

# The False Claims Act

# 1

THE FALSE CLAIMS ACT (sometimes referred to as the FCA),<sup>1</sup> also called the “Lincoln Law,” the “Informer’s Act,” or the “*qui tam*” statute, was effective in 1863 and has been amended only twice since then, in 1943 and in 1986. “*Qui tam*” is shorthand for the Latin phrase “*qui tam pro domino rege quam pro se ipso in hac parte sequitur*,” meaning “who brings the action for the king as well as himself.”<sup>2</sup>

As with the French phrase “*voir dire*,” lawyers differ in their pronunciation of the Latin words “*qui tam*.” Many, including most at the Department of Justice, say “kwee,” perhaps because “quid pro quo” is pronounced “kwid pro quo,” or because when “qui” is sung by choirs in Latin it is enunciated “kwee.” Another large contingent uses the French pronunciation of “qui” (“kee”), meaning “who” in that language, which fits the context perfectly and has a pleasant ring to it. There is further debate over whether “tam” rhymes with “yam” or with “tom.” No one will look askance if you say either of these, combined with “kwee” or “kee.” But other pronunciations, such as “kai,” “kwai” and “cooey” are best avoided by practitioners who want to be taken seriously.

---

1. 31 U.S.C. §§ 3729–3733.

2. United States *ex rel.* Stinson v. Prudential Ins., 944 F.2d 1149, 1152 (3d Cir. 1991).

The *qui tam* statute was targeted at stopping dishonest suppliers to the Union military at a time when the government's involvement in the war effort hampered effective investigation and prosecution. It allows a private individual with knowledge of past or present fraud on the federal government to sue on the government's behalf to recover compensatory damages, civil penalties, and triple damages. The person bringing the suit (a whistleblower) is known as the "relator."

Section 3729(a)(1) imposes civil liability on anyone who "knowingly presents . . . to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval."

Section 3729(a)(2) imposes liability on anyone who "knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government."

Section 3729(a)(3) imposes liability on anyone who "conspires to defraud the Government by getting a false or fraudulent claim allowed or paid. . . ."

## A CLAIMS

The statute defines "claim" as "any request or demand, whether under a contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient" if any portion of it will be provided or reimbursed by the United States.<sup>3</sup> Thus, even if the false claim is made to a party other than the government, it will arguably be actionable under the FCA if payment of the claim would result in a loss to the United States. However, the law is in flux with respect to whether the relator must plead the actual false claims that were presented to the government to meet the specificity requirements of Rule 9(b) and also with respect to whether the allegedly false claims must have been presented to the federal government itself or whether presentment to a federal designee administering the funds is sufficient.<sup>4</sup>

---

3. 31 U.S.C. § 3729(c).

4. These issues are discussed in detail in Chapter VIII, *infra*.

## B. QUI TAM DAMAGES AND AWARDS

If the *qui tam* suit is successful, the government may recover its actual damages, trebled, in addition to civil penalties of between \$5,500 and \$11,000 for each false claim.<sup>5</sup> The relator may recover as much as 30 percent of this total. A successful *qui tam* suit not only stops the dishonest conduct, but also deters similar conduct by others.

The government's resources are limited. Damages are not an element of a *prima facie* case, and statutory fines may be imposed on a per-false claim basis regardless of the amount of the actual damage to the government. Since statutory damages mount up quickly, it can be tempting to focus on falsity and forget about proving actual damages, but defense counsel will lose no time invoking the Eighth Amendment's Excessive Fines Clause. To sidestep this issue and make the case more attractive to the government, it behooves relators' counsel to make a plausible argument that substantial damages exist in their cases.

There can be confusion over how the government and the courts assess damages in FCA cases. For example, if someone not eligible to bill a government program nevertheless provides services, bills the government for them, and the government pays, what are the damages to the government? After all, it did receive the services for which it paid. Yet the claims were false because the provider was not eligible to participate in the program.

A recent Seventh Circuit decision<sup>6</sup> holds that when a defendant causes the submission of a claim to the federal government that is false because a condition of payment has not been met, that defendant causes the government to pay funds it otherwise would not. The measure of the government's damages in this situation is the entire value of the false claim, because had it known of the falsity, the government would have paid *nothing* on the claim. Even though a good or service of some benefit was arguably provided, this is not germane to the damages calculation.

