of the United States Department of Health and Human Services (HHS).

NMC Homecare, Inc. was charged with conspiring from May, 1988 to June 1996 to defraud the United States in connection with claims submitted to Medicare for intradialytic parenteral nutrition (IDPN), a nutritional therapy provided to patients during their dialysis treatments.

LifeChem, Inc., NMC's clinical blood testing laboratory, was charged with conspiring from January, 1991 to June, 1997 to defraud the United States by obtaining payment for hundreds of thousands of false, fictitious and fraudulent blood testing claims.

NMC Medical Products, Inc. (MPD), NMC's dialysis products distribution

subsidiary, was charged with conspiring from May, 1987 to July, 1996 to violate the Medicare Anti Kickback Act, by means of payments, discounts and other inducements provided to dialysis facilities to obtain their clinical blood testing business for LifeChem.

Under the terms of the plea agreements, each of the subsidiaries will plead guilty to the conspiracy charged and be fined.

NMC Homecare will pay \$49.3 million fine, LifeChem will pay \$36.6 million fine, and MPD will pay \$15.2 million fine. All of the fines are subject to court approval.

Fresenius will pay \$253.3 million to resolve claims it filed false and fraudulent claims with Medicare and other government health benefit programs relating to IDPN, \$112.2 million to resolve claims it filed false and fraudulent claims with Medicare and other government programs for clinical blood tests performed by LifeChem which were medically unnecessary or for which Medicare had already paid, \$16.8 million to resolve claims that NMC failed to properly report, and repay, credit balances and other overpayments it received from Medicare, and \$2.8 million to resolve claims that it improperly billed Medicare for certain diagnostic tests which were provided to dialysis patients as part of clinical studies.

The relators in those suits, including a former employee in the Mexico, Missouri office of NMC Homecare and a Key West, Florida infusion pharmacy, which competed against NMC, will receive \$44.8 million as relators.

Under the terms of the LifeChem civil settlement, Fresenius will pay the United States \$112.2 million and the United States will intervene and dismiss the False Claim Act allegations in a qui tam action filed in Boston by three former MPD salesmen. The United States has agreed to pay these relators \$18.1 million.

In the credit balances civil settlement, Fresenius agrees to pay the United States \$16.8 million and the United States will intervene in two qui tam actions, one pending in Boston and the other in Miami, Florida.

The relators in these two separate actions are each former NMC employees. The United States has agreed to pay these relators \$2.9 million.

The diagnostic tests civil settlement was the result of matters uncovered by the government investigators during the course of their investigation. No relator is involved in this settlement and the United States will retain the entire \$2.8 million recovery.

("Fresenius Medical Care of North America to Pay \$486 Million," 14 *Corporate Crime Reporter* 4(3), January 24, 2000)

## **6) SmithKline Beecham Clinical Laboratories Inc. (\$325,000,000)**

SmithKline Beecham Clinical Laboratories Inc. (SBCL) was ordered to pay \$325 million for filing of false claims with the government.

The False Claims Act permits private citizens to sue on the behalf of the United States.

The case against SBCL arose out of the company's performance of clinical laboratory services for patients whose services are paid for in whole or in part by the federal government.

Under the settlement, SBCL paid \$325 million to resolve the civil allegations. SBCL also committed to adopt a corporate compliance agreement.

SBCL, a clinical laboratory firm based in Collegeville, Pennsylvania, is a subsidiary of SmithKline Beecham, plc, a British medical products and services firm.

Federal officials said that the company engage in six types of fraud:

\* Add on tests. The company provided certain standard profiles (groups of tests) to ordering physicians. To increase profits per transaction, the company performed additional tests not needed or ordered by the physicians. Medicare and other payors only pay for tests which are medically needed for the patient, and the company falsely certified that all tests were medically necessary.

\* Tests not performed. SBCL billed for certain tests not actually performed. Often the

tests were not performed due to insufficient specimen amount or other technical problems.

\* Code jamming. Medicare pays for certain laboratory tests only when they are performed to diagnose or treat a specific disease. It does not pay for screening tests which are unrelated to a specific medical problem. Where a physician ordered a screening test, SBCL would "jam" or insert a diagnostic code, without any knowledge of whether it would apply to the patient's condition.

\* Kickbacks. In order to obtain a physician's Medicare business, SBCL provided physicians with various inducements, including free or below-cost testing for tests billed directly to the physician, free computers and facsimile machines, free refrigerators, placement of an SBCL employee in physicians' offices, and payment of "rent" to physicians. Medicare law prohibits providing anything of value to a physician in order to induce a referral of Medicare business.

\* Dialysis testing. SBCL billed Medicare a second time for tests for kidney dialysis patients, when SBCL had already been paid by the kidney dialysis centers for these tests. SBCL also billed Medicare for testing of such patients where such testing was not needed.

\* Additional indices. Each time a physician ordered a complete blood count, which is the second most common laboratory test ordered, SBCL, at certain of its regional labs, provided and billed for certain additional test results known as additional indices, even when these tests were not ordered by the treating physician.

The case was triggered when three whistleblowers filed qui tam actions against the company.

One whistleblower, Robert Merena was an employee at SBCL with responsibility for systems and data management and access to all data related to SBCL's billing activity.

The second, Charles Robinson Jr. had been the medical director of SBCL's laboratory in San Antonio, Texas before and after it was acquired by SBCL.

The third allegation was lodged by a competing sales person.

"Laboratory enforcement initiatives including LabScam have recovered approximately \$800 million and convicted three corporations of criminal fraud," said Attorney General Janet Reno. "Now, all three major independent laboratories are operating under extensive corporate integrity agreements that are designed to prevent the abuse from occurring again."

("SmithKline Labs Ordered to Pay \$325 Million for Making False Claims," 11 *Corporate Crime Reporter* 9(1), March 3, 1997)

## **7) National Medical Enterprises (\$324,200,000) \***

A record \$379 million in criminal fines, civil damages, and penalties will be paid by health care corporation National Medical Enterprises Inc. for kickbacks and fraud at NME psychiatric and substance abuse hospitals in more than 30 states.

NME, which manages more than 60 psychiatric hospitals and substance centers nationwide, pleaded guilty to six counts of making unlawful payments to induce doctors and other professionals to refer Medicare and Medicaid patients to the hospitals, and one count of conspiracy to defraud the U.S. and make unlawful referrals.

NME Psychiatric Hospitals is a wholly owned subsidiary of NME, which is headquartered in Santa Monica, California.

The charges were based on NME Psychiatric Hospitals' payment of kickbacks to doctors, referral services, and other persons so that they would refer patients to NME's hospitals.

The patients were insured under federal health programs, such as Medicare and Medicaid.

NME Psychiatric Hospitals will pay \$33 million in criminal fines.

Northshore Hospital Management Corp, another NME subsidiary, will plead guilty to one count of fraud and will pay a \$1 million fine for making payments to a doctor to send patients to NME's Northshore hospital, an acute care hospital in New Orleans.

On the civil side, NME will pay \$324.2 million in damages and penalties to the federal government for losses it caused to government insurance programs.

The agreement resolves claims resulting from various fraudulent practices at NME's psychiatric and substance abuse facilities.

("National Medical Enterprises Hit with Record Fine in Health Care Fraud Case," 8 *Corporate Crime Reporter* 27(3), July 4, 1994)

### **8) AstraZeneca Pharmaceuticals (\$266,127,844)**

In June 2003, AstraZeneca Pharmaceuticals LP, a major pharmaceutical manufacturer headquartered in Wilmington, Delaware, pled guilty in federal district court in Wilmington, Delaware to a health care crime and will pay \$355,000,000 to resolve criminal charges and civil liabilities in connection with its drug pricing and marketing practices with regard to Zoladex, a drug sold by AstraZeneca Pharmaceuticals LP and used primarily for the treatment of prostate cancer.

AstraZeneca pled guilty to conspiring to violate the Prescription Drug Marketing Act by causing to be submitted claims for payment for the prescription of Zoladex which had been provided as free samples to urologists.

This criminal conduct caused losses of \$39,920,098 to Medicare, Medicaid and other federally funded insurance programs.

Zoladex is marketed by AstraZeneca primarily for the treatment of prostate cancer, as is the drug Lupron which is produced by TAP Pharmaceuticals, Inc.

In October 2001, TAP agreed to pay \$875,000,000 to resolve civil and criminal liabilities in connection with its pricing and marketing of Lupron.

As part of the plea agreement, AstraZeneca will pay a \$63,872,156 criminal fine.

AstraZeneca will also settle civil federal False Claim Act liabilities and pay the U.S. government \$266,127,844 to resolve allegations that the company caused false and fraudulent claims to be filed with the Medicare, TriCare, Department of Defense and Railroad Retirement Board Medicare programs as a result of AstraZeneca's fraudulent drug pricing schemes and sales and marketing misconduct.

("AstraZeneca Pleads Guilty to Health Care Crime," 17 *Corporate Crime Reporter* 26(7), June 30, 2003)

### **9) Bayer Corp. (\$257,200,000) \***

In April 2003, Bayer Corp. paid \$257,200,000 to settle allegations engaged in a "lick and stick" scheme in which it sold re-labeled products to an HMO at deeply discounted prices, and then concealed and avoided their obligation to pay millions of dollars in additional rebates to the Medicaid program. The company also pled guilty to one criminal count of Medicare fraud and paid a \$5.5 million criminal fine.

("Bayer Pleads Guilty in Medicare Fraud Case," 17 *Corporate Crime Reporter* 16(1), April 21, 2003)

### **10) First American Health Care of Georgia (\$225,000,000) \***

A bankrupt home health care organization and its purchaser will reimburse the federal

government \$255 million for overbilled and fraudulent Medicare claims submitted by the company, under an agreement reached with the Justice Department.

Under the agreement, First American Health Care of Georgia, Inc., the nation's largest home health provider, and its new owner, Integrated Health Services, Inc, will reimburse the United States money that Medicare allegedly overpaid the company and money the company allegedly fraudulently billed Medicare.

The agreement settles allegations that First American billed Medicare for costs unrelated to the care of patients in their homes, including personal expenses of First American's senior management, marketing and lobbying expenses.

In a related criminal action, the company's two major principals, Jack and Margie Mills, were found guilty of defrauding Medicare, and are currently serving prison terms of 90 months and 32 months respectively for their involvement in the scheme.

First American provided care to approximately 30,000 patients a day, about 94 percent of them Medicare beneficiaries.

The company, which operated approximately 425 locations in more than 30 states, filed for bankruptcy protection earlier this year in Georgia.

Under a plan of reorganization, First American merged with IHS, which has agreed to pay the government the settlement amount on First American's behalf.

(Justice Department press release, October 18, 1996)

### **11) Laboratory Corporation of America (\$182,000,000) \***

Laboratory Corporation of America Holdings (LabCorp), headquartered in Burlington, North Carolina, will pay \$182 million to resolve allegations that it submitted false claims for medically unnecessary laboratory tests to federal and state health care programs.

Immediately before the announcement of the civil settlement, the San Diego Regional Laboratory of Allied Clinical Laboratories, Inc., which is now owned by LabCorp, pled guilty to submitting a false claim to Medicare and to the California Medicaid Program for an unnecessary blood test and was fined \$5 million.

LabCorp entered into a pre-trial diversion program with the U.S. Attorney in North Carolina and a corporate integrity program with the Department of Health and Human Services.

The LabCorp case came to the attention of law enforcement officials after a doctor noticed that the blood laboratory he was using routinely did tests that he neither needed nor wanted for his patients.

The doctor felt frustrated in his attempts to bring the issue to the attention of federal officials, and in January 1993 turned to Getnick & Getnick, a New York law firm that specializes in the civil prosecution of white collar crime.

In August 1993, Getnick filed a qui tam action against Roche Biomedical Laboratories on behalf of the doctor and met with representatives of the U.S. Attorney's office in Manhattan to present the case.

Roche Biomedical merged last year with National Health Laboratories to form Laboratory Corporation of America Holdings, now the world's largest clinical laboratory company.

"This is a case where an alert and persistent doctor blew the whistle on a practice that has cost taxpayers hundreds of millions of dollars," said Neil Getnick, the lawyer who represented the doctor.

Getnick said that the labs marketed packages of blood tests to doctors at prices that were often lower than the price for a single test. Often the packages included tests that were unnecessary, but because of the package pricing it seemed

to make no difference.

"That was fine for doctors when they were doing direct billing," Getnick said. But when those tests were done for patients whose bills were being picked up by Medicare and other government agencies, the labs "unbundled" the packages and charged separately for each test in the package.

"The labs billed government health care agencies more than eight times what they were charging for doctors," Getnick said. "Since the doctors never saw the bills that were sent to the third party payers, they did not know what was happening."

Lesley Ann Skillen, a partner at the Getnick firm, said that the doctor noticed that the lab was doing unnecessary screening and asked them to stop. "They did not, and in fact he was told at one point not to worry about it since Medicare was paying," Skillen said. "That piqued his curiosity and he began to pursue the issue."

Skillen said that percent of the settlement that will go to the doctor has yet to be determined.

The criminal guilty plea and the civil settlement are the most recent developments in a nationwide crackdown on health care fraud by laboratories.

In December 1992, National Health Care Laboratories pled guilty to submitting false claims to the government and paid \$111 million in criminal and civil fines.

On October 9, 1996, Damon Chemical Laboratories, Inc. pled guilty to similar charges related to its billing of unnecessary blood tests and paid a total of \$119 million in criminal fines and civil payments.

Since 1993, Corning Inc. has paid approximately \$62 million on behalf of its Metpath and Metwest laboratories to settle civil allegations of fraudulent billings.

Federal officials said that in the LabCorp case, the criminal plea, civil settlement, pre-trial diversion, and administrative compliance agreements are part of a global resolution designed to punish past criminal activity, to restore funds to Medicare and other federal and state programs, and to implement safeguards preventing future reoccurrences of health care fraud.

("Major Clinical Lab to Pay \$182 Million to Settle False Claims Act Charge," 10 *Corporate Crime Reporter* 45(1), November 25, 1996)

## **12) Beverly Enterprises Inc. (\$170,000,000) \***

In February 2000, Beverly Enterprises Inc., the nation's largest nursing home chain, agreed to pay \$175 million to resolve civil and criminal charges that it defrauded Medicare.

Under the terms of the plea agreement, Beverly will pay \$170 million in civil penalties and a Beverly subsidiary, Beverly Enterprises-California, Inc., will plead guilty to mail fraud and false statement charges filed in federal court in San Francisco.

Under the agreement, the company will pay a \$5 million criminal fine and divest itself of ten nursing homes.

The \$175 million represents the largest settlement ever in a nursing home case.

The case focused on a Medicare rule that the Medicare program reimburses only costs of caring for Medicare patients. Such reimbursable costs include nurses' salaries. If a nurse spends part of the work day caring for Medicare patients and the remainder on non-Medicare patients, Medicare pays only that portion of the salary attributable to caring for Medicare patients.

Federal officials alleged that the Ft. Smith, Arkansas based company in 1992 began to charge Medicare improperly for the salaries of nurses caring for non-Medicare patients.

This practice, which occurred at 10 homes owned by Beverly-Enterprises-California and other Beverly facilities, resulted in Beverly filing cost reports that falsely inflated the number of hours attributable to Medicare patients.



Instead of recording the true time spent on Medicare patients, Beverly-California fabricated nursing cost figures based on set formulas designed to maximize profits while avoiding detection by Medicare auditors.

The phony cost figures were backed by false documents, such as phony nurse sign-in sheets, that appeared to support Beverly's claims for payment.

In addition to the guilty plea, the civil settlement and the divestiture of the ten nursing home facilities, the settlement also requires Beverly to submit to extensive monitoring by the Department of Health and Human Service's Office of Inspector General.

Under the monitoring program, Beverly is required to contract with an independent professional organization to review Beverly's cost report policies, procedures and practices on an annual basis.

"By its conduct, Beverly victimized not only the Medicare program, but American taxpayers whose dollars fund government health care programs," said U.S. Attorney Robert Mueller III.

While the company acknowledged that "errors were made by individual employees" in the submission of ten cost reports to Medicare, it said that the ten cost reports represent .8 percent of the 1,370 Medicare cost reports filed by Beverly subsidiaries in 1996 and 1997 and .2 percent of the 4,680 cost reports filed by Beverly subsidiaries for the period investigated by the government.

Beverly said that of the \$170 million civil penalty, \$25 million will be paid within 30 days. Beverly will pay the balance over an eight year period, interest free, by accepting pro rata reductions in its periodic interim Medicare payments totaling \$145 million.

("Beverly Enterprises to Pay \$175 Million," 14 *Corporate Crime Reporter* 6(1), February 7, 2000)

### **13) United Technologies (\$150,000,000)**

United Technologies Corporation will pay the U.S. \$150 million to settle claims that the company's Sikorsky Aircraft Division improperly billed the Department of Defense for sales of helicopters.

The settlement was brought under the False Claims Act in 1989 by Douglas Keeth, a former UTC Vice President of Finance.

Keeth will receive \$22.5 million from the recovery.

Keeth alleged that Sikorsky knowingly filed inflated progress payment billings on government contracts.

Keeth charged that UTC officials attempted to suppress disclosure of the improper Sikorsky practices after the company discovered and investigated the practices while participating in the Defense Department's voluntary disclosure program. Keeth was a member of the UTC voluntary disclosure team.

("United Technologies Pays Government \$150 Million to Settle Whistleblower Charges," 8 *Corporate Crime Reporter* 14 (3), April 4, 1994)

### **14) Blue Cross Blue Shield Illinois (\$140,000,000)\***

Health Care Service Corporation (HCSC), also known as Blue Cross Blue Shield of Illinois, plead guilty to eight felony counts and will pay \$144 million after admitting it concealed evidence of poor performance in processing Medicare claims for the federal government.

HCSC, the Medicare contractor for Illinois and Michigan, also admitted obstructing justice and conspiring to obstruct federal auditors.

The company will pay \$4 million in criminal fines and \$140 million in a civil settlement to resolve its liability under the False Claims Act.

HCSC has been under contract with the Health Care Finance Administration (HCFA) to process claims submitted by Medicare beneficiaries and their doctors to other health care providers in accordance with Medicare coverage and payment rules.

HCSC's headquarters are in Chicago, although its claims processing units for Medicare Part B are in Marion and Mattoon, Illinois.

The company admitted that it was guilty of conspiracy to obstruct a federal audit and obstruction of a federal audit.

It also admitted to six instances of false statements based on the actions of many of its managers and supervisors who administered HCSC's Medicare Part B carrier contracts with HCFA from 1984 through 1995.

At a press conference at the Justice Department, federal officials said that the company manipulated work samples and falsified reports used by HCFA to evaluate how well HCSC was performing its contractual duties.

The company concealed its poor performance and falsely claimed superior performance.

"Medicare fraud and abuse is always a serious matter but it is particularly grievous when the abuse involves a contractor entrusted to protect the financial integrity of the program," said June Gibbs Brown, the Inspector General at the Department of Health and Human Services. "In this case, the trust was flagrantly violated by a prestigious nationally known company. It engaged in unconscionable conduct that adversely affected Medicare beneficiaries, providers and the program itself."

Brown said the company "compromised protections by artificially inflating performance results."

"It also falsified and destroyed documents for the purpose of disguising its shortcomings," Brown said.

"I would like to be able to tell you this is an unprecedented case, but it is not," Brown said. "Rogue contractors have been caught cheating the program in the past and I am sure, because of the vast amount of money spent on Medicare, others will be tempted to scam the program in the future."

Over the past five years, Brown's office has investigated five additional cases that have resulted in criminal or civil actions against a Medicare contractor.

In 1993, Blue Cross/Blue Shield of Florida paid \$10 million to settle charges that it falsified and failed to properly screen provider claims.

In 1994, Blue Cross/Blue Shield of Massachusetts paid a \$2.75 million fine to settle charges that it falsified its performance reports.

In 1995, Blue Cross/Blue Shield of Michigan paid a total of \$51.6 million to settle charges that it falsified audit reports and used Medicare money to pay claims that were the responsibility of other insurers.

In 1997, Blue Shield of California pled guilty and paid \$12 million in civil penalties to charges of falsifying documents and failing to properly process claims and destroying claims.

And in 1997, Blue Cross/Blue Shield of Massachusetts paid \$700,000 to settle charges that it falsified statements related to its Medicare HMO application.

Brown said that her office and other federal investigators are currently investigating a number of other Medicare contractors.

The case against Blue Cross/Blue Shield of Illinois was brought to prosecutors' attention by a company employee, Evelyn Knoob.

("Blue Cross Blue Shield Illinois Pleads Guilty to Eight Felony Counts, 12 *Corporate Crime Reporter* 29(1), July 28, 1998)

### **15) Northrop Grumman (\$111,200,000)**

In June 2003, Northrop Grumman will pay \$111.2 million to the federal government to settle a lawsuit alleging that TRW Inc., which it recently acquired, padded bills submitted to the government under space and technology contracts.

The whistleblower lawsuit, which the federal government joined, charged that TRW defrauded the government through deceitful accounting practices from 1990 to 1997, including billing the government for work done on non-government contracts.

Daniel S. Goldin, the former NASA administrator, was at the time general manager of TRW's space and technology group, which was at the center of the fraud scheme.

The lawsuit alleges that Goldin approved mischaracterizing at least some of the charges to the government. He was deposed for three days during the litigation.

The settlement comes just months before the trial date for the case, which was set for November.

As part of the litigation, the whistleblower, Richard Bagley, and the government, won a series of rulings, in which the court essentially said that the undisputed evidence showed the TRW had overcharged the government.

"TRW could have settled the case five years ago for about one-quarter of what it ended up paying," said Eric Havian, an attorney with Phillips & Cohen in San Francisco, which is representing the whistleblower. "Instead, it chose to engage in a drawn-out, losing battle that proved very costly for the company. The more we looked at company records, the more fraud we uncovered."

Bagley, a former senior financial executive at TRW's space division, filed a False Claims Act lawsuit against TRW in 1994 under seal in federal district court in Los Angeles. The seal was lifted in 1998, making the lawsuit public.

"TRW tried to intimidate our client by suing him in response to his false claims lawsuit against the company," Havian said. A judge ruled that TRW's claims were meritless and dismissed them.

("Northrop Grumman Pays \$111 Million to Settle Fraud Case, 17 *Corporate Crime Reporter* 24(5), June 5, 2003)

### **16) Shell Oil Company (\$110 million)**

In January 2001, Shell Oil Company agreed to pay \$110 million to resolve claims under the False Claims Act, and administrative claims that Shell underpaid royalties due for oil produced on federal leases from 1980 to December 31, 1998.

Federal leases are administered by the Minerals Management Service of the United States Department of the Interior. Each month, oil companies are required to report the amount of oil produced and the value of the oil produced on Federal and Indian leases.

The companies pay royalties based upon the value of the oil they report.

Two whistleblowers -- J. Benjamin Johnson, Jr., and John Martinek -- filed a complaint in the United States District Court in Lufkin, Texas against the Shell on behalf of the United States under the qui tam or whistleblower provisions of the False Claims Act. The two will share in the proceeds of the settlement.

("Shell Oil to Pay United States \$110 Million," 15 *Corporate Crime Reporter* 5(7), January 29, 2001)

### **17) Vencor, Inc./Ventas Inc. (\$104,500,000)**

In March 2001, Vencor Inc. - one of the nation's largest nursing home chains -- and

Ventas Inc. – a related real estate investment trust - will pay the United States \$104.5 million to resolve civil claims that Vencor knowingly submitted false claims federal health care plans.

Failure of care claims account for more than \$20 million of the \$104.5 million False Claims Act settlement.

The failure of care claims include false claims relating to inadequate staffing, improper care of decubitus ulcers, and failure to meet resident's dietary needs.

The remaining portions of the \$104.5 million settlement include more than \$54 million for improper claims made on Vencor's hospital Medicare cost reports and more than \$24 million for over billing for respiratory care services and supplies.

The Louisville, Kentucky based health care provider and Ventas will pay the government \$25 million to resolve certain administrative non fraud based Medicare claims.

Vencor separately is reimbursing Medicare for other overpayments of approximately \$90 million, about one third of which has been paid to date.

Vencor filed for protection under the federal bankruptcy laws in September 1999.

(“Vencor and Ventas Paying U.S.,” 15 *Corporate Crime Reporter* 13(7), March 26, 2001)

### **18) National Health Labs (\$100,000,000)**

National Health Labs will pay \$100 million in damages and penalties to the U.S. to settle a whistleblower lawsuit under the False Claims Act.

The payments settles a lawsuit brought by C. Jack Dowden, a former sales manager for a clinical testing laboratory.

In early 1990, Dowden contacted the Department of Health and Human Services Office of the Inspector General in San Diego to alert the government to NHL's manipulation of orders for blood tests.

Dowden had uncovered a nationwide scheme where NHL and other medical testing laboratories were systematically submitting false claims to the government for medically unnecessary blood chemistry tests not requested by physicians and not legally reimbursable under Medicare and Medicaid.

According to Dowden's lawsuit, NHL designed its order form to make it almost impossible for a physician to order a blood profile without also getting additional tests that were not medically necessary.

(“National Health Laboratories Pays \$100 Million In False Claims Act Settlement,” 7 *Corporate Crime Reporter* 1(3), January 4, 1993)

### **19) Quorum Health Group Inc. (\$95,500,000)**

In October 2000, Quorum Health Group Inc., the nation's largest hospital management company, agreed to pay the federal government \$95.5 million to settle two whistleblower lawsuits involving Medicare fraud.

The largest payment -- \$77.5 million -- will be made to settle a whistleblower lawsuit that charged the company systematically defrauded Medicare for years of filing fraudulent "cost reports."

Quorum will pay the remaining amount, \$18 million, to settle a second whistleblower case involving the misallocation of costs from an Alabama hospital to a home health services agency, the company said.

The whistleblower in the cost report case, James F. Alderson, filed his qui tam lawsuit in January 1993 and provided the government with substantial evidence of the fraud. Alderson, formerly chief financial officer for a Quorum-managed hospital in Whitefish,

Montana, was fired from his job 10 years ago after refusing to go along with the cost report scheme.

("Quorum To Pay \$95.5 Million," 14 *Corporate Crime Reporter* 39(5), October 9, 2000)

## **20) Chevron (\$95,000,000)**

Chevron Corporation will pay \$95 million to settle claims brought under the federal False Claims Act that it underpaid royalties for oil produced on federal and Indian lands since 1988.

The settlement resolves allegations that Chevron systematically underreported the value of oil they produced on federal and Indian leases and that they paid less royalties than they owed.

Federal leases are administered by the Minerals Management Service of the U.S. Department of Interior.

Each month, Chevron is required to report the amount of oil produced and the value of the oil produced on federal and Indian lands. Chevron pays royalties based upon the value of the oil it reports. The oil comes from throughout the western United States and from the Gulf of Mexico.

Two relators, J. Benjamin Johnson Jr. and John Martineck, who filed the complaint in federal court in Lufkin, Texas will share \$14.5.

Under the qui tam provisions of the False Claims Act, a private party can file an action on behalf of the United States and receive a portion of the recovery.

In a statement, Chevron said that it agreed to the payment to close the dispute and avoid the expense of litigation and attendant risk, but does not acknowledge any wrongdoing or liability.

"The payment is to resolve the dispute over the amount of royalties owed," the company said. "Chevron did not pay a civil fine or penalty as part of the agreement."

("Chevron Pays \$95 Million to Settle Charges that It Underpaid Oil Royalties," 14 *Corporate Crime Reporter* 3(5), January 17, 2000)

## **21) Lucas Industries (\$88,000,000) \***

A British industrial corporation, Lucas Industries plc, and two of its U.S. subsidiaries, will pay the United States \$88 million to settle a lawsuit alleging they failed to properly test military airplane parts and knowingly shipped defective parts to the Navy, Army and Air Force under contracts with the Department of Defense.

The agreement settles a suit, *United States ex rel. Copeland v. Lucas Western, Inc., et al.*, filed as a qui tam, or "whistleblower" action, under the False Claims Act against Lucas Western Inc. in September 1993 by Frederick C. Copeland, a former machinist for the company.

LWI, based in Park City, Utah, manufactures aerospace gearboxes, hoists and similar devices for the military.

The Department filed an amended complaint in May 1995 claiming that LWI employees falsified gear charts for the Airframe Mounted Accessory Drive (AMAD), a key component of the Navy's front line carrier based fighter, the F/A 18 Hornet.

LWI personnel, after finding one conforming gear in a lot with many non conforming gears, ran multiple gear charts from the single good gear and attached the charts to uninspected gears.

The government's complaint also alleged that LWI falsified manufacturing and assembly inspections on the AMADs.

The government alleged that 100 percent of approximately 80 AMAD gearboxes subjected to tear down inspections as part of the investigation contained parts with major defects.

LWI's illegal practices affected other military programs. For example, the government alleged that a tear down inspection of a gearbox called the Azimuth Drive Unit (ADU), which LWI produced for one of the Army's premier artillery systems, the Multiple Launch Rocket System, showed that 100 percent of the 35 ADU samples contained major defects.

Lucas manufactured the parts under military contracts totalling \$400 million.

The Navy will receive \$8.8 million of the settlement in the form of in-kind considerations: products and spare parts for the AMAD program.

Copeland will receive 21 percent, or \$19,360,000, as his share of the settlement.

On January 10, 1995, following a criminal investigation supervised by the U.S. Attorney's office in Los Angeles, California, LWI pleaded guilty to 37 felony counts of making false certifications to the Department of Defense that 35 AMAD and two ADU gearboxes had been fully inspected in accordance with the applicable contractual requirements, when, in fact, they had not. LWI paid a criminal fine of \$18.5 million.

The U.S. subsidiary of Lucas Industries plc, Lucas Industries, Inc. (LINC), also was a defendant in the civil action. LINC owns 100 percent of LWI.

("Lucas Industries Pays U.S. \$88 Million to Settle Lawsuit," 9 *Corporate Crime Reporter* 38(7), October 9, 1995)

## **22) GlaxoSmithKline (\$87,600,922)**

In April 2003, GlaxoSmithKline paid \$87,600,000 to settle allegations engaged in a "lick and stick" scheme in which it sold re-labeled products to an HMO at deeply discounted prices, and then concealed and avoided their obligation to pay millions of dollars in additional rebates to the Medicaid program.

("Bayer Pleads Guilty in Medicare Fraud Case," 17 *Corporate Crime Reporter* 16(1), April 21, 2003)

## **23) PacifiCare Health Systems (\$87,300,000)**

In April 2002, PacifiCare Health Systems agreed to pay the United States \$87.3 million to settle allegations that it and its predecessor companies violated the False Claims Act with respect to claims submitted to the Office of Personnel Management.

The predecessor firms were FHP International and TakeCare Corporation.

It was the largest civil settlement involving contracts with OPM to provide benefits to federal employees under the Federal Health Benefits Program (FEHBP).

The settlement resolves allegations by the United States that PacifiCare, through its subsidiary health maintenance organization plans, submitted inflated claims for insurance payments based on rates that were not developed in accordance with OPM regulations and rating instructions.

Federal officials alleged that PacifiCare's subsidiaries failed to follow the applicable OPM rules and regulations when developing the rates it charged for health care benefits under its FEHBP contracts, including failing to give the health care program the most favorable rates PacifiCare gave its similarly situated commercial customers, failing to coordinate FEHBP benefits with those provided to annuitants over age 65 under the Medicare Program, and submitting statements to OPM that failed to fully disclose rate adjustments due to FEHBP.

The settlement agreement involved allegations of improper rating by PacifiCare for

certain contracts in effect between 1990 and 1997.

The civil settlement includes a full resolution of claims brought against PacifiCare and its predecessor FHP International, Inc. by a former employee of the defendants, Valerie Fletcher, under the qui tam provisions of the False Claims Act.

Fletcher filed her suit in the U.S. District Court for the District of Columbia in November 1998.

Fletcher's suit will be dismissed and she will receive approximately \$3.5 million of the total recovery as her statutory award.

("PacifiCare to Pay More than \$87 Million," 16 *Corporate Crime Reporter* 16(3), April 22, 2002)

#### **24) Teledyne (\$85,000,000) \***

Teledyne settled two major civil fraud suits brought by the Justice Department and four whistle-blowers for \$112.5 million, the second-highest such settlement in defense industry history.

Under a deal negotiated over recent months, Teledyne will pay \$85 million to settle charges that its relays subsidiary in Hawthorne sold the Pentagon millions of improperly tested electronic relays, and \$27.5 million to settle charges that its systems unit in Northridge padded contracts on aircraft electronics equipment.

Under terms of the settlement, Teledyne will pay half of the \$112.5 million damages before the end of this year and the balance in two equal installments next year. The whistle-blowers in the cases will receive between 15% and 25% of the awards, subject a federal judge's ruling on the award.

In addition to the \$85 million civil settlement, Teledyne has previously paid a \$17.5-million criminal fine for the illegal testing of relays and an additional \$3.1 million in an administrative settlement with the Pentagon. Teledyne also must pay \$4.6 million to the whistle-blowers' attorneys.

The allegations in the relays case were made by Emil Stache and Almon Muehlhausen, two employees at Teledyne's plant in Hawthorne. They alleged that Teledyne improperly tested 8 million to 10 million relays, which are tiny switches used in a variety of jets, missiles, spacecraft and other systems.

The allegations in the systems case were made by Klaus Kirchhoff and Max Killingsworth, who alleged that executives at the Northridge plant routinely padded contracts by adding illegal "negotiation yields" that would provide a cushion in cutting prices during contract negotiations.

("Teledyne to Pay \$112 Million," *Los Angeles Times*, April 22, 1994)

#### **25) Damon Clinical Laboratories, Inc. (\$83,700,000) \***

Damon Clinical Laboratories, Inc., a unit of Corning Inc., plead guilty to a one-count criminal information charging the company with conspiring to defraud the United States by submitting false claims to the Medicare program.

The Corning unit will pay \$119 million to resolve the dispute -- \$35.2 million as a criminal fine and \$83.7 to resolve related civil liabilities.

If approved by U.S. District Court in Boston, the criminal penalty will be the largest ever recovered in a health care fraud prosecution and the largest criminal fine ever in Massachusetts.

Federal officials said that the \$119 million payment represents a recovery of three dollars for every one dollar that the company stole from federal and state health care programs.

"Faced with declining profits and a changing health care marketplace, Damon decided to cheat the Medicare program," said U.S. Attorney Donald Stern. "It did so by submitting literally millions of fraudulent claims for payment to federal and state health care programs for medically unnecessary laboratory tests. What was marketed as a LabScan was actually a massive lab scam."

Federal officials charged that the company bundled three different tests with certain blood panels, causing doctors to order tests that were not medically necessary for the treatment and diagnosis of Medicare beneficiaries.

After physicians had ordered the medically unnecessary tests, Damon then billed Medicare for the bundled tests, knowing that the tests were in fact not necessary.

Medicare, the largest government payer for laboratory services, reimburses labs for clinical testing services only if those services are medically necessary for the diagnosis and treatment of illness or injury to Medicare beneficiaries.

In 1988 and in 1989, Medicare announced across-the-board fee reductions to clinical laboratories like Damon for all lab services. Federal officials charged that Damon, in direct response to Medicare's attempt to control its costs, bundled the unnecessary tests with other tests for the purpose of offsetting the Medicare rate reduction.

The civil settlement resolves two disputes that were originally brought as qui tam actions. Whistleblowers alleged wrongful conduct by Damon in the billing to Medicare for medically unnecessary test that had not knowingly been ordered by doctors.

Federal officials said that one of the whistleblowers, a former sales representative for the company, will recover \$9 million. The other whistleblowers, who are former sales representatives at one of Damon's competitors, will recover \$1.4 million.

In August 1993, Damon was purchased by Corning Clinical Labs, a division of Corning Inc.

Federal officials said that when Corning Labs discovered Damon's practices of bundling tests with profiles and panels and billing them separately to Medicare, Corning Labs immediately stopped the conduct.