Nor do we think it important that most of the patients for which claims were submitted received some medical care—perhaps

---

5. 28 C.F.R. § 85.3(a)(9) (2008). This regulation increased the minimum penalty from \$5,000 to \$5,500 and increased the maximum penalty from \$10,000 to \$11,000.

6. *United States v. Rogan*, 517 F.3d 449 (7th Cir. 2008).

all the care reflected in the claims forms. . . . Edgewater did not furnish any medical service to the United States. The government offers a subsidy (from the patients' perspective, a form of insurance), with conditions. When the conditions are not satisfied, nothing is due. Thus the entire amount that Edgewater received on these 1,812 claims must be paid back. Now it may be that, if the patients had gone elsewhere, the United States would have paid for their care. Or perhaps the patients, or a private insurer, would have paid for care at Edgewater had it refrained from billing the United States. But neither possibility allows Rogan to keep money obtained from the Treasury by false pretenses, or avoid the penalty for deceit.<sup>7</sup>

The FCA's legislative history is consistent with this analysis, stating: "Claims may be false even though the services are provided as claimed if, for example, the claimant is ineligible to participate in the program."<sup>8</sup> Moreover, the court of appeals in *Rogan*<sup>9</sup> found it questionable whether the Excessive Fines Clause applies to civil actions under the False Claims Act in light of the U.S. Supreme Court's unwillingness to consider the Act punitive.<sup>10</sup>

During fiscal 2007 alone, the government collected approximately \$1.45 billion in settlements and judgments in connection with cases filed under the *qui tam* statute, with payments to whistleblowers of approximately \$177 million. According to Department of Justice statistics released in November 2007, 5,813 *qui tam* suits had been filed since the 1986 amendments. The government had recovered over \$12.6 billion as a result of these suits, of which almost \$2 billion has been paid to relators/whistleblowers. Total recoveries in cases in which the government intervened or otherwise participated were \$12.3 billion, with relators' awards of \$1.9 billion (an average of 16.84 percent of recovery). In cases where the government did not participate, \$282

---

7. *Id.* at 453.

8. S. REP. NO. 345, 99th Cong., 2d Sess. 9 (1986), reprinted in 1986 U.S.C.A.A.N. 5266, 5274.

9. See note 6, *supra*.

10. For example, see *Hudson v. United States*, 522 U.S. 93 (1997), in which the Court overruled *United States v. Halper*, 490 U.S. 435 (1989), and held that penalties under the False Claims Act are not criminal punishment for the purpose of the Fifth Amendment's Double Jeopardy Clause.

million had been recovered, of which relators' awards totaled approximately \$70 million, and the average relator share was 24.73 percent. More than 80 percent of the False Claims Act cases being pursued by the U.S. Department of Justice were initiated by whistleblowers.

### C. RETALIATION CLAIMS

Section (h) of the FCA prohibits an employer from retaliating against an employee for attempting to uncover or report fraud on the federal government.<sup>11</sup> If retaliation does occur, the relator may also be awarded "all relief necessary to make the employee whole," including reinstatement, back pay, two times the amount of back pay, litigation costs, and attorney fees.<sup>12</sup>

### D. BURDEN OF PROOF

The 1986 amendments to the FCA provide that the relator and/or the government bear the burden of proving all elements of the case by a preponderance of the evidence.<sup>13</sup> (Prior to the amendments, some courts applied a "clear and convincing" standard.)<sup>14</sup>

### E. STATUTE OF LIMITATIONS

The FCA's statute of limitations has three prongs: three years, six years, and 10 years.<sup>15</sup> It provides that "a *qui tam* action may not be brought after the later of a) more than six years after the date on which the false claim is made, or b) more than three years after the date on when facts material to the right of action are known or reasonably should have been known by the official of the U.S. charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed."<sup>16</sup>

---

11. 31 U.S.C. § 3730(h).

12. For more on retaliation claims, see *infra* Chapter IX.

13. 31 U.S.C. § 3731(c).

14. *See, e.g.*, United States v. Ueber, 299 F.2d 310 (6th Cir. 1962).