("Corning Unit Pleads Guilty to Health Care Fraud Charges," 10 *Corporate Crime Reporter* 39(5), October 14, 1996)

## **26) Litton (\$82,000,000)**

Litton Industries will pay \$82 million to resolve allegations it overcharged the government for computer work on defense contracts, vindicating a former employee who did not live to see his courage bear fruit.

More than six years ago, James Carton, a Litton data systems analyst, sued the defense conglomerate, alleging that the company used illegal accounting techniques to make the Pentagon pick up the tab for data-processing costs that should have been borne by commercial customers.

With Thursday's settlement, Carton's widow, Anita -- who runs a Simi Valley hair salon -- could garner up to \$20 million. Carton himself died of a heart attack in December during a Caribbean cruise celebrating the couple's 25th wedding anniversary. He was 51.

In a statement, Litton said it settled without any admission of wrongdoing or liability.

Carton's suit was originally filed under seal in April, 1988. Several government agencies then launched investigations, and in March, 1989, the Justice Department unsealed the case and announced it would take it over in conjunction with Carton's lawyers.



The lawsuit alleged that Litton -- apparently in an attempt to attract more commercial computer customers -- did not charge commercial clients for using the company's computer memory banks beyond a certain "cap" level. There were no such "caps" for government clients, the suit said, so the government ended up paying the excess overhead for commercial customers.

(“Litton Settles Fraud Suit for \$82 Million, *Los Angeles Times*, July 15, 1994)

## **27) (tie) Northrop Grumman (\$80,000,000)**

The Northrop Grumman Corporation will pay \$80 million to resolve allegations of overcharging the government and selling the Navy defective military equipment.

The two actions against the company were brought under the False Claims Act.

In one action, the government alleged that, from 1994 to 1999, Northrop Grumman subsidiary Newport News Shipbuilding (NNS), mischarged as Independent Research and Development (IR&D) its costs for the design and development of double hulled tankers that the shipbuilder had contracts to build for commercial customers.

Under applicable regulations, costs may only be charged as IR&D to government contracts if they are not for effort required to perform a contract.

Newport News will pay \$60 million to settle the allegations.

Since November 2001, NNS has been a wholly owned subsidiary of Northrop Grumman.

In a second action, Northrop Grumman agreed to pay \$20 million to resolve allegations that the company knowingly sold the Navy unmanned aerial vehicles, known as Target drones, that contained defective parts.

The target drones assembled at Northrop Grumman's Hawthorne, California facility are remotely operated aerial vehicles used for training purposes and for weapons qualification and development.

With respect to eight Navy contracts for drones in the late 1980's and early 1990's, the United States alleged that Northrop knowingly provided the Navy with a deficient quality assurance program that failed to meet military specifications, knowingly delivered drones that contained various defective parts, and that the drones failed to meet contractual reliability requirements.

In addition, the United States alleged that various drones experienced major operational failures during Navy operations due to defective Northrop Grumman parts.

The original suit against the company was filed in Los Angeles as a qui tam, or whistleblower suit, under the False Claims Act by a then Northrop Grumman employee.

Under the False Claims Act, private individuals who bring suits against companies can receive between 15 and 25 percent of the government's recovery in a case that the government joins.

(“Northrop Grumman to Pay \$80 Million for Selling Defective Military Equipment to the Navy and Making False Claims,” 17 *Corporate Crime Reporter* 33(1), September 1, 2003)

## **27) (tie) FMC Corp. (\$80,000,000)**

FMC Corp. will pay \$80 million to settle a lawsuit filed by a former worker who raised questions about the viability of the Bradley Fighting Vehicle, the company announced.

In 1998, a federal jury in San Jose, Calif., found in favor of Henry Boisvert, who filed a lawsuit alleging FMC had defrauded the government by squelching a report Boisvert had written questioning the Bradley's safety in water.

The jury awarded Boisvert \$125 million in damages. Because damages can be tripled

in such cases, FMC initially faced more than \$375 million in legal penalties. But the judge reduced the jury's award so that FMC obligations would not exceed \$87 million, excluding legal fees and interest.

Boisvert filed the lawsuit in 1986 under the False Claims Act.  
("FMC Settles Lawsuit," *Defense Week*, October 30, 2000)

### **29) (tie) General American Life Insurance Co. (\$76,000,000)**

In June 2002, General American Life Insurance Company, Inc., will pay \$76 million to settle Medicare fraud charges brought by the federal government.

The company will also "refrain from seeking business with Medicare for a five year period," according to an agreement reached with the Department of Justice.

Federal officials alleged that General American knowingly provided false information to the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration), the agency responsible for administering the Medicare program.

The allegations were originally brought in a whistleblower case under provisions of the False Claims Act by two former employees of General American, Harry and Nancy Riggs.

Under the Act, the plaintiff, also known as a "relator," can recover 15 to 25 percent of the damages paid to the United States, if the government intervenes in the action.

As part of the settlement of this case, the relators will receive 19 percent or \$14.4 million of the \$76 million settlement.

("General American Life Insurance Inc. Pays \$76 Million," 16 *Corporate Crime Reporter*, 26(7), July 1, 2002)

### **30) (tie) Boeing Company (\$75,000,000)**

The Boeing Company paid a \$75 million fine to settle charges of overbilling the U.S. government on defense contracts.

The settlements concludes a six-year investigation into Boeing's charging and cost accounting practices between 1980 and 1981. Boeing admitted that it had mischarged the government.

The U.S. Attorney in Seattle alleged the Boeing violated the False Claims Act by improperly charging the government for millions of dollars in research and development costs, which Boeing falsely characterized as overhead associated with Boeing's manufacturing and production efforts.

By misclassifying these costs as manufacturing overhead, Boeing improperly shifted costs to the government which should have been absorbed by Boeing.

Boeing also admitted that it improperly charged the government for millions of dollars in hazardous waste disposal costs, contrary to Boeing's disclosed accounting practices.

("Boeing Pays \$75 Million Fine for Overcharging Pentagon," 8 *Corporate Crime Reporter* 19(4), May 9, 1994)

### **31) State of California, Los Angeles County (\$73,300,000)**

The State of California and the County of Los Angeles will pay the United States \$73.3 million to settle allegations that they violated the False Claims Act with respect to claims submitted to Medicaid.

The settlement resolves allegations that the state and the county directly or indirectly billed the federal health care program for services provided to certain minors when these

jurisdictions had no basis for concluding that these individuals financially qualified for Medicaid services.

The services at issue in this matter involve drug and alcohol abuse, pregnancy and pregnancy related services, family planning, sexual assault treatment, sexually transmitted diseases and mental health services.

The civil settlement includes the resolution of claims brought against the state and the county by Gurubanda Singh Khalsa, an employee of the Los Angeles Department of Mental Health, under the qui tam or whistleblower provisions of the False Claims Act.

Khalsa will receive approximately \$1.36 million of the total recovery as his statutory award.

Under the qui tam provisions of the False Claims Act, a private party can file an action on behalf of the United States and receive a portion of the settlement if the government takes over the case and reaches a monetary agreement with the defendants.

(Justice Department press release, June 20, 2002)

### **32) Philips Electronics (\$65,300,000) \***

Philips Electronics North America Corporation will pay the United States \$65.3 million to settle claims Philips sold improperly tested capacitors and resistors to the government for a number of military and aerospace programs.

The settlement involves capacitors sold from 1983 through 1992 by Philips' Tantalum Capacitor Operation, which was headquartered in Jupiter, Florida, and resistors sold by Philips' Mineral Wells, Texas, facility in the same period.

Resistors and capacitors are key electronic components in a number of military and aerospace systems, including aircraft, missiles, satellites and radar systems.

The Department said the government was not aware of any field failures of such systems attributed to Philips's resistors and capacitors.

Between 1983 and 1992, Philips sold millions of dollars worth of capacitors and resistors, many of which were required to be manufactured and tested in accordance with detailed military specifications.

The government purchased many of these devices, either directly or indirectly through third parties such as distributors and equipment manufacturers.

In the settlement, Philips admitted that "in a significant number of instances" its Florida facility falsified test reports for capacitors and failed to report when the capacitors failed tests.

Philips also admitted that certain assembly and testing processes that were required to be performed in its Florida facility actually were performed in a factory in the Dominican Republic.

Philips' sale of non-conforming capacitors was the subject of a 1992 report the company submitted to the Department of Defense's Inspector General's Office under the Department's Voluntary Disclosure Program.

Philips has paid the government \$9.6 million in connection with that disclosure and Philips will receive a credit for that amount under the settlement.

Philips also admitted that its Texas facility sold resistors that were tested improperly, falsified some resistor test results and failed to report resistor test failures.

Last June, Philips pleaded guilty to 18 criminal counts in connection with these claims and paid the government \$9 million in criminal fines. Those fines are not included in the \$65.3 million civil settlement.

The settlement resolves claims the United States could have brought against Philips

under the False Claims Act, which provides that anyone who knowingly submits false claims for payment to the government is liable for treble damages plus a \$5,000 to 10,000 penalty for each false claim submitted.

### **33) General Electric (\$59,500,000) \***

General Electric Co. pled guilty to criminal fraud charges and agreed to pay \$69 million in criminal and civil penalties in a massive fraud and bribery scandal involving the sale of military jet engines to Israel.

In a federal court in Cincinnati, GE agreed to reimburse the U.S. Treasury \$59.5 million to resolve a civil fraud suit, making it the largest settlement of a whistle-blower-initiated government fraud lawsuit in U.S. history.

The company also agreed to a \$9.5-million criminal fine.

U.S. District Judge Carl B. Rubin approved the settlement, in which GE admitted diverting \$40 million in U.S. military aid intended for Israel.

The Justice Department said it had recovered \$6 million of the diverted funds from secret foreign bank accounts, bringing the total recovery to \$75 million.

Brian Rowe, senior vice president of GE's aircraft engines unit, appeared in Cincinnati federal court to enter the company's guilty plea on charges of conspiracy to defraud the U.S. government, money laundering, submitting false claims and failing to make and keep accurate records. It was the first time a defense contractor had been charged with money laundering.

The case was triggered in November, 1990 by Chester Walsh, a longtime GE employee. He used the federal False Claims Act, which allows an individual with knowledge of wrongdoing against the government, to sue on behalf of the United States.

The lawsuit alleged that key GE aircraft engines division employees in Cincinnati, together with Israeli air force Brig. Gen. Rami Dotan, falsified documents to misdirect \$40 million in U.S. military aid to Israel that had been intended for the purchase, maintenance and support of the F110 engine used in the F-16 fighter aircraft. The false documents allowed GE to garner considerable profit on work never performed, the lawsuit alleged.

“GE Pleads Guilty to Fraud in Arms Deal,” *Los Angeles Times*, July 23, 1992)

### **34) Shell Oil Company (\$56,000,000)**

Shell Oil will pay \$56 million to resolve claims that it underpaid royalties owed on natural gas produced from federal leases.

The settlement resolves allegations that Shell systematically underreported the value of natural gas that it produced on federal leases in the Gulf of Mexico from August 1, 1986 to December 31, 1999 and consequently paid less in royalties than it owed to the government.

The Minerals Management Service (MMS) of the Department of Interior is responsible for overseeing the collection of royalties on federal leases.

Each month, oil companies are required to report to the MMS the value of the natural gas produced from their federal leases and to pay a percentage of the reported value as royalties.

In March 1998, the Justice Department intervened in several lawsuits filed under the False Claims Act by private parties alleging that a number of oil companies, including Shell, had systematically undervalued their natural gas production from federal leases.

Since 1998, the Department of Justice has recovered more than \$200 million in related lawsuits alleging underpayment of royalties on crude oil extracted from federal lands.

Previously, settlement agreements were reached with several companies, including Mobil Oil for \$45 million, Oxy USA Inc. for \$7.3 million, Chevron for \$95 million and Conoco

for \$26 million.

("Shell Oil to Pay \$56 Million for Underpayment of Royalties," 14 *Corporate Crime Reporter* 38(1), October 2, 2000)

### **35) Singer (\$55,500,000)**

Bicoastal Corp. and CAE-Link Corp. will pay the United States \$55.5 million in a civil settlement to resolve claims Link failed to provide the government with complete cost data on more than 100 sole-source contracts to manufacture military flight simulators, resulting in an overpayment by the government on the contracts.

Assistant Attorney General Stuart M. Gerson, head of the Civil Division, said Bicoastal, currently in Chapter 11 bankruptcy, was formerly known as The Singer Co. and manufactured the simulators through its Link Flight Simulation Division until that division was sold to CAE Industries, a Canadian company, in 1988. Following that sale, the division became CAE-Link Corp. based in Binghamton, N.Y.

Gerson said the government initiated its investigation after Christopher Urda, a former Link employee, told the United States that Link routinely concealed information from government negotiators concerning its sole-source cost proposals.

In November 1988, Urda and Taxpayers Against Fraud, a nonprofit organization, filed a qui tam suit, which allows private parties, known as relators, to file fraud claims on behalf of the government in return for a percentage of the government's recovery if the government intervenes in the suit. The department intervened in this case in the spring of 1989.

Under the terms of the settlement, Urda and Taxpayers Against Fraud will receive \$8.725 million of the government's recovery. The award is the largest received by a relator since the passage of the qui tam amendments to the False Claims Act in 1986.

Gerson, who has urged Congress to change the qui tam provisions, said, "While I fully support the dual purposes of the qui tam provisions -- to encourage the reporting of fraud against the government and to compensate generously those who take the risks in coming forward -- I question whether it is really necessary to divert sums of this nature from the U.S. treasury to qui tam relators in order to achieve these goals."

In investigating the case, the government discovered that Link submitted cost proposals containing undisclosed so-called "negotiation reserves" which were used to offset cost reductions obtained by the government during negotiations to purchase the flight simulators from 1980 through 1988.

According to Gerson, Link maintained two sets of estimates for each cost proposal: a "best estimate" of the anticipated cost of performing the contract and a second, inflated, estimate that included the negotiation reserve, which it provided government negotiators. Under regulations governing negotiations and the awarding of sole source contracts, Link was required to provide the government with its "best estimate" of anticipated costs and certify that all cost or pricing information provided to the government was complete and accurate.

(Justice Department press release, July 13, 1992)

### **36) Hercules (\$55,000,000)**

A whistle blower's suit against Hercules Inc. contending that the company falsified manufacturing and inspection records over 11 years in its production of nine rocket systems including those carrying nuclear warheads has been settled out of court for \$55 million, according to two San Diego attorneys who represented the whistleblower, Katherine A. Colunga, a former Hercules employee.

The attorneys, Michael Thorsnes and Daral Mazzearella of the San Diego firm of Thorsnes, Bartolotta, McGuire & Padilla, said the award is the largest in history in a case in which the government itself declined to prosecute.

Settlement was reached on May 15, two weeks before the case was to be tried in federal court in Salt Lake City.

The court now will decide whether to give final approval to the settlement.

The U.S. government had declined to bring suit against Hercules after Colunga produced her evidence against the aerospace firm, so Colunga had to go it alone against the defense industry giant.

Hercules decided to end the nine year legal battle by paying \$36 million to Colunga, whose portion will be shared by the U.S. government, and \$19 million in court costs, attorneys fees and expenses.

("Hercules Settles Whistleblower Lawsuit for \$55 Million," 12 *Corporate Crime Reporter* 21(3), May 25, 1998)

### **37) (tie) Tenet Healthcare Corporation (\$54,000,000)**

Tenet Healthcare Corporation will pay \$54 million to settle allegations that it billed the federal government for unnecessary cardiac procedures and surgeries the Redding Medical Center in California.

While the settlement clears the corporation from a threatened criminal prosecution, federal prosecutors said that "the civil settlement does not limit the government's criminal or civil investigation of any individuals."

The settlement represents the largest recovery in the history of the United States Department of Justice in a case alleging lack of medical necessity, so-called "medical necessity fraud," which include cases involving allegations of unnecessary procedures, tests, lab studies, surgeries and similar conduct.

According to Assistant U.S. Attorney Michael A. Hirst, who prosecuted the civil case, the settlement covers allegations that Tenet billings were fraudulent under the False Claims Act.

Tenet agreed to implement changes at the Redding hospital to ensure that no future unnecessary procedures will be performed.

These include:

- \* Twice yearly for the next three years random audits of cardiology procedures will be performed by outside experts consisting of board certified physicians who do not practice at RMC;

- \* Each audit will generate a written report that will be provided to the United States Attorney's Office;

- \* Specified training for three years will be provided on peer review and informed consent for all physicians who practice at RMC;

- \* Reports of training and attendees will be provided to the United States; and

- \* Defendants will create a position for a new, full-time employee who will serve for at least three years to direct compliance and training at the Redding Medical Center.

Federal officials said that the Department of Health and Human Services will continue its investigation to determine whether to exclude Tenet from further participation federal health programs.

Federal officials said that Tenet did not admit liability in the settlement, and the settlement should not be construed as any evidence of criminal, civil or administrative liability of any individuals.

(Tenet Healthcare to Pay \$54 Million to Settle Health Care Fraud Charges," 17 *Corporate Crime Reporter* 32(5), August 11, 2003)

### **37) (tie) Boeing Company (\$54,000,000)**

In August 2000, the Boeing Company agreed to pay the United States up to \$54 million to settle two lawsuits that allege the Seattle based manufacturer placed defective gears in CH 47D "Chinook" helicopters and then sold the aircraft to the United States Army.

The CH 47D, which can carry 33 combat ready soldiers in addition to its four person flight crew, is the Army's medium lift helicopter used to move troops and equipment.

Boeing used two subcontractors, Litton Precision Gear of Bedford Park, Illinois and SPECO Corporation of Springfield, Ohio to manufacture the flight critical transmission gears for the helicopter. One of the gears, manufactured by Litton, failed in flight, causing an Army Chinook helicopter to crash and burn while on a mission in Honduras in 1988. Five servicemen aboard were killed.

Two of the gears manufactured by SPECO failed in flight in Chinook helicopters.

One craft, which crashed in January 1991 during Operation Desert Shield in Saudi Arabia, was totally destroyed. Two individuals aboard were injured.

In another incident at Ft. Meade, Maryland in June 1993 during a training flight, a Chinook sustained over one half million dollars in damage. The helicopters destroyed in Honduras and Saudi Arabia were valued at more than \$10 million each.

Since January 2000, the Army's Chinook fleet has been partially grounded due to additional defects found in SPECO transmission gears, which are currently being replaced.

In 1997, SPECO, which had filed for bankruptcy, settled the allegations against it by agreeing to pay the United States \$7.5 million.

"This case demonstrates the tragic consequences that can occur when faulty parts are sold to the Defense Department," said David W. Ogden, Acting Assistant Attorney General of the Justice Department's Civil Division. "The lives of our service members, not only dollars, are at stake. This lawsuit sends a message that the United States will not stand by if contractors provide our military with substandard and dangerous equipment."

The settlement allows the government to recover the amounts lost due to the destruction of two helicopters and significant damage to a third, as well as the costs to replace all of the defective SPECO made transmission gears.

The two lawsuits were filed in the Southern District of Ohio in Cincinnati by Brett Roby, a former SPECO quality engineer.

Roby filed the suits under the False Claims Act, which permits private citizens, known as "relators," to sue on behalf of the government to recover federal funds that were obtained by false or fraudulent claims.

The United States, which joined as a party in the two cases, alleged that Boeing and its subcontractors violated the False Claims Act when they sold the Army more than one hundred and forty helicopters containing defective SPECO gears.

In accordance with the False Claims Act, Roby will be paid \$10.5 million from the Boeing settlement with the balance of \$43.5 million going to the federal government.

Of the \$54 million to be paid by Boeing, \$19 million plus interest will depend on the outcome of the aircraft manufacturer's appeal of two legal issues which the federal district court in Cincinnati previously decided in the government's favor. In addition, Boeing will pay \$7.5 million for Mr. Roby's legal fees.

("Boeing to Pay U.S. for Selling Army Defective Helicopters," 14 *Corporate Crime*

**39) Gambro Healthcare Inc. (\$53,100,000)**

In July 2000, Gambro Healthcare, Inc. and its subsidiary, Gambro Healthcare Laboratory Services, Inc. agreed to pay \$40 million to settle allegations of health care fraud.

Gambro and another subsidiary, Dialysis Holdings Laboratory Services, Inc. also agreed to pay more than \$13.1 million to settle similar allegations.

The settlements with the Gambro companies resolve allegations that the firms submitted false claims to Medicare, Medicaid and TRICARE the Defense Department's health care program for laboratory services.

Federal officials alleged that the services were provided by GHLSI's Ft. Lauderdale, Florida laboratory and DHLSI's Deland, Florida laboratory (formerly known as Vivra Laboratory) to End Stage Renal Disease (ESRD) patients. ESRD occurs when chronic renal failure progresses to the point at which the kidneys are permanently functioning at less than 10% of their capacity.

In early 1997, as part of Operation Restore Trust, the Office of the Inspector General of the Department of Health and Human Services commenced an investigation of the billing practices of the Gambro renal dialysis laboratory located in Ft. Lauderdale and the Vivra Laboratory in Deland.

The government's investigation discovered that Gambro's Ft. Lauderdale lab billed the federal healthcare programs for medically unnecessary lab tests provided to ESRD patients, double billed for lab tests included in Medicare's ESRD composite rate payments to dialysis clinics and violated the 50/50 rule which prohibits ESRD laboratories from billing Medicare Part B for lab test panels comprised of more than 50 percent composite rate tests.

The government's investigation similarly uncovered that the Deland lab billed Medicare, Medicaid and TRICARE for medically unnecessary tests provided to ESRD patients and double billed for tests included in Medicare's ESRD composite rate payments to dialysis clinics. The Deland lab was closed in 1998.

("Gambro Healthcare Inc. To Pay \$53 Million for Overcharging Medicare," 14 *Corporate Crime Reporter* 30(1), July 24, 2000)

**40) (tie) Pfizer Inc. (\$49,000,000)**

In October 2002, Pfizer Corporation and its subsidiaries, Warner Lambert and Parke Davis, will pay \$49 million to settle allegations that the company violated the False Claims Act.

The United States will receive \$27,915,300 plus accrued interest. The remainder of the settlement amount, \$21,084,700 plus accrued interest, will be shared among 40 states.

David Foster, a former Parke Davis/Warner Lambert employee in the company's Southeast Region, was the qui tam relator or whistle blower who filed the initial suit on behalf of the United States.

Foster will receive 21.3 percent of the federal government's portion of the recovery or \$5,945,958.90.

The government alleged that the defendants fraudulently avoided paying fully the rebates owed to the state and federal governments under the national drug Medicaid Rebate program for the cholesterol lowering drug Lipitor.

Congress enacted the Medicaid Rebate program in 1991 to ensure that state Medicaid programs and the federal government do not overpay for the cost of providing drugs to Medicaid beneficiaries.

The rebate program is embodied in the Medicaid Rebate Agreement that each drug



company signs with the federal government in exchange for the privilege of having its products approved for use by Medicaid beneficiaries.

The Medicaid Rebate program requires drug companies to pay quarterly rebates to states in a way intended to account for discounts given by the drug companies to their favored customers.

The key to the program is the requirement that, for each drug sold, drug companies report to the Center for Medicare and Medicaid Services the best price they offered to any commercial, for profit customer and pay a quarterly rebate based, in part, upon that best price.

Parke Davis Labs, then a subsidiary of Warner Lambert, which was subsequently acquired by Pfizer in 2000, allegedly overstated the Lipitor best price in the first and second quarters of 1999 by concealing \$250,000 of cash discounts that were given to a key managed care customer in Louisiana in exchange for favorable status on the managed care organization's drug formulary.

The alleged unreported discounts to the managed care organization allowed Parke Davis/Warner Lambert to retain over \$20 million in Medicaid Rebates owed to the Medicaid program.

("Pfizer to Pay \$49 Million," 16 *Corporate Crime Reporter* 42(3), November 4, 2002)

#### **(40) (tie) Shell Oil Company (\$49,000,000)**

Shell Oil Company will pay \$49 million to settle claims it violated the False Claims Act and various administrative provisions relating to its unauthorized venting and flaring of gas in the Gulf of Mexico.

The settlement resolves a lawsuit filed by the Justice Department alleging that Shell improperly vented and flared gas from various offshore federal leases.

The suit also alleged that the energy company failed to properly report, or pay royalties on, the vented and flared gas.

Regulations issued by the Department of the Interior prohibit unauthorized venting and flaring of gas in excess of small volumes that are not economical to recover.

The lawsuit charged that Shell vented and flared for extended periods large volumes of gas at its Auger platform, located about 150 miles off the coast of Louisiana, and other facilities in the Gulf of Mexico.

The government alleged that Shell's conduct violated the False Claims Act, as well as other administrative requirements.

As part of the agreement settling the lawsuit, Shell acknowledged that it improperly vented and flared gas from its offshore leases, and failed to properly report or pay royalties on that gas.

The settlement represents the third case settled by Shell in the last four years alleging that it underpaid royalties owed to the United States.

In 2000, Shell agreed to pay \$56 million to resolve claims that it undervalued gas produced from federal leases.

In 2001, Shell paid \$110 million to resolve claims that it undervalued crude oil extracted from federal lands.

"Shell Oil Company to Pay \$49 Million to Settle False Claims Act Case," 17 *Corporate Crime Reporter* 32(1), August 11, 2003)

**(40) (tie) New York State and City of New York (\$49,000,000)**

In November 1999, New York City and New York State will pay \$49 million to settle a civil lawsuit brought by a city employee who charged that New York fraudulently collected hundreds of millions of dollars in Federal funds between 1990 and 1994 for required foster care services that were not provided.

The settlement includes no admission of wrongdoing, but requires the city and the state to give Federal officials access to foster care computer records over the next three years so they can determine whether the city is providing mandated services to children in foster care.

The city will pay \$14 million and the state, which is responsible for overseeing the city's system and collected most of the Federal money, will pay \$35 million.

Bracha Graber will receive \$4.9 million under the settlement. Ms. Graber, an employee of the city's child welfare agency, said she would use a substantial portion of the award to establish a foundation, called the Mel Collins Memorial Children's Foundation, to provide scholarships for art, music and other extracurricular activities to New York City foster children.

("City and State to Pay \$49 Million To Settle Foster-Care Fraud Suit," *New York Times*, November 11, 1998)

**43) Texaco Inc. (\$43,000,000)**

In September 2000, Texaco, Inc. agreed to pay \$43 million to resolve claims that the oil company underpaid royalties due for oil produced on Federal and Indian leases from January 1, 1980 to December 31, 1998.

Federal leases are administered by the Minerals Management Service of the United States Department of the Interior.

Each month, Texaco is required to report the amount of oil produced and the value of the oil produced on Federal and Indian leases.

Texaco pays royalties based upon the value of the oil it reports.

The settlement resolves allegations that Texaco systematically under reported the value of oil its affiliated companies produced on Federal and Indian leases and, consequently, that the companies paid less royalties than they owed.

The settlement agreement was signed by representatives of several Indian tribes, as well as the federal government and Texaco. Two relators who had filed a complaint in the United States District Court in Lufkin, Texas against Texaco on behalf of the United States under the qui tam provisions of the False Claims Act will share in the proceeds of the settlement.

("United States Settles with Texaco," 14 *Corporate Crime Reporter* 39(3), October 9, 2000)

**44) Olsten Corporation (\$41 million) \***

In July 1999, Olsten Corporation and a subsidiary, Kimberly Home Health Care, Inc., agreed to pay \$61 million to settle allegations that both companies defrauded the Medicare program.

Olsten will pay nearly \$51 million as part of a civil settlement, and Kimberly will enter into criminal plea agreements in three districts and pay more than \$10 million in criminal fines.

Kimberly will plead guilty to three separate felony charges, which were filed in Florida and Georgia.

Kimberly will plead guilty to conspiracy, mail fraud and violating the Medicare Anti Kickback statute, and will pay \$10.08 million in criminal fines in connection with its scheme to defraud the Medicare program.

Kimberly's parent company, Olsten, entered into a civil settlement agreement with the United States and will pay \$50.92 million to resolve its civil liability stemming from the same Medicare fraud schemes and an additional scheme in Brooklyn, New York.

Olsten and its subsidiaries own and operate management and staffing services for home health agencies in several states, including Florida and Georgia.

Federal officials alleged kickbacks and false Medicare billings made in connection with Kimberly's receipt of fees from another company for Kimberly's management of certain home health agencies.

As part of the plea agreement, Olsten and Kimberly will cooperate with the government in its ongoing investigations of others involved in these schemes.

The civil settlement resolves allegations that Olsten defrauded Medicare in connection with its agreement to sell its home health agencies to Columbia/HCA in 1995 and 1996 and to assist Columbia/HCA in obtaining other home health agencies, and with its subsequent management arrangement with Columbia/HCA.

Federal officials alleged that Olsten and Columbia/HCA caused the taxpayers to foot the bill for Columbia's acquisition of the agencies by passing on part of the purchase costs to Medicare disguised as management fees charged by Olsten. Medicare does not pay for most acquisition costs but it does pay for legitimate management fees.

The civil settlement also resolves allegations that Olsten caused Medicare to be charged for sales and marketing activities that are not reimbursable under Medicare rules.

The civil case was initially filed by former Olsten Vice President, Donald McLendon, under the qui tam provisions of the False Claims Act, a federal law that allows private individuals to sue on behalf of the government.

Under the agreement McLendon will receive \$9.8 million.

The remaining \$10 million of the civil settlement resolves Olsten's liability in an unrelated matter in the Eastern District of New York.

Olsten also accepted deferred criminal prosecution there. In the New York matter, the U.S. alleged that Olsten filed fraudulent cost reports which sought Medicare payment for non reimbursable costs including personal expenses of corporate executives.

In addition to paying \$61 million, Olsten also has agreed with the Department of Health and Human Services to adopt and apply a corporate integrity agreement, which will extend to all of its health care facilities and lines of business located in the United States.

Kimberly will be permanently excluded from participation in Medicare and other federal health benefit programs.

#### **45) MetPath/MetWest (Corning Labs) (\$39,800,000)**

Two of the nation's largest independent blood testing laboratories have paid the United States \$39.8 million to settle allegations they submitted false Medicare claims for unnecessary blood tests.

The department settled the case on behalf of the Department of Health and Human Services, which administers medicare.

The agreement settles claims with MetPath, a division of Corning Lab Services Inc.

headquartered in Teterboro, N.J. and MetWest, headquartered in Tarzana, Calif. Metpath is the nation's second largest independent blood laboratory, while MetWest is the sixth largest.

Federal officials said the two labs manipulated doctors into receiving medically unnecessary test results for HDL (high density lipoprotein), total iron binding capacity (TIBC) and protein bound glucose (PBG) whenever doctors ordered certain basic, automated blood tests.

The agreement settles claims initially brought as a qui tam or whistleblower" action under the False Claims Act in 1991 by C. Jack Dowden alleging that MetPath and MetWest defrauded Medicare with regard to their HDL marketing and billing practices. Dowden will receive \$5.97 million for bringing the case to the attention of the government. Dowden also will receive \$15 million from a previous settlement involving National Health Laboratories.

The allegations involved a series of laboratory tests conducted on a "sequential multiple analysis computer" (SMAC) for which Medicare reimbursed laboratories on a flat fee basis for any 19 or more tests, even if the physicians needed the results of only a few of the tests.

The SMAC series of tests, because it is highly informative and relatively low in cost, is an extremely popular laboratory test ordered by doctors for a variety of diagnostic and monitoring purposes.

MetPath and MetWest regional laboratories revised their order forms and compendium of services in 1988 to combine the HDL test with the SMAC, market them as a "ChemScreen Profile" or "ChemPanel" and bill HDL, not performed on the SMAC, separately to Medicare.

In 1990 and 1991, MetPath and MetWest regional laboratories engaged in similar programs to package the TIBC and PBG tests (performed on the SMAC) as part of the "ChemScreen Profile" or "ChemPanel" and also billed each to Medicare separately.

Although specific sales, marketing, and billing practices varied among the companies' regional laboratories, generally each of these additional tests were added routinely to the SMAC for a "nominal" additional price or as part of annual across-the-board price increases to the physicians, while the fact that Medicare would be billed separately for each test at retail prices often was not revealed to the doctors.

Medicare claims for each additional test were submitted directly by the labs to the Medicare insurance carriers, who reimbursed the labs for each separately billed additional test -- HDL, TIBC and PBG -- based on retail fee schedules.

As a result of this marketing scheme, some doctors ordered the labs' Chemscreens Profiles or ChemPanels even if they needed only the SMAC, not realizing that the unnecessary HDL, TIBC and PBG tests were costing Medicare millions of dollars.

As a result of these practices, hundreds of thousands of claims for payment to Medicare for TIBC and other tests were submitted to Medicare that MetPath and MetWest regional labs knew were not reasonable and necessary for the diagnosis or treatment of an illness or injury, as required by Medicare.

Under the settlement, MetPath has paid the government \$35.013 million and MetWest has paid the government \$4.787 million.

(Justice Department press release, September 13, 1993)

#### **46) Basin Electric Power Cooperative (\$39,100,000)**

In March 1999, a North Dakota district court awarded the Government \$39.1 million in a qui tam suit against Basin Electric Power Cooperative of Bismarck, North Dakota.

Federal officials alleged multiple frauds under a contract with the Department of Energy's Western Area Power Administration (WAPA).

The United States was also awarded \$8,232,031 on its related breach of contract claims

The qui tam suit was originally filed in 1995 by Robert Norbeck, a former chief auditor

for Basin.

The court ruled that Basin, a power cooperative organized to build power plants and supply power to its member distribution cooperatives, misapplied the proceeds from the sale of a power unit that it should have used to retire debt costs used in the computation of costs to WAPA.

This resulted in a \$15,468,662 overcharge in power costs to WAPA. After Norbeck made an internal complaint, but prior to the filing of his qui tam suit, Basin acknowledged an overcharge in this area and paid a refund of \$2.4 million to the Government.

The court ruled in the Government's favor on a number of related common law claims .  
(16 *False Claims Act and Qui Tam Quarterly Review* 44, April 1999)

#### **47) Highmark Inc. (\$38,500,000)**

Highmark Inc. will pay \$38.5 million to the federal government in settlement of a series of civil complaints brought by the U.S. Department of Justice alleging that certain employees of Highmark's Xact Medicare Services division had engaged in conduct that violated the federal Civil False Claims Act.

The settlement covers conduct during the period from 1989 to 1996, and relates to charges that Xact Medicare Services did not adequately safeguard Medicare funds in its performance as a Medicare Part B contractor in the early 1990s.

The settlement came about following a two-year federal investigation based in substantial part on voluntary disclosures made by one of Highmark's predecessor organizations, Pennsylvania Blue Shield, to the federal government following an internal investigation commissioned by Blue Shield's management.

According to Highmark spokesperson Brian Herrmann, "Highmark regrets the actions leading to this investigation and settlement. Highmark cooperated fully with the investigation. Our company is totally committed to compliance with all applicable laws and regulations attendant to our federal contracts."

(Justice Department press release, September 3, 1998)

#### **48) Salomon Smith Barney (\$38,000,000)**

In April 2000, 17 investment banks agreed to pay about \$140 million to the federal government to settle charges that they defrauded the federal government by overpricing securities sold in connection with certain municipal bond transactions.

The scheme involved what has come to be known as "yield burning" and was first brought to the public's attention in 1995 by whistleblower Michael Lissack, who filed a qui tam lawsuit against more than a dozen Wall Street firms under the False Claims Act.

Yield-burning occurs when an investment bank marks up the price of securities that it sells to a municipality in order to lower the return on those securities, so that the portfolio that is being sold complies with tax-law.

The net effect of yield-burning is that money has been transferred from the federal government to the investment banker.

The settlement involves a separate qui tam lawsuit brought by Joseph Mooney, a public finance banker in Florida, and separate government charges brought against three investment banks.

The settlement wraps up the government's case against most of the major players in the municipal finance market. It covers potential False Claims Act, security law and IRS liabilities against the investment banks and was agreed to by the Justice Department, Securities and Exchange Commission, the Internal Revenue Service and NASD Regulation, the

independent subsidiary of the National Association of Securities Dealers Inc. charged with regulating the securities industry.