15. 31 U.S.C. § 3731(b).

16. This complex limitations provision gives rise to a number of issues that are discussed in detail, in Chapter VIII, *infra*.

## F. COMMON TYPES OF QUI TAM CASES

The subject matter of FCA cases is limited only by the imaginations of those who seek to defraud the government. As of November 2007, Department of Justice statistics show health care fraud, at 74 percent, accounting for more *qui tam* settlement and intervention dollars than any other type of fraud. The following types of fraud are common, and the government has recovered under the FCA based on these factual scenarios, among others. Bear in mind, however, that the government's prior successes with a given *qui tam* legal theory or fact pattern is no guarantee of future interest or a positive intervention decision in a different, albeit similar case.<sup>17</sup>

- “Mischarging” for goods or services that were not provided (i.e., charging employee labor to a government contract even though the employee did not work on the contract, or making claims to the government for medical services that were not rendered).
- Submitting false cost and pricing data to the government during the negotiation of a contract in order to obtain an inflated contract price (“false negotiation” or “defective pricing”).
- Providing an inferior product and then falsely certifying that the product met specifications or that reliability testing was done.
- Falsely certifying that medical procedures were medically necessary or that federal laws such as Stark were complied with in order to obtain federal health program payments, or falsely certifying other types of information to obtain FHA mortgage guarantees or other government benefits, or falsely certifying that products were made in America (“false certification”).
- Using a physician identifier number to bill for a service provided by a nurse practitioner or physician assistant, whose services would be reimbursed at a lower rate if properly billed under his or her own number.
- Charging federal health programs for devices that are not covered, such as experimental devices, or misrepresenting those

---

17. For more on how the intervention decision is made, see *infra* Chapter VII.

devices as having FDA or other approval when in fact they do not in order to obtain federal reimbursement.

- Billing Medicaid for hospice drugs when the federal government has already paid for them as part of a facility's hospice reimbursement.
- Billing federal health programs for tests or services that were not performed or that were performed but that were not medically necessary.
- Billing the government for equipment or supplies never ordered, or billing the government for new equipment and supplies when used ones were in fact provided to the patient/beneficiary.
- Completion of certification forms by someone other than the person whose signature appears on the form—for example, a certificate of medical necessity being prepared by a nurse or a drug or equipment supplier.
- Performing and billing the government for tests not requested by a physician.
- Billing for a test even though the test or part of a test was not performed due to an insufficient or destroyed sample or a machine malfunction.
- Using false diagnosis codes to obtain coverage for services not otherwise covered.
- Offering inducements for Medicare or Medicaid numbers and then billing to those numbers for services not performed.
- Billing separately (at a higher rate) for services that are subsumed into a single billing code (“unbundling”).
- “Upcoding” (inflating bills by using diagnosis codes that indicate the patient experienced medical complications and/or needed more expensive treatments than actually rendered; for example, billing for complex services when only simple services were performed, billing for brand-name drugs when generic drugs were provided, listing treatment as having been for a more complicated diagnosis than was actually the case).
- Submission of false cost reports in order to obtain higher reimbursements than permitted.
- Seeking reimbursement for the provision of substandard nursing home care.

- Routinely waiving Medicare patient co-payments to encourage indiscriminate use of medical providers by the elderly.
- Short-filling of prescriptions so that the federal government pays for more pills than the beneficiary received.
- Marketing pharmaceuticals for purposes not approved by the FDA (“off-label”).
- Billing Medicare as the primary insurer when in fact it is a secondary payer that should pay only after the primary insurer has paid its share.
- “Marketing the spread” or “AWP” (average wholesale price): pharmaceutical manufacturers falsely inflating a drug’s AWP (on which the federal government’s reimbursement rate is based), thereby increasing the spread between the drug’s actual acquisition cost and the reported AWP, resulting in a magnification in the drug’s profitability to pharmacies and higher prices being paid by the federal government.
- Transporting people by ambulance and billing Medicare and Medicaid for basic life support services when the patients are capable of being transported by other means, the required Certificate of Medical Necessity is absent or copied from previous transports, and/or the required ambulance documentation is falsely written to conceal the fact that the patient was actually ambulatory at the time of transport.