"Today's agreement ends a disgraceful chapter of abuse and deception in Wall Street's history," said John R. Phillips, a Washington, D.C., attorney whose firm, Phillips & Cohen, represents both Lissack and Mooney. "There is no doubt that without the help of our clients, investment banks would have continued to milk the U.S. Treasury for hundreds of millions of dollars."

The settlement has two components. The securities firms will pay approximately \$120.4 million to the federal government, the bulk of which will go toward settling the qui tam lawsuits. About \$20 million will be returned to municipalities nationwide that were harmed by the firms' yield burning practices.

The firms that were named in the qui tam lawsuits and the amounts they paid to settle the lawsuits are:

- Dain Rauscher Corp. -- \$11 million
- Salomon Smith Barney Inc. -- \$38 million
- William R. Hough & Co. -- \$3.1 million
- U.S. Bancorp Piper Jaffray Inc. (as successor to Piper Jaffray) -- approximately \$1 million
- CS First Boston Corp. -- almost \$1 million
- Dillon Read Securities Inc. -- \$6.3 million
- Goldman Sachs & Co. -- \$5.1 million
- PaineWebber Inc. -- \$21.6 million
- Prudential Securities Inc. -- \$5.8 million
- Raymond James & Associates Inc. -- \$2.6 million
- Morgan Stanley & Co. -- \$2.5 million
- Lehman Brothers Inc. -- \$4.5 million
- Merrill Lynch Pierce Fenner & Smith Inc. -- \$4.6 million
- First Union (as successor to Wheat First) -- \$6.3 million

Three banks that were not named in the qui tam lawsuits also settled government fraud charges at the same time and paid about \$6.6 million for damages to the federal government and municipalities: JC Bradford, Southwest Securities and AG Edwards.

("Big Securities Firms to Pay \$140 Million to Settle Yield Burning Cases," 14 *Corporate Crime Reporter* 15(4), April 10, 2000)

#### **49) Lockheed Martin (\$37,900,000)**

Lockheed Martin Corporation will pay the United States \$37,900,000 to resolve allegations that it inflated the cost of performing several Air Force contracts.

The case was originally filed in the United States District Court in Orlando, Florida by a former employee of Lockheed Martin, Albert Campbell, under the qui tam or whistleblower provisions of the False Claims Act.

The qui tam suit accused Lockheed Martin of deliberately inflating the cost of four contracts for the purchase of navigation and targeting pods for military jets.

Campbell's complaint alleged that Lockheed Martin violated the Act by knowingly failing, among other things, to provide current, accurate and complete cost and pricing data to Air Force contract negotiators.

Government contractors are required by the Truth in Negotiations Act to provide accurate and complete cost data to government contract negotiators.

The complaint also alleged mischarging of costs on a fifth Air Force contract.

The Justice Department intervened and took over litigation of the case as it related to

one  
of the contracts.

The federal complaint alleged, among other things, that Lockheed Martin program management purposely inflated its contract proposal for a foreign military sales contract under the LANTIRN (Low Altitude Navigation and Targeting Infrared for Night) program in order to create additional profit which could be used to offset overruns on another Air Force contract.

The Air Force entered into the contract with Lockheed Martin to purchase the LANTIRN pods for resale to the governments of Saudi Arabia, Greece and Bahrain.

The settlement resolves Lockheed Martin's potential liability under the False Claims Act arising from both Campbell's complaint and that of the United States.

Under the qui tam statute, a private party, known as a "relator," can file an action on behalf of the United States and receive a portion of the recovery.

Campbell will receive \$8,750,000 as his share of the proceeds of the settlement.

("Lockheed Martin to Pay \$37 Million to Settle Charges it Ripped off the Air Force," 17 *Corporate Crime Reporter* 33(5), September 1, 2003)

### **50) Jacobs Engineering Group Inc. (\$35,000,000)**

Jacobs Engineering Group Inc. will pay \$35 million to settle a whistleblower lawsuit that alleged the company bilked the federal government for improper expenses over a period of 15 years.

The case was originally filed in July 1997 under seal by Edwin Bond, a former employee of Jacobs.

Bond claimed that the Pasadena, California-based Jacobs charged the government for unallowable overhead costs.

In his lawsuit, Bond alleged that between 1983 and 1997, Jacobs knowingly and improperly charged the United States for excess rental costs following the sale and leaseback of its corporate headquarters building.

After selling its headquarters in 1982, Jacobs leased back the property at rates higher than it would have paid if it owned the property.

Federal acquisition regulations limit rental costs following a sale/leaseback to ownership costs that could have been charged if title had been retained.

Jacobs allegedly charged the full rental costs for its corporate headquarters to the government, in excess of ownership costs that could have been charged if ownership had been retained.

("Jacobs Engineering to Pay \$35 Million," 14 *Corporate Crime Reporter* 12(3), March 20, 2000)

### **51) NEC (\$34,000,000)**

A subsidiary of the NEC Corporation, one of Japan's largest electronics manufacturers, had agreed to pay the United States Government \$34 million to settle bid-rigging charges arising from telecommunications contracts with the United States military in Japan.

The settlement with NEC Information Technologies Ltd., which runs telephone and microwave operations at American Air Force bases in Japan, represents the largest payment by a single Japanese concern facing a civil fraud claim by the Government.

The department previously recovered money from Japanese construction companies that faced bid-rigging charges, asserting as its legal basis both United States law, like the False Claims Act, and Japanese anti-monopoly laws.

In Japan, the Fair Trade Commission said today that it was fining NEC and two other

companies a total of about \$2 million as a penalty for the bid-rigging.

The Justice Department said it initiated an inquiry after Air Force officials detected a suspicious pattern of bidding on communications contracts between 1981 and 1988. The Air Force investigation discovered that bids on 27 contracts totaling \$103 million had been rigged in advance by a group of 12 Japanese telecommunications companies. No United States companies competed for any of the contracts.

The other contractors submitted what the department said were higher-priced "complementary bids." Department officials said many of these bids were actually prepared by NEC-IT in a conspiracy that raised the price of telecommunications services to the military in Japan about 30 percent.

(“NEC Unit to Pay US \$34 Million in Bid-Rigging Case,” *New York Times*, May 10, 1991)

### **52) BP Amoco (\$32,000,000)**

In April 2000, BP Amoco agreed to pay \$32 million to resolve claims under the False Claims Act and administrative claims that the corporation underpaid royalties due for oil produced on federal and Indian leases since 1988.

BP Amoco, which is based in Chicago, was created in 1998 by the merger of Amoco Corporation of the United States and the British Petroleum Company p.l.c. of the United Kingdom.

Federal leases are administered by the Minerals Management Service of the United States Department of the Interior. Each month, BP Amoco is required to report the amount of oil produced and the value of the oil produced on federal and Indian leases. The oil company pays royalties based upon the value of the oil they report.

The settlement agreements were signed by representatives of several Indian tribes, as well as the federal government and BP Amoco.

Two relators, J. Benjamin Johnson, Jr., and John Martinek, who had filed a complaint in the United States District Court in Lufkin, Texas against BP and Amoco on behalf of the United States under the qui tam provisions of the False Claims Act will share in the proceeds of the settlement. The two will share more than \$5.4 million.

The Department has already reached settlement agreements with several other oil companies for underpayment of royalties Mobil Oil, \$45 million, Oxy USA, Inc., \$7.3 million, Chevron, \$95 million and Conoco, \$26 million.

“BP Amoco to Pay \$32 Million,” 14 *Corporate Crime Reporter* 16(3), April 17, 2000)

### **53) Community Health Systems Inc. (\$31,000,000)**

Community Health Services (CHS), a Tennessee-based hospital chain, will pay \$31 million to resolve allegations that it submitted false claims for reimbursement to Medicare, Medicaid, and TRICARE, the Defense Department's health care program.

The settlement with CHS followed allegations of "upcoding" – the improper assignment of diagnostic codes to hospital inpatient discharges for the purpose of increasing reimbursement amounts. The overcharges stemmed from misuse of eight different codes, including those for pneumonia, septicemia, certain cardiac conditions, and respiratory failure and ventilators.

After being notified of pending investigations of several of its hospitals, CHS disclosed the chain-wide upcoding to the government.

As part of the settlement, the company agreed to assist the federal officials in the investigation or prosecution of related cases.

The company also entered into a corporate compliance agreement with the Department of Health and Human Services that is designed to ensure that accurate claims are submitted



to government health care programs with respect to inpatient treatment.

("Tennessee-Based Hospital Chain Pays \$31 Million," 14 *Corporate Crime Reporter* 20(5), May 15, 2000)

#### **54) Lifescan (Johnson & Johnson) (\$30,600,000) \***

In December 2000, LifeScan, Inc., a Johnson & Johnson subsidiary and the world's largest manufacturer of home blood glucose monitors for diabetes, pled guilty to federal crimes and will pay the federal government \$60 million in restitution and criminal fines following a two year grand jury investigation.

The plea resulted from the company's decision to market the devices despite two defects that its own safety adviser warned might have "catastrophic" consequences.

Lifescan is headquartered in Milpitas, California and is a wholly owned subsidiary of Johnson & Johnson.

The company pled guilty to three criminal charges -- selling a misbranded medical device, failing to notify the Food and Drug Administration (FDA), and submitting false reports to the FDA.

Lifescan was ordered to pay a \$29.4 million criminal fine and \$30.6 million in civil penalties, damages, attorneys fees and restitution.

Lifescan will be on probation for three years, meaning that the Food and Drug Administration and U.S. Probation Office will oversee certain aspects of the company's operation.

In addition, Lifescan entered into a civil compliance agreement with the Department of Health and Human Services (HHS), which provides for additional oversight of Lifescan by HHS.

LifeScan introduced its blood glucose meter and test strips, known as the SureStep system, in 1996. LifeScan marketed the SureStep system as "easier to use" and "sure at every step," and claimed that it was designed specifically for those with failing eyesight or shaky or numb hands, symptoms common among diabetics.

But according to corporate documents seized in a 1998 government raid and obtained in the civil case, the readout on the meter at times failed to display the "HI" alert for patients in need of immediate lowering of glucose levels, leading to a risk of diabetic coma, renal failure or toxic shock.

Another design defect in the test strips used with the meters also caused false readings and posed a similar risk, according to a second memo.

The SureStep meter is supposed to warn patients when a strip is inserted incorrectly. Instead, if a diabetic did not insert a test strip completely the meter would indicate a falsely low glucose level. Taking measures to increase low blood glucose when in fact levels are very high can have catastrophic effects.

Company supervisors were warned that incorrect readings had "the potential to create a life threatening field failure ...[a patient] could go into katabidosis a critical medical emergency." At least three diabetics may have died as a result of the faulty readings from the SureStep meter.

Documents seized by federal agents indicate that LifeScan's management chose to ignore an internal recommendation in June of 1997 that it recall the meters. The company's Director of Clinical Analysis, a medical doctor, urged LifeScan's top management to recall the product, describing the readout flaw as "a catastrophic failure that could lead to serious injury."

One memo quotes him as saying that "if lawyers got hold of this, LifeScan would be in serious trouble."

Although LifeScan sent out a letter in June of 1997 notifying physicians of a possible

problem with the SureStep, the letter claimed no danger existed "this situation does not constitute a risk to health, but is one of labeling clarity."

("Johnson & Johnson Lifescan Unit Pleads Guilty," 15 *Corporate Crime Reporter* 1(1), January 1, 2001)

### **55) (tie) Contech Construction (\$30,000,000)**

In January 2001, Ispat-Inland and Contech Construction agreed to pay \$30 million to the Federal Government and the State of Louisiana to settle two qui tam suits alleging that the construction companies falsely certified compliance with contract specifications. According to the Justice Department, from 1992 through 1997 the companies utilized unapproved polymer-coated steel pipe when building drainage culverts for highway and road construction projects. Both the Federal Highway Administration and the Louisiana Department of Transportation and Development (LADOTD) required that Ispat-Inland and Contech use only approved materials from sources that had passed LADOTD testing.

According to the government, the companies used steel that had been laminated by an unapproved source and pipe that had been specifically rejected after testing by LADOTD. To conceal these violations, false information was reportedly stenciled on the exterior of the coated steel to indicate that the materials used to produce the pipe were acceptable.

(22 *False Claims Act and Qui Tam Quarterly Review* 34, April 2001)

### **55) (tie) University of Pennsylvania (\$30,000,000)**

The Clinical Practices of the University of Pennsylvania (CPUP), a component of the University of Pennsylvania Health System (UPHS), will pay \$30 million to the United States government after a federal audit disclosed that false Medicare bills were submitted for faculty physician services.

As part of the settlement, CPUP also agreed to undertake an extensive compliance and disclosure program to assure that future billings by its physicians comply with Medicare requirements.

Federal law provides for triple damages in false claims cases. Triple damages of \$30 million in this case covers false claims for the years 1989 to 1994.

The federal audit disclosed:

- \* Billing by faculty physicians for services actually performed by resident physicians in training. Under the Medicare program, the United States already pays for a substantial portion of the residents' training and salaries, and their services cannot be billed to the Medicare program on a fee-for-service basis. Certain physicians' bills represented that they had personally provided the service done by the residents.

- \* Billing by faculty physicians for in-patient consultations at the highest levels of the coding system, without reference to the service actually performed.

- \* Inadequate documentation for many different types of bills submitted. Auditors used a scientific sampling of CPUP billings to arrive at the amount of false claims. Individual medical charts were analyzed by experts from XACT Medicare Services, a subsidiary of Pennsylvania Blue Shield. The compliance program agreed to has four elements:

- \* CPUP will centralize all business and financial functions under the direction of its Chief Financial Officer. This means that all professional fee services will be billed out of a central office, instead of by individual physicians or departments using differing standards and policies.

- \* Over the next five years, CPUP will put into place separate internal monitoring and external auditing procedures.

- \* CPUP will continue for the next five years mandatory education and training for all

physicians and billing personnel that began in 1994.

\* CPUP will install two telephone lines dedicated to providing billing education as well as the reporting of improper billing for use by physicians, staff and billing personnel.

The \$30 million CPUP will pay will be distributed between the Medicare Trust Fund and the U.S. Treasury.

(In Brief, 9 *Corporate Crime Reporter* 46(8), December 16, 1995)

### **57) Lifemark Hospital (Tenet) (\$29,000,000)**

Tenet Healthcare Corporation subsidiary Lifemark Hospitals of Florida has paid the United States \$29 million to settle allegations that Lifemark, Tenet and various affiliated and predecessor companies violated the False Claims Act in connection with false claims submitted to the Medicare Program.

Lifemark, which does business as Palmetto General Hospital in Hialeah, Florida, was acquired by Tenet in March of 1995.

The settlement agreement resolves allegations by the United States that the hospital's submissions to Medicare from 1994 to 1997 included false claims for home health services purportedly provided by three agencies in Dade, Islamorada and Key West, Florida.

The government contended that these submissions included claims that contained or were based on false, fraudulent and misleading statements or omissions regarding the patient's medical condition, history and/or eligibility for coverage by Medicare.

Federal officials alleged that the hospital's submissions included claims for services that were not reimbursable by Medicare because they were not rendered, were provided by unskilled, unlicensed or uncertified personnel, were based upon insufficient, forged or missing documents, and/or were never ordered by a physician.

The government contended that certain cost reports Palmetto submitted between 1994 and 1997 improperly maximized its Medicare reimbursements through various means, including the reclassification of the costs of one of the home health agencies to the other two and the misallocation of certain capital related, operating, nursing administration, cafeteria and social service costs.

The United States contended that the hospital improperly claimed non reimbursable billing fees paid to a related company; and also failed to disclose the related party nature of that relationship.

Federal officials contended that the hospital improperly classified certain non reimbursable acquisition costs as reimbursable consulting fees.

The civil settlement includes a full resolution of claims brought against Tenet and one of its home health agencies by a former employee of the defendants, Isabel Ayers, under the qui tam or whistleblower provisions of the False Claims Act.

Ms. Ayers filed her suit in the U.S. District Court for the Southern District of Florida in August of 1997.

As a result of the settlement, she will receive approximately \$4 million of the total recovery as her statutory award, and her suit will be dismissed. Under the qui tam provisions of the False Claims Act, a private party can file an action on behalf of the United States and receive a portion of the settlement if the government reaches a monetary agreement with the defendants.

("Tenet Hospital In Florida Pays \$29 Million," 16 *Corporate Crime Reporter* 29(1), July 22, 2002)

### **58) Blue Cross Blue Shield Michigan (\$27,600,000)**

Blue Cross Blue Shield of Michigan Inc. will pay the United States \$27.6 million to settle civil claims it improperly billed and submitted false documentation to the government as the fiscal intermediary of the Medicare program in Michigan.

Assistant Attorney General Frank W. Hunger, in charge of the Civil Division, and U.S. Attorney Lynne A. Battaglia of Baltimore said the settlement resolves a qui tam complaint, United States ex rel. Darcy Flynn v. Blue Cross Blue Shield of Michigan, that was filed in U.S. District Court in Baltimore on August 4, 1992.

Blue Cross Blue Shield, under a contract with the Health Care Financing Administration, managed the Medicare Part A program and was required to audit the cost reports of participating hospitals, determine which costs were authorized under the Medicare regulations and make the appropriate payments.

HCFA, the federal agency which administers the Medicare program, monitored Blue Cross by reviewing a sample of the audits.

The complaint alleged that Blue Cross Blue Shield, which is headquartered in Detroit, defrauded the government by performing cursory and inadequate audits.

When HCFA asked to review specific audits, a federal investigation revealed, Blue Cross Blue Shield "corrected" the audits and backdated revised work papers to conceal the fact that the original audits were inadequate and poorly done.

HCFA, based on the "corrected" audits, concluded that Blue Cross Blue Shield was performing its audits responsibly when in fact Blue Cross Blue Shield was not identifying hospital payment claims that did not qualify for Medicare reimbursement, causing the improper payment of federal funds to the hospitals.

"It is particularly disappointing that one of the very fiscal intermediaries that HCFA relied on to administer the Medicare program would defraud Medicare by the way it carried out its contractual obligations," said Hunger.

Under the qui tam provisions of the act, Darcy Flynn, a former Blue Cross auditor who filed the original action on behalf of the government, will receive 20 percent of the proceeds. The False Claims Act permits the government to recover three times the amount of its actual loss plus civil penalties of \$5,000 to \$10,000 for each false claim.

In addition, HCFA has cancelled both the Part A and Part B contracts it had with Blue Cross Blue Shield.

(Justice Department press release, January 18, 1995)

## **59) Teledyne (\$27,500,000)**

Teledyne settled two major civil fraud suits brought by the Justice Department and four whistle-blowers for \$112.5 million, the second-highest such settlement in defense industry history.

Under a deal negotiated over recent months, Teledyne will pay \$85 million to settle charges that its relays subsidiary in Hawthorne sold the Pentagon millions of improperly tested electronic relays, and \$27.5 million to settle charges that its systems unit in Northridge padded contracts on aircraft electronics equipment.

Under terms of the settlement, Teledyne will pay half of the \$112.5 million damages before the end of this year and the balance in two equal installments next year. The whistle-blowers in the cases will receive between 15% and 25% of the awards, subject a federal judge's ruling on the award.

In addition to the \$85 million civil settlement, Teledyne has previously paid a \$17.5-million criminal fine for the illegal testing of relays and an additional \$3.1 million in an administrative settlement with the Pentagon. Teledyne also must pay \$4.6 million to the

whistle-blowers' attorneys.

The allegations in the relays case were made by Emil Stache and Almon Muehlhausen, two employees at Teledyne's plant in Hawthorne. They alleged that Teledyne improperly tested 8 million to 10 million relays, which are tiny switches used in a variety of jets, missiles, spacecraft and other systems.

The allegations in the systems case were made by Klaus Kirchhoff and Max Killingsworth, who alleged that executives at the Northridge plant routinely padded contracts by adding illegal "negotiation yields" that would provide a cushion in cutting prices during contract negotiations.

("Teledyne to Pay \$112 Million," *Los Angeles Times*, April 22, 1994)

### **(60) (tie) National Healthcare (\$27,000,000)**

In December 2000, National Healthcare Corporation (NHC) agreed to pay the United States \$27 million to resolve allegations under the False Claims Act that the company submitted falsely inflated reports to Medicare.

Federal officials alleged that beginning in 1991 the company submitted nursing home cost reports that falsely claimed that facility staff members spent more time caring for Medicare patients than they actually did in order to collect additional money from the federal health care program.

The complaint against NHC alleges that the company submitted cost reports that included false claims for reimbursement. NHC, headquartered in Murfreesboro, Tennessee, owns, leases or provides services to 105 nursing homes nationwide.

The complaint alleges that the cost reports overstated the number of hours that the nursing staff spent taking care of Medicare patients. The hours submitted on the cost reports were contradicted by the nursing staff's time records.

The lawsuit also alleges that certain personnel at some nursing homes were billed as performing therapy on Medicare patients when they did not do that type of work. By billing these employees as performing therapy, the homes received additional payments from Medicare.

The suit was initially brought in 1996 by Philip Charles Braeuning, a former nursing home administrator at Palm Gardens of Orlando, a facility then managed by NHC. The United States intervened in the suit on March 18, 1997. Under the False Claims Act, those who file false claims against the federal government may be subject to three times the damages caused and penalties of \$5,000 to \$10,000 per violation.

Under certain circumstances, the whistleblower is entitled to a portion of the government's recovery. The United States has agreed to pay Mr. Braeuning 20 percent of the settlement, as it is collected.

As a condition of the settlement of this case, NHC entered into a Corporate Integrity Agreement with the Office of Inspector General of the United States Department of Health and Human Services.

("Tennessee Based National Healthcare Settle Medicare Fraud Case," 15 *Corporate Crime Reporter* 1(1), January 1, 2001)

### **(60) (tie) Rockwell International (\$27,000,000)**

Rockwell International will pay the United States \$27 million to settle allegations the company knowingly failed to provide the United States with accurate, complete and current information in negotiating multi billion dollar contracts in 1981 to develop the B1 B bomber and the first nine B1 B bomber planes.

Federal officials alleged Rockwell failed to tell the government that changes in its corporate costs and a change in California law reduced the company's costs of doing business.

These cost reductions were not passed on to the government despite Rockwell's specific agreement with the United States to do so, federal officials alleged.

Rockwell, based in Seal Beach, California, was awarded two contracts totaling \$4.4 billion in 1982.

Justice Department Civil Division Chief Frank Hunger said the Department reached the agreement with Rockwell after informing the corporation of its potential liability under the False Claims Act.

("Rockwell International To Pay \$27 Million in B1-1 Bomber Overcharging Case," 9 *Corporate Crime Reporter* 31(3), August 7, 1995)

### **62) New York State (\$26,970,00)**

The United States has received almost \$27 million from the State of New York, several New York State colleges and five state employees to settle claims that they knowingly overbilled, falsely billed and improperly billed the federal government to collect funds disbursed for the training of social service workers.

The federal government disburses funds to states under the Social Security Act for the training of social service workers who will implement such federal programs as Medicaid, adoption and foster care, child support enforcement and Aid to Families with Dependent Children.

The investigation by the United States arose from allegations that were made in an action filed on November 14, 1992, under the qui tam provisions of the False Claims Act by a former NYSDSS employee, George Denoncourt. The United States alleged in its negotiations with the State that the defendants obtained the funds by filing false claims for the training funds under the Social Security Act.

Before Denoncourt filed his suit, HHS's Division of Cost Allocation and the Albany office of HHS's Office of Audit Services had questioned a significant portion of the unallowable costs attributable to the practices challenged by Denoncourt.

Denoncourt's complaint then led the United States to uncover additional unallowable costs as well as evidence that the United States alleged showed "knowing" false claims by the defendants.

As part of the settlement, Denoncourt will receive 15 percent of the United States' recovery, or \$4.05 million.

(Justice Department Press Release, December 27, 1994)

### **63) Conoco Inc. (\$26,000,000)**

Conoco Inc. will pay \$26 million to resolve claims that the company underpaid royalties due for oil produced on federal and Indian leases since 1988.

The settlement resolves allegations that the Ponca City, Oklahoma based company systematically underreported the value of oil it produced and, consequently, that they paid less royalties than they owed.

Federal leases are administered by the Minerals Management Service of the United States Department of the Interior. Each month, Conoco is required to report the amount of oil produced and the value of the oil produced on federal and Indian leases.

The company pays royalties based upon the value of the oil they report.

The settlement agreements were signed by representatives of several Indian tribes, as well as the federal government and Conoco.

Two whistleblowers, J. Benjamin Johnson, Jr., and John Martinek, who had filed a

complaint in the United States District Court in Lufkin, Texas against Conoco, on behalf of the United States under the qui tam provisions of the False Claims Act will share in the proceeds of the settlement.

The two will share more than \$4.2 million.

("Conoco to Pay \$26 Million," 14 *Corporate Crime Reporter* 14(1), April 3, 2000)

#### **64)(tie) Perkin Elmer/Hughes (\$25,000,000)**

Hughes Aircraft and Perkin-Elmer Corp. will pay \$25 million to head off a threatened government lawsuit charging them with liability for the defect that crippled the \$2-billion Hubble space telescope.

Under terms of the settlement, Perkin-Elmer, which owned the Danbury Optical System unit that produced the flawed mirror in the telescope, will pay \$15 million. Los Angeles-based Hughes, which acquired the Danbury unit after the mirror was produced, will pay \$10 million.

The Justice Department asserted that the two companies knew or should have known about the defect. Hughes officials said Monday that they agreed to the settlement only as a goodwill gesture because NASA, the Hubble sponsor, is a valued customer.

When Perkin-Elmer's Danbury unit produced the mirror in the early 1980s, a microscopic optical flaw was ground into the mirror's surface. It was not discovered until NASA launched the Hubble in April, 1990, and the telescope was unable to focus properly.

("Hughes, Perkins Elmer to Pay U.S. for Hubble Telescope Flaw," *Los Angeles Times*, October 5, 1993)

#### **64) Continental Grain (\$25,000,000) \***

Arab Finagrain Agri-Business Trading, Ltd., a foreign based affiliate of Continental Grain Company of New York, pled guilty to a criminal information charging Arab Finagrain with conspiring to defraud the U.S. Department of Agriculture (USDA) in connection with sales of agricultural products to Iraq.

The plea agreement requires Arab Finagrain to pay a \$10 million criminal fine. In a related civil settlement, Continental will pay the United States an additional \$25 million to resolve the government's civil claims against Continental and Arab Finagrain.

Federal officials charged that Arab Finagrain fraudulently participated through Continental in the USDA's Export Credit Guarantee Programs, known as the GSM Programs.

Through the GSM programs, which are funded by the Commodity Credit Corporation (CCC), the USDA provides payment guarantees to exporters which sell their goods on credit to importers in designated countries.

The USDA established the GSM program to expand foreign markets for domestic agricultural goods by reducing the risk of doing business with financial institutions in developing countries.

Federal officials charged that, from 1987 through 1990, Arab Finagrain caused Continental to register for, and obtain, GSM export credit guarantees for sales of agricultural goods specifically protein concentrate and soybean meal to Iraqi government agencies.

The criminal information charged that Arab Finagrain, a company organized under laws of the United Kingdom, with offices in Geneva, Switzerland, and its joint venture partner, used Continental to register these sales for the GSM guarantees because Arab Finagrain which had no office or presence in the United States was not eligible to participate in the federally backed program.

USDA Inspector General Roger C. Viadero said that the criminal plea and civil

settlement bring to a successful conclusion a major investigation by personnel from his office and attorneys of the Department of Justice.

“Continental Grain Affiliate to Pay \$35 Million,” 10 *Corporate Crime Reporter* 46(3), December 2, 1996)

#### **64) (tie) Koch Industries (\$25,000,000)**

In May 2001, Koch Industries agreed to pay the Government \$25 million to settle a qui tam lawsuit alleging that from 1985 to 1989 the company underreported the amount and quality of oil purchased from federal and Indian leases. Bill Koch, the brother of Charles Koch, chairman of Koch Industries, filed the qui tam suit in 1991. During a 1999 jury trial, Koch Industries admitted that it received approximately \$170 million in oil it did not pay for, but argued that the amount was small enough to fall within industry standards. However, the jury found that Koch Industries intentionally cheated oil producers on federal and Indian lands, and found actual damages of \$553,504 and 24,587 false claims, exposing the company to potential liability in fines and treble damages in excess of \$210 million. The complete terms of the settlement were not disclosed. However, the relator’s share was reportedly 29.5 percent or \$7.37 million.

(23 *False Claims Act and Qui Tam Quarterly Review* 36 (July 2001))

#### **67) Lovelace Health Systems (\$24,500,000)**

In December 2002, Lovelace Health Systems, a New Mexico hospital and health maintenance organization owned by Cigna Corporation, paid the federal government \$24.5 million to resolve allegations that it submitted fraudulent claims in 10 years of Medicare cost reports and reopening requests.

The \$24.5 million settlement represents the largest settlement ever against a single hospital to resolve allegations involving solely cost reporting fraud.

Cost reports are the vehicle by which hospitals are reimbursed by federally funded health insurance programs such as Medicare, Medicaid and Tricare.

The settlement resolves the hospital's liability for allegedly submitting cost reports to Medicare and other federal health insurance programs that sought reimbursement for costs that Lovelace knew were unallowable, while simultaneously establishing reserves in an amount equal to the unallowable costs.

This allegedly fraudulent conduct allowed Lovelace to set aside sufficient funds to repay the government in the event that the unallowable costs were detected.

One of the schemes used by Lovelace was to shift the costs of its HMO patients in the Lovelace Health Plan to the Medicare Program, an insurance program for the elderly and disabled.

“Cigna Owned Hospital Pays Record \$24.5 Million,” 16 *Corporate Crime Reporter* 47(3), December 9, 2002)

#### **68) North Carolina (\$23,800,000)**

North Carolina will pay the United States \$23.8 million to resolve multiple allegations of False Claims Act violations, as well as administrative violations, concerning federal funding of the state’s foster care and childcare services.

North Carolina agreed to resolve allegations that the State Division of Mental Health, Developmental Disabilities and Substance Abuse knowingly billed the federal government for



costs that were ineligible for federal foster care training funds. The settlement agreement also resolves allegations outlined in reports by the U.S. Department of Health and Human Services' Office of Inspector General that North Carolina committed administrative violations by failing to document its actual costs spent on day care services.

According to the terms of the settlement agreement, the state has agreed to make cash payments totaling \$20 million, agreed to a disallowance of federal funding in the amount of \$3.8 million and agreed to implement a new record-keeping system for identifying child care expenditures.

In 2002, the U.S. Attorney's Office for the Eastern District of North Carolina criminally prosecuted Dr. Lenore Behar, the former Chief of the Child and Family Section of the Division of Mental Health. Behar was indicted for her role in mischarging foster care training funds and was subsequently convicted of obstruction of justice.

(Justice Department press release, September 22, 2003)

### **69) Toshiba Corporation (\$23,000,000)**

In October 2000, Toshiba Corporation settled a federal lawsuit in connection with the company's sale of defective laptop computers to government agencies.

The settlement also releases Toshiba from liability under the False Claims Act for the sale of defective laptop computers.

In addition to paying the United States \$23 million, Toshiba will provide the government with \$10.5 million in coupons from the company for the purchase of Toshiba products.

The case arose from an investigation that arose following allegations that a defect in the floppy disk controllers (FDC) contained in Toshiba's laptops periodically cause undetected data corruption when the FDC, a microchip located on the computer's motherboard, is transferring data to and from a floppy disk.

The risk of data corruption increases when multiple software applications are running.

The class action suit against Toshiba was filed in 1999 in the Eastern District of Texas. The United States opted into the settlement reached in the class action and settled all potential government claims arising from the allegations.

"This settlement provides proper compensation to the United States government for defects in laptop computers purchased from Toshiba," stated Mike Bradford, United States Attorney for the Eastern District of Texas. "We will continue to vigorously enforce the False Claims Act for the protection of the taxpayers and the United States government."

("Toshiba to Pay \$23 Million," 14 Corporate Crime Reporter 41 (October 23, 2000))

### **70) Olympus American Inc. (\$22,800,000)**

A government contractor will pay the United States \$22.8 million to settle claims it overcharged the Department of Veterans Affairs (VA) for medical equipment by not giving the government the same discount it gave commercial customers.

Assistant Attorney General Frank Hunger of the Civil Division and U.S. Attorney Zachary W. Carter of Brooklyn, New York, said the settlement resolves all allegations against Olympus America Inc. of Melville, New York.

"When companies do business with the government and promise to give the government a fair price, we intend to hold them to their bargain," said Hunger.

According to Hunger, Olympus' contracting personnel failed to provide VA negotiators

with accurate information concerning its commercial pricing practices for such equipment as colonoscopes, laparoscopes and other medical supplies.

Olympus, which manufactures medical imaging equipment, offered private businesses a discount on the equipment, but offered a lesser discount to the government. The VA negotiated this lesser discount based upon Olympus' representation that it did not give any discounts to commercial users. As a result, VA paid too much for the equipment.

Olympus, which was required by law and by its contract with VA to disclose the information to the government, informed the government of the overcharges under the VA's voluntary disclosure program.

(In Brief, 11 *Corporate Crime Reporter* 33(9), September 1, 1997)

### **71) University of California (\$22,500,000)**

The University of California will pay \$22.5 million to settle allegations that physicians at teaching hospitals at UCLA and four other campuses overbilled the government in filing Medicare claims.

The University of California was targeted by this national initiative when former UC employees filed two separate whistle-blower lawsuits in federal court.

The suits alleged that UC's medical centers fraudulently billed Medicare, Medi-Cal and other government-funded insurance programs for medical services performed or supervised by faculty physicians. In actuality, the suits charged, the procedures were performed by residents with little or no supervision.

(“UC to Pay \$22.5 Million in Medicare Investigation,” *Los Angeles Times*, February 3, 2001)

### **72) RR Donnelley (\$22,000,000)**

R.R. Donnelley & Sons Co., the Chicago printing and catalog company, agreed to pay a \$ 22 million penalty for under-reporting and under-paying postage on its catalog and periodical mailings since August 1989. In the agreement with the Justice Department, the company admits no wrongdoing. The settlement came after an inquiry by U.S. Postal Service investigators in Philadelphia.

(*Chicago Sun-Times*, August 26, 1999)

### **73) Paine Webber Inc. (\$21,600,000)**

In April 2000, 17 investment banks agreed to pay about \$140 million to the federal government to settle charges that they defrauded the federal government by overpricing securities sold in connection with certain municipal bond transactions.

The scheme involved what has come to be known as "yield burning" and was first brought to the public's attention in 1995 by whistleblower Michael Lissack, who filed a qui tam lawsuit against more than a dozen Wall Street firms under the False Claims Act.

Yield-burning occurs when an investment bank marks up the price of securities that it sells to a municipality in order to lower the return on those securities, so that the portfolio

that is being sold complies with tax-law.

The net effect of yield-burning is that money has been transferred from the federal government to the investment banker.

The settlement involves a separate qui tam lawsuit brought by Joseph Mooney, a public finance banker in Florida, and separate government charges brought against three investment banks.

The settlement wraps up the government's case against most of the major players in the municipal finance market. It covers potential False Claims Act, security law and IRS liabilities against the investment banks and was agreed to by the Justice Department, Securities and Exchange Commission, the Internal Revenue Service and NASD Regulation, the independent subsidiary of the National Association of Securities Dealers Inc. charged with regulating the securities industry.

"Today's agreement ends a disgraceful chapter of abuse and deception in Wall Street's history," said John R. Phillips, a Washington, D.C., attorney whose firm, Phillips & Cohen, represents both Lissack and Mooney. "There is no doubt that without the help of our clients, investment banks would have continued to milk the U.S. Treasury for hundreds of millions of dollars."

The settlement has two components. The securities firms will pay approximately \$120.4 million to the federal government, the bulk of which will go toward settling the qui tam lawsuits. About \$20 million will be returned to municipalities nationwide that were harmed by the firms' yield burning practices.

The firms that were named in the qui tam lawsuits and the amounts they paid to settle the lawsuits are:

- Dain Rauscher Corp. -- \$11 million
- Salomon Smith Barney Inc. -- \$38 million
- William R. Hough & Co. -- \$3.1 million
- U.S. Bancorp Piper Jaffray Inc. (as successor to Piper Jaffray) -- approximately \$1 million
- CS First Boston Corp. -- almost \$1 million
- Dillon Read Securities Inc. -- \$6.3 million
- Goldman Sachs & Co. -- \$5.1 million
- PaineWebber Inc. -- \$21.6 million
- Prudential Securities Inc. -- \$5.8 million
- Raymond James & Associates Inc. -- \$2.6 million
- Morgan Stanley & Co. -- \$2.5 million
- Lehman Brothers Inc. -- \$4.5 million
- Merrill Lynch Pierce Fenner & Smith Inc. -- \$4.6 million
- First Union (as successor to Wheat First) -- \$6.3 million

Three banks that were not named in the qui tam lawsuits also settled government fraud charges at the same time and paid about \$6.6 million for damages to the federal government and municipalities: JC Bradford, Southwest Securities and AG Edwards.

("Big Securities Firms to Pay \$140 Million to Settle Yield Burning Cases," 14 Corporate Crime Reporter 15(4), April 10, 2000)

#### **74) Unocal (\$21,500,000)**

In December 2001, Union Oil Company of California (Unocal) agreed to pay \$21.5 million to resolve claims under the False Claims Act and administrative claims that the company underpaid royalties due for oil produced on federal and Indian leases from 1980 to

December 31, 1998.

Unocal will pay \$20,757,482, in cash and will cancel claims for refunds of overpayments of \$742,518 due from the United States.

Federal leases are administered by the Minerals Management Service of the United States Department of the Interior. Each month, oil companies are required to report the amount of oil produced and the value of the oil produced on federal and Indian leases.

The companies pay royalties based upon the value of the oil they report.

J. Benjamin Johnson, Jr. and John Martinek filed a complaint in the United States District Court in Lufkin, Texas against Unocal on behalf of the United States under the qui tam or whistleblower provisions of the False Claims Act.

The two will share in the proceeds of the settlement.

("Unocal to Pay More than \$21 Million for Underpayments of Oil Revenues," 15 *Corporate Crime Reporter* 47(7), December 10, 2001)

### **75) American Medical Response Inc. (\$20,000,000)**

In June 2002, American Medical Response, Inc. (AMR), the nation's largest ambulance provider, agreed to pay \$20 million to settle allegations that the company submitted false claims for ambulance services to Medicare.

The company submitted thousands of false claims for non-emergency ambulance transportation that was not medically necessary or that lacked valid documentation of medical necessity.

Federal officials alleged that the company stated that certain patients were confined to bed or unable to walk when in fact there was no information supporting the statement or the company knew that the patients in question were not bed-confined and were able to walk.

Susan Caporaletti and Robin Rau, former employees of AMR, brought this qui tam action in 1998.

The relators' share (not including interest) is \$3.775 million or approximately 18.9%. (*27 False Claims Act and Qui Tam Quarterly Review*, 55, July 2002)

### **76) Dana Corp (\$19,500,000)**

The Dana Corporation of Toledo, Ohio will pay the United States \$19.5 million to partially settle a lawsuit alleging that Dana's former division, Beaver Precision Products Inc. of Troy, Michigan, overcharged the Army, Air Force and Navy for missile and aircraft parts from 1981 through 1989.

Justice Department officials said the settlement resolves a lawsuit filed in U.S. District Court in Detroit, Michigan in November 1989, charging Dana with violating the False Claims Act.

According to the lawsuit, the United States was overcharged on 18 sole-source, negotiated contracts for ball screw actuators, which are highly machined parts used as control mechanisms on Patriot and MLRS missile systems, B-1, C-5A, C-130, and F-14 aircraft and the Air Force's F100 high-performance jet engines. The actuators control such parts as the landing gear and flaps of aircraft, among other equipment.

The lawsuit alleged that Beaver inflated prices for the parts by providing misleading cost data to government negotiators and withholding accurate data. A further investigation and audit disclosed additional damages. The Defense Contract Audit Agency detected the original overcharges when it audited Beaver's contracts and purchase orders.

The partial settlement does not affect claims arising from Beaver's sales of F100 jet engine parts, which were included in the 1992 lawsuit. Those claims are pending.

In March 1991, Dana Corporation sold its Beaver operations to a subsidiary of LHC Capital Corporation, and has had no ownership interest in Beaver since that time.  
(In Brief, 9 *Corporate Crime Reporter* 40(10) October 23, 1995)

**77) Dey Inc. (Merck) (\$18,500,000)**

Dey, Inc., a manufacturer of prescription drugs for the treatment of allergies and respiratory diseases, will pay the United States and the state of Texas \$18.5 million to settle allegations of health care fraud.

Dey is a wholly owned subsidiary of Merck in Germany.

Federal officials alleged that the company submitted false pricing information and caused providers to submit fraudulently inflated reimbursement claims to the state and federally funded Texas Medicaid program.

The United States claimed the Napa, California-based company submitted false pricing information to the Texas Vendor Drug Program, which resulted in inflated reimbursement for the Dey drugs at issue, which are primarily used to treat asthma and other respiratory conditions.

"The Medicaid program was created to help ensure that those least able to afford healthcare receive medical treatment – not to enrich drug companies," said Robert D. McCallum, Jr., Assistant Attorney General for the Justice Department's Civil Division. "The reporting of false pricing information by certain drug manufacturers has adversely impacted not only the federal health care programs, but also our most vulnerable citizens."

The Civil Medicaid Fraud Section of the Texas Attorney General's Office sued Dey and two other drug manufacturers in 2000 as part of its ongoing effort to combat Medicaid Fraud in Texas. The remaining defendants are scheduled for trial in August of this year.

("Merck Unit to Pay U.S. and Texas \$18.5 Million to Settle Medicaid Fraud Charges," 17 *Corporate Crime Reporter* 24(7), June 16, 2003)

**78) Quorum Health Group (\$18,000,000)**

In October 2000, Quorum Health Group Inc., the nation's largest hospital management company, agreed to pay the federal government \$95.5 million to settle two whistleblower lawsuits involving Medicare fraud.

The largest payment -- \$77.5 million -- will be made to settle a whistleblower lawsuit that charged the company systematically defrauded Medicare for years of filing fraudulent "cost reports."

Quorum will pay the remaining amount, \$18 million, to settle a second whistleblower case involving the misallocation of costs from an Alabama hospital to a home health services agency, the company said.

The whistleblower in the cost report case, James F. Alderson, filed his qui tam lawsuit in January 1993 and provided the government with substantial evidence of the fraud. Alderson, formerly chief financial officer for a Quorum-managed hospital in Whitefish, Montana, was fired from his job 10 years ago after refusing to go along with the cost report scheme.

("Quorum To Pay \$95.5 Million," 14 *Corporate Crime Reporter* 39(5), October 9, 2000)

**79) Baptist Medical Center (\$17,500,000)**

Baptist Medical Center, a Kansas City, Missouri hospital, will pay the United States

\$17.5 million to settle allegations that it paid more than \$1 million in kickbacks to a local medical group in return for the group's referral of Medicare eligible patients.

The Department said that the agreement resolves claims that Baptist submitted fraudulent Medicare claims for patients whose referrals it received through various kickback schemes.

Department attorneys claimed that Baptist entered into sham consulting contracts with three osteopaths, Robert C. LaHue, D.O.; Ronald H. LaHue, D.O.; and Robert C. LaHue, D.O., Chartered d/b/a the Blue Valley Medical Group (collectively referred to as "Blue Valley").

The agreement also settles claims that Baptist violated the Stark I statute, by submitting clinical laboratory claims for Medicare patients referred by Blue Valley, with which the hospital had a financial relationship.

The Office of the Inspector General of the Department of Health and Human Services and Baptist entered into a "Corporate Integrity Agreement" in which Baptist agreed to undertake measures to ensure compliance with applicable laws and Medicare rules and regulations in the future.

(In Brief, 11 *Corporate Crime Reporter* 37(10), September 29, 1997)

### **80) University of Texas (\$17,200,000)**

The University of Texas Health Science Center at San Antonio (UTHSCSA) will pay the United States \$17.2 million to settle allegations that UTHSCSA submitted false claims for reimbursement to several federally funded health care insurance programs.

The settlement resolves allegations that UTHSCSA, a component of the University of Texas, submitted claims to Medicare, Medicaid and other federal programs without possessing sufficient documentary evidence to support those claims.

The charges were brought against UTHSCSA and University of Texas Medical School at San Antonio, a component of UTHSCSA, by a former employee, Benjamin Kready, under the qui tam provisions of the False Claims Act.

Kready filed his suit in U.S. District Court in San Antonio, Texas, in 1996.

Kready's complaint alleged that University of Texas Medical School at San Antonio submitted claims between January 1990 and December 1995 for services that were personally provided by faculty physicians when, in fact, defendants' records do not support these claims.

Kready alleged that four federally funded programs were overcharged by these practices.

Under the settlement, Kready will receive \$2.58 million for bringing the matter to the attention of the government.

(In Brief, 12 *Corporate Crime Reporter* 25(9), June 22, 1998)

### **81)(tie) 139 Hospitals Owned by Tenet Healthcare Corporation (\$17,000,000)**

One hundred thirty-nine hospitals currently or formerly operated by Tenet Healthcare Corporation will pay the United States and 22 states \$17 million to settle allegations that the facilities overcharged federal health care programs in connection with laboratory services.

Under the settlement, the United States would receive \$16.18 million. The remaining \$820,000 of the settlement amount would be put in an escrow account for the benefit of the participating states - Alabama, Arizona,

Arkansas, California, Florida, Georgia, Indiana, Iowa, Louisiana, Massachusetts, Mississippi, Missouri, Nebraska, Nevada, North Carolina, Oregon, South Carolina, Tennessee, Texas, Washington, West Virginia and Wyoming.

The settlement with the Santa Barbara, California-based corporation resolves allegations by the United States that the hospitals submitted claims to the government to pay

for laboratory tests without regard as to whether the tests were medically necessary, had been properly ordered by physicians, or were otherwise reimbursable under certain federal health care programs. These programs include Medicare, Medicaid, TRICARE - the military's health care program - and the Federal Employees Health Benefits Program.

(U.S. Justice Department Press Release, June 18, 2002)

**81)(tie) Rotech Medical Corp. (\$17,000,000)**

In February 2002, Rotech Medical Corp. agreed to pay \$17 million to settle allegations that it fraudulently overbilled government health care programs for respiratory equipment, supplies and services.

From 1995 to 2000 Rotech submitted false claims to Medicare, Montana Medicaid, the Department of Veterans Affairs, and Indian Health Service programs.

Allegations against the company included: submitting forged and falsified documents to bill the Government for durable medical equipment like oxygen cylinders; duplicate claims; claims for undelivered items; claims for medically unnecessary drugs and equipment; claims for treating deceased patients; claims that were arbitrarily inflated due to a lack of competition; and claims for oxygen services and equipment based upon self-qualifying tests that violated federal payment regulations.

In February 2000, Rotech filed for bankruptcy under Chapter 11. The terms of the settlement agreement are part of Rotech's reorganization plan.

(26 *False Claims Act and Qui Tam Quarterly Review* 48, July 2003)

**83)(tie) Curative Health Services (\$16,500,000)**

In January 2002, Curative Health Services, an HCA-related wound care company, agreed to pay \$16.5 million to settle allegations that it caused hospitals to disguise marketing expenses as management fees on Medicare cost reports from 1993 to 1998.

Mickey Parslow, a former CFO at an HCA hospital, filed suit in 1998 in Florida, and Francesco Lanni, a Curative employee, filed in New York.

In the qui tam suits, HCA and non-HCA hospitals were named as defendants. The claims against Curative and the non-HCA hospitals originally filed in Florida and New York were consolidated in the Southern District of New York.

The claims against Curative and HCA were transferred to the District of Columbia for consolidation with a multi-district litigation proceeding involving all actions against HCA.

The non-HCA hospitals were released from the lawsuit. Other false claims allegations are still pending against HCA hospitals, and an HCA subsidiary pled guilty in a related criminal case.

(26 *False Claims Act and Qui Tam Quarterly Review* 44 (April 2002))

**83)(tie) Fresenius Medical Care Holdings Inc. (\$16,500,000)**

In May 1999, Massachusetts dialysis company will pay the government \$16.5 million to settle federal False Claims Act charges.

Fresenius National Medical Care Holdings Inc. was charged in a whistleblower action,

filed on May 26, 1995, by Franklin West and Robert Kane.

The company is engaged in the multibillion dollar business of providing dialysis services to severely debilitated patients with end stage renal disease (ESRD) or kidney failure.

The federal government, through the Medicare Program, pays for medical services provided to patients with kidney failure.

The costs of the ESRD program have skyrocketed in recent years.

In 1974, taxpayers spent \$229 million to provide dialysis treatment to 11,000 kidney failure patients.

In 1986, only ten years later, taxpayers spent more than one billion dollars to provide dialysis care to these kidney patients.

Federal officials alleged that Fresenius induced physicians, through aggressive marketing, to order many tests that had no medical justification and that served no benefit to the patient.

"Individuals like Mr. Kane and Mr. West, who are extremely knowledgeable in arcane areas such as ultrasound and medical diagnostic testing, enhance the government's capabilities," said Marc Raspanti, the lawyer for the two whistleblowers. "Without the whistleblowers, undoubtedly, the type of schemes perpetrated by the defendants in this case would go undetected."

Raspanti said that the case represented "the first real probe by the government into a complex multi-billion dollar industry which services some of the most vulnerable members of society."

"This case is just the tip of the iceberg," Raspanti said.

A spokesperson for Fresenius said that "the settlement resolves lawsuits that were aimed at old business practices of a company -- BioTrax International -- which was acquired by Fresenius Medical Care North America along with other diagnostic testing businesses in October 1996." "Since taking over the businesses, Fresenius has cooperated fully with the government, working closely with the U.S. Attorney's Office (Philadelphia) to come to this final agreement," the company spokesperson said. "Further, Fresenius Medical Care North America sold most of its diagnostic business in June 1998. We are pleased to be able to put this matter behind us."

("Dialysis Company to Pay \$16.5 Million," 13 *Corporate Crime Reporter* 23(3), June 7, 1999)

### **85) Allina Health Systems (\$16,000,000)**

In January 2002, Allina Health System agreed to pay the United States \$16 million to resolve allegations that the Minneapolis, Minnesota based company fraudulently overbilled three government health care programs -- Medicare, Medicaid, and the military health care programs.

Allina is an integrated health care provider that operates more than 10 hospitals, 50 clinics, a medical equipment supplier, a medical transportation service provider, as well as several nursing homes, hospices, and other related providers throughout Minnesota.

Until the Summer of 2001, Allina also operated Medica, a health insurance plan.

Also as part of the settlement, Allina has entered into a Corporate Integrity Agreement with the U.S. Department of Health and Human Services and will be required to ensure continuing compliance with Medicare program requirements.

The settlement resolves the government's contention that Allina's hospitals and clinics violated the False Claims Act in certain respects between 1994 and 2001, including knowingly seeking reimbursement through a variety of improper billing methods, such as duplicate billing and upcoding, billing for a more highly reimbursed service or product than the one provided.

The settlement also resolves three whistleblower lawsuits that were filed against Allina.



These suits contained an allegation that Allina knowingly retained overpayments after the company's own audits demonstrated that it had submitted erroneous claims.

Although Allina repaid the specific claims identified as erroneous in the audits, according to the lawsuits, it did nothing to ensure that other false claims were repaid, nor did the health care firm take sufficient steps to ensure the accuracy of its billings going forward.

("U.S. Health Care Chain to Pay U.S. \$16 Million," *16 Corporate Crime Reporter* 3(9), January 21, 2002)

### **86) McLeod Regional Medical Center (\$15,909,470)**

In November 2002, McLeod Regional Medical Center of South Carolina will pay the United States \$15,909,470 to resolve allegations of health care fraud against the government.

The settlement resolves allegations that McLeod submitted false claims for payment to the Medicare and other federal health care programs.

The United States alleged that McLeod submitted false claims to Medicare, Medicaid and TRICARE by billing for hospital and home health services ordered by certain physicians with whom McLeod, and its for profit subsidiary McLeod Physician Services, had improper financial relationships.

When McLeod purchased certain physician practices it agreed to pay doctors associated with those practices purchase prices and salaries that far exceeded the fair market value of the practices and the services provided.

The U.S. also alleged that McLeod entered into these financial relationships to induce and maintain referral relationships with those physicians.

The government's investigation also revealed that McLeod sought to offset losses incurred in acquiring the practices by including false claims for Medicare reimbursement of unallowable costs on the hospital's cost reports.

These unallowable costs included amounts paid to physicians for the "good will" associated with the acquired practices.

("McLeod Regional Medical Center to Pay Over \$15 Million," *16 Corporate Crime Reporter* 43(4), November 11, 2002)

### **87)(tie) W. R. Grace & Co. (\$15,500,000)**

In August 2000, the nation's leading supplier of books to public schools and libraries will pay \$15.5 million to settle charges that it unlawfully overcharged those customers.

Eighteen states and the U.S. Department of Justice filed civil complaints in 1998 against Baker and Taylor Inc. and its former owner, W.R. Grace & Co., alleging that they overcharged public sector customers.

"In contracts with public schools and libraries, Baker & Taylor promised to pass along most of the discounts it received from book publishers," said Florida Attorney General Bob Butterworth said. "Instead, the company adopted a so called 'profit enhancement' scheme to remove thousands of books from the deep discount category. The result was higher prices for taxpayers, who ultimately footed the bill."

The \$15.5 million payment comes in addition to \$3 million already paid to settle the federal government's complaint. Of the \$1,106,000 earmarked for Florida, \$100,000 will cover investigative costs and the rest will be used for youth educational purposes.

The lawsuit, brought under the federal False Claims Act, seeks damages and penalties based on Baker & Taylor's contracts with institutional customers, in which the company agreed to provide trade discounts of approximately 40 percent on trade books, but then failed to provide the full discounts by misclassifying trade titles into non-trade categories.

Meanwhile, Baker & Taylor, which was a division of W.R. Grace until 1993, provided full trade discounts on the same books to retailers.

("Leading Book Supplier to Pay \$15.5 Million," 14 *Corporate Crime Reporter* 32(3), August 7, 2000)

**87)(tie) Emergency Physicians Billing Services Inc. (\$15,500,000)**

Emergency Physicians Billing Service, had promised its clients it would increase their reimbursements by 10 to 25 percent. It did so by "upcoding," or filing claims for a higher level of service than was actually delivered. Reassignment violations and misrepresentations on Medicare enrollment applications were also identified. In an October 1999 settlement agreement with the federal government and 28 individual states, the firm and its owner, and J. D. McKean, Jr., M.D., agreed to pay \$15.5 million. In addition, McKean is excluded for 15 years from participation in any federal health care program. The firm has entered into a comprehensive Corporate Integrity Agreement with the Inspector General.

(Testimony Ms. Penny Thompson Director Medicare Program Integrity Group, Health Care Financing Administration, *Third Party Billing Company Fraud: Assessing the Threat Posed to Medicare*, before the House Subcommittee on Oversight & Investigations April 06, 2000)

**89) Ventura County, California (\$15,300,000)**

Ventura County, California will pay the U.S. \$15.3 million to settle a False Claims Act lawsuit.

The lawsuit was brought by Jerome Lance, 65, who has worked as a psychiatrist at Ventura County Medical Center for about five years. He filed a civil lawsuit under the federal False Claims Act in September 1998, after the controversial merger of the county's mental health and social service departments.

That prompted the U.S. Attorney's Office to undertake a massive, 10-month investigation of eight years of county Medicare billing records.

The U.S. Department of Health and Human Service, Office of Inspector General, Federal Bureau of Investigation and Blue Cross of California joined the investigation.

Their probe led to a \$15.3 million settlement, which the county began paying this week.

Lance will collect 15 percent to 25 percent, or \$2.3 million to \$3.8 million, of the settlement over five years.

In his lawsuit, Lance claimed the mental health department used the provider number of several county psychiatrists to bill for services without their knowledge and which they had not authorized.

He also claimed that VCMC no longer had psychiatrists take part in creating treatment plans for patients, as required for Medicare reimbursement. Instead, he said -- and the county's self-audit confirmed -- the hospital was relying on a "coordinated service plan," which was being prepared by nonphysicians.

("U.s. Names Doctor Who Was Trigger for Probe," *Ventura County Star*, November 20, 1999)

**90) BT Alex Brown (\$15,177,572)**

Deutsche Banc Alex. Brown will pay \$15.3 million to settle claims by federal investigators that it overcharged the state of Pennsylvania and other local jurisdictions in bond underwriting offerings in the early 1990s.

The Securities and Exchange Commission said that in March 1994, Baltimore-based Alex. Brown Inc. illegally marked up \$494 million in U.S. Treasury bonds that it sold to the state of Pennsylvania, which was replacing higher yielding tax-exempt bonds with lower yielding securities. Alex. Brown also resolved probes into whether it overcharged other cities and local agencies -- including Montgomery County and the Washington Suburban Sanitary Commission -- on 69 bond transactions for more than \$5 billion between 1991 and 1995.

Deutsche Banc Alex. Brown will pay \$15.177 million to the U.S. government to resolve its False Claims Act liability and related Internal Revenue Service claims.

Alex. Brown was acquired by Bankers Trust Corp. in September 1997, and subsequently by Germany's Deutsche Bank AG. It neither admitted nor denied the findings in the order.

(“Alex Brown Overcharge Case Settled,” Baltimore Sun, November 18, 1999)

### **91) Superior Home Health Care (\$15,250,000)**

Gayle M. Rogers of Chattanooga, Tennessee, and the Estate of her late husband agreed to pay the United States \$15.25 million to settle a lawsuit brought for filing false claims with Medicare.

The settlement resolves civil claims under the False Claims Act and common law, that Tom Rogers Sr. and his management company, Alpha Medical, Inc., submitted false claims to Medicare for services his firm provided to a network of six Tennessee operations using the name Superior Home Health Care.

Federal officials alleged that Tom Rogers erected the network, locating the agencies to buy and installing as its owners his relatives, his best friend and others indebted to him. This arrangement guaranteed that Alpha would manage the agencies.

Rogers and the company then caused the agencies to claim reimbursement from Medicare for Alpha's fee which included profits, while misleading the federal health care program about the true nature of the controlling relationships.

Through these false claims, Alpha obtained its fee, including profit that Medicare otherwise would not have paid had it known of the relationships.

The government health care program's rule against paying such a profit when there is a controlling relationship is designed to protect the Medicare Trust Fund from unscrupulous demands for excessive fees.

Gayle Rogers, who, along with Tom Rogers, received the improper profits in the form of unreasonable salaries and bonuses from Alpha, has had possession of most of the wrongfully obtained profits since her late husband's death.

Also as a part of the settlement, Superior Home Health Care of Chattanooga, Inc., now called Charitable Health Care Foundation, Inc., agreed to waive its claims that Medicare owed it over \$1 million in unrelated claims.

(In Brief, 16 *Corporate Crime Reporter* 11(12), March 16, 2002)

### **92)(tie) Lifescan (Johnson & Johnson) (\$15,000,000)**

A subsidiary of Johnson & Johnson will pay the United States \$15 million to settle civil claims that it overcharged the Department of Veterans Affairs (VA).

The settlement resolves allegations that Lifescan, Inc. failed to notify the VA that it had

reduced prices to certain commercial customers below the cost negotiated by the agency.

As a result, the VA, and other federal agencies purchasing through the contract, were overcharged. The overcharging was brought to the attention of the government by Johnson & Johnson, Inc., Lifescan's parent company, under the VA's voluntary disclosure program.

Johnson & Johnson informed the VA that the company's contracting personnel failed to notify the federal agency about an agreement with a national account which gave that customer significantly lower pricing for certain medical supplies.

The contract between the VA and Lifescan required that the company notify the agency of any such cost reductions and to pass the lower prices on to government customers purchasing through the VA contract.

The VA Office of Inspector General investigated the case and confirmed that the government had been overcharged.

("Johnson & Johnson Unit to Pay \$15 Million for Overcharging Veterans Affairs Department," 15 *Corporate Crime Reporter* 45(1), November 26, 2001)

### **92)(tie) Motorola (\$15,000,000)**

William R. Barton, inspector general, U.S. General Services Administration (GSA), announced receipt of \$15,100,000 from Motorola Inc. in settlement of U.S. government claims that the company violated the False Claims Act.

The payment settled claims that the company violated the False Claims Act by failing to disclose to GSA discounts Motorola offered on its computer equipment and maintenance and that Motorola knowingly sold the government refurbished computer equipment which it represented as new.

The GSA inspector general office found that Motorola knowingly made false statements and claims to GSA in connection with Motorola's maintenance of automated data processing equipment under GSA multiple award schedule contracts for fiscal years 1984 through 1987.

Under the multiple award schedule program, GSA negotiates contracts with vendors who then sell to federal agencies at established contract prices. During negotiations, a Motorola subsidiary furnished GSA with its commercial price list and submitted what it represented to be complete, accurate and current information concerning discounts from its list prices.

Motorola company representatives disclosed and certified that no regular discounts were given to any customer on maintenance. The Office of Inspector General found, however, that the company had granted maintenance discounts to commercial customers. In addition, it found that Motorola had not disclosed purchase discounts on several lease-to-purchase conversions. GSA contracting officers relied on the information furnished by Motorola and as a result, awarded contracts at higher prices than would have been negotiated had there been proper disclosure.

The Office of Inspector General also determined that between 1979 and 1984 Motorola sold a significant quantity of refurbished computer equipment under the schedule that it represented as new equipment.

(GSA Press Release, February 16, 1992)

### **92)(tie) American Management Systems Inc. (\$15,000,000)**

American Management Systems, Inc. (AMS) and the United States have resolved their disputes arising out of AMS's 1997 contract to deliver an automated record-keeping system to the Federal Retirement Thrift Investment Board (FRTIB).

The system was intended to improve the Board's services to the participants and

beneficiaries of the Thrift Savings Fund, which contains the retirement fund of millions of active and retired federal employees.

Under the settlement, the Fairfax, Virginia-based firm will pay \$15 million to the Thrift Savings Plan. The Board agreed to modify its contract with AMS to provide \$10 million to AMS, in exchange for the past delivery of various services under the 1997 contract. The settlement, which will pay a net amount of \$5 million to the Thrift Savings Plan, resolves allegations that AMS violated the False Claims Act and the common law in submitting claims for payment to the Board.

The settlement represents a global resolution of two separate lawsuits, both of which will now be dismissed. One suit, filed by the Board against the company in the federal court in Washington, D.C. on July 17, 2001, alleged that AMS defrauded and breached its contract with FRTIB. The suit was dismissed on November 30, 2001 on jurisdictional grounds and an appeal to the United States Court of Appeals for the District of Columbia Circuit was pending at the time the settlement was reached.

The Board's complaint in that case contained allegations that AMS misrepresented the costs that FRTIB would incur under the contract, misrepresented its own proficiency in customizing the relevant software to meet the Board's needs and engaged in a bait-and-switch tactic concerning the personnel who would be assigned to the project. These and other allegations that the United States raised in the settlement agreement with AMS were resolved as a result of that agreement.

Also resolved as a result of the settlement agreement was a separate action that AMS filed on October 10, 2001 against the United States in the U.S. Court of Federal Claims seeking a declaration that the Board's July 2001 termination of the contract for default was improper.

(Justice Department Press Release, June 20, 2003)

#### **92)(tie) Gottlieb Financial Services Inc. (\$15,000,000)**

A Florida-based emergency physician billing company, Gottlieb's Financial Services, Inc. (GFS), and its owner, Medaphis Physician Services Corporation, based in Atlanta, Georgia, will pay the United States and thirty-five states \$15 million to settle allegations that GFS submitted false claims to various federal health care programs.

The settlement resolves allegations of false billings by GFS to the Medicare, Medicaid, and TRICARE programs, as well as the Federal Employees Health Benefits Program.

The Department alleged that GFS submitted false claims to the health care programs on behalf of emergency physicians around the country. According to the Department, GFS typically upcoded claims and billed for services to make it appear more extensive services were rendered than those actually provided by the physicians.

The agreement settles a dispute with GFS and Medaphis originally brought as a qui tam case in U.S. District Court in Grand Rapids, Michigan. As part of the settlement, relator Greg Robinson, who filed the suit on behalf of the United States, will receive approximately \$2,422,500.

(Justice Department Press Release, July 12, 1999)

#### **96) Pratt & Whitney (United Technologies) (\$14,800,000)**

The Pratt & Whitney Group of United Technologies Corp. will pay the U.S. \$14.8 million for allegedly conspiring to divert \$10 million in U.S. military aid into a slush fund subject to the exclusive control of an Israeli Air Force officer.

The Justice Department announced the agreement yesterday in the wake of a

complaint that UTC submitted false billings under a contract with Israel to develop and manufacture a PW1120 turbojet engine for an Israeli LAVI fighter aircraft.

("UTC to Pay \$14.8 Million to Settle Military Aid Complaint," *Armed Forces Newswire Service*, May 22, 1997)

#### **97) Humana Inc. (\$14,500,000)**

Humana Inc. will pay \$14.5 million to settle allegations that the company provided inaccurate payment information to Medicare.

Federal officials alleged that false information was submitted to obtain inflated Medicare managed care payments.

In addition to paying the fine, Humana entered into a comprehensive five-year corporate integrity agreement with the Department of Health and Human Services Office of Inspector General.

Under that agreement, which is designed to promote compliance with all federal health care program requirements, Humana will provide compliance training to employees, undergo annual independent audits, and submit annual reports to the Inspector General.

("Humana to Pay \$14.5 Million to Settle Fraud Charges," *14 Corporate Crime Reporter* 24(4), June 12, 2000)

#### **98) Bayer Corporation (\$14,000,000)**

Bayer Corporation will pay a total of \$14 million to the federal government and 45 states to settle allegations under the federal False Claims Act that the company caused physicians and other health care providers to submit fraudulently inflated reimbursement claims to the state and federally funded Medicaid program.

A whistleblower's lawsuit revealed that the pharmaceutical company beginning in the early 1990's falsely inflated the reported drug prices -- referred to by the industry as the Average Wholesale Price (AWP), the Direct Price and the Wholesale Acquisition Cost.

These drug prices were used by state governments to set reimbursement rates for the Medicaid program.

By setting an extremely high AWP and, subsequently, selling the product to doctors at a dramatic discount, Bayer induced physicians to purchase its products rather than those of competitors by enabling doctors to profit from reimbursement paid to them by the government.

The Bayer AWP's, at issue in the investigation, involved several of Bayer's biologic products such as Kogenate, Koate HP, and Gamimmune, which are widely used in treating hemophilia and immune deficiency diseases.

The investigation revealed that the practice in which Bayer selectively engaged, commonly referred to by drug manufacturers as "marketing the spread," also has the effect of discouraging market competition from manufacturers that do not inflate AWP's as a way of inducing doctors to purchase their products.

In addition to the monetary settlement, Bayer has reached a five year agreement with the Department of Health and Human Services' Office of Inspector General that the company's conduct will be monitored by the government under a corporate integrity agreement.

Under the compliance agreement, Bayer will provide the state and federal governments with the average selling prices of its drugs in order to facilitate the government's setting of fair reimbursement rates for the company's products and, potentially, the products of any competitors attempting to take advantage of Bayer's cooperation.

The parties also are settling allegations that Bayer knowingly underpaid the Medicaid program for rebates owed by it to the states.

The Medicaid Rebate program requires drug companies to pay quarterly rebates to states in a way intended to account for discounts given by them to customers. Bayer was required to report to the Health Care Financing Administration the best price it offered to any commercial, for profit customer and pay a quarterly rebate based, in part, upon that best price.

Bayer understated the extent of the discounts given to certain customers thereby allowing the company to underpay the rebates its owed.

Ven A Care of the Florida Keys Inc., the qui tam relator or whistleblower which filed the suit on behalf of the United States, will receive 20 percent of the federal government's share of the recovery. Bayer's headquarters are located in Leverkusen, Germany.

“Bayer to Pay \$14 Million to Settle Claims,” 15 *Corporate Crime Reporter* 5(7), January 29, 2001)

### **99) Quest Diagnostics (\$13,100,000)**

In January 2001, Quest Diagnostics Incorporation agreed to pay \$13.1 million to settle allegations of health care fraud related to billing practices at Nichols Institute, which Quest acquired in 1994.

The settlement resolves allegations that certain clinical laboratories operated by Nichols defrauded Medicare, Medicaid, the Defense Department health care program, and the Federal Health Benefits Program (FEHBP) by routinely billing for laboratory tests that were not medically necessary.

Federal officials alleged that the overbilling practices, which began in 1989, ended shortly after Quest purchased Nichols in 1995.

The federal government's investigation of Nichols began as part of Operation LABSCAM, which targeted laboratory unbundling practices -- the separate billing for groups of lab tests performed together in order to get a higher reimbursement.

“Quest Diagnostics to Pay \$13.1 Million,” 15 *Corporate Crime Reporter* 2(1), January 8, 2001)

### **100)(tie) Kerr-McGee (\$13,000,000)**

In October 2000, Kerr McGee Corporation agreed to pay \$13 million to resolve claims under the False Claims Act and administrative claims that the corporation underpaid royalties due for oil produced on federal and Indian leases from 1988 to 1998.

Federal leases are administered by the Minerals Management Service of the United States Department of the Interior.

Each month, Kerr McGee is required to report the amount and value of oil produced on federal and Indian leases. The oil company pays royalties based upon the value of the oil they report.

The settlement agreements were signed by representatives of several Indian tribes, as well as the federal government and Kerr McGee.

J. Benjamin Johnson, Jr., and John Martinek, who had filed a complaint in the United States District Court in Lufkin, Texas against the company on behalf of the United States under the qui tam provisions of the False Claims Act will share in the proceeds of the settlement.

“Kerr-McGee To Pay \$13 Million,” 14 *Corporate Crime Reporter* 42(1), October 30, 2000)

### **100(tie) FMC (\$13,000,000)**

The Chicago-based FMC Corporation will pay the United States \$13 million to settle claims it falsely inflated the cost of military contracts to produce the Bradley Fighting Vehicle and the M113 tank.

The settlement resolves the allegations in a complaint filed under the qui tam provisions of the False Claims Act by Robert F. Nearing, a former manager at FMC's Ground Systems Division in San Jose, California.

In his complaint, Nearing alleged, among other things, that GSD, in various documents submitted to the Department of the Army, falsely inflated the amount it intended to spend on independent research and development (IR&D) and bid and proposal (B&P) projects during 1991 and 1992. The complaint further alleged that the Army, in relying on those false statements, agreed to reimburse GSD for a higher amount of IR&D and B&P expenditures than it would have if the Army had known GSD's true spending plans.

IR&D involves the cost of research and development of new technologies and products, while B&P are the costs companies incur in preparing bids and proposals for government contracts. During the years in question, the U.S. reimbursed companies for a negotiated percentage of their IR&D expenditures if the projects had some military relevance and also reimbursed companies for a negotiated percentage of B&P costs.

A portion of FMC's inflated IR&D and B&P costs were included in the prices of its contracts for the Bradley Fighting Vehicle and the tanks.

("FMC to Pay \$13 Million to Settle False Claims Act Violations," 10 *Corporate Crime Reporter* 39(3), October 14, 1996)

### **100)(tie) First Health Services (\$13,000,000)**

In April 2003, First Health Services Corporation reportedly agreed to pay \$13 million to settle allegations that it neglected to correct a computer glitch that caused the District of Columbia Medicaid program to overpay millions of dollars between 1993 and 1996. As a result of that computer program error, First Health recorded thousands of ineligible Medicaid beneficiaries as eligible, and thus they received Medicaid benefits to which they were not entitled.

(31 *False Claims Act and Qui Tam Quarterly Review* 44 (July 2003).