



**BENCH OPINION OF THE HONORABLE HARVEY BARTLE, III**  
**UNITED STATES DISTRICT COURT**  
**SEPTEMBER 18th, 1998**

**JAMES A. BACKSTROM, ESQ., FRANK CASE, III, ESQ. AND MARTIN JAY GAYNES, ESQ.**  
**FOR THE DEFENDANTS**  
**STEPHEN J. BRITT, ESQ. FOR THE PLAINTIFF**

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IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITED STATES OF AMERICA

VS.

ALAN ROSE, et al  
Defendant

CIVIL ACTION NO. 98-4345

Philadelphia, Pennsylvania  
September 18, 1998  
3:00 o'clock p.m.

BENCH TRIAL OPINION  
BEFORE THE HONORABLE HARVEY BARTLE, III  
UNITED STATES DISTRICT COURT

APPEARANCES:

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1                   (The following was heard in open court at 3:00  
2                   o;'clock p.m.)

3                   THE COURT: Good afternoon. You may be seated.

4                   ALL: Good afternoon, your Honor.

5                   THE COURT: Before the Court this afternoon is the  
6 case of the United States of America versus Alan Rose, et al,  
7 Civil Action Number 98-4345. This is an action under the  
8 injunctions against the fraud statute, Title 18, United  
9 States Code, Section 1345.

10                  The Government alleges that defendants, Alan Rose,  
11 Core Care Health Systems, Inc., Health Care Technology  
12 Services, Inc., Priority Medical Systems, Inc. and Progress  
13 Health Care, Inc. is committing and will continue to commit  
14 mail and wire fraud by submitting false and fraudulent claims  
15 to the Medicare program, see Title 18, United States Code,  
16 Section 1341 and 1343.

17                  The Government seeks permanent injunctive relief  
18 including the freezing of certain defendants' assets. We  
19 entered a temporary restraining order on August 20th, 1998  
20 and signed the stipulation to extend and amend the temporary  
21 restraining order on August 26th, 1998.

22                  The parties also agree that the Court should conduct  
23 a final hearing as expeditiously as possible. The Court did  
24 so on September 16th and 17th, 1998. Following the Court's  
25 findings of fact and conclusions of law pursuant to Rule 52

1 of the Federal Rules of Civil Procedure.

2 Medicare is the federal program which provides  
3 health care to the nation's elderly. The defendant companies  
4 which are located in Bensalem, Pennsylvania, participate in  
5 Medicare as suppliers of surgical dressings.

6 The defendant, Alan Rose, is a principal in each of  
7 the corporate defendants. Surgical dressings are  
8 characterized as durable medical equipment and are covered  
9 under Part B of the Medicare program.

10 Medicare Part B is administered through private  
11 companies known as carriers which contract with the Health  
12 Care Finance Administration to process health care claims  
13 submitted by providers, suppliers or beneficiaries.

14 The Medicare program has divided into four regions,  
15 A, B, C and D and there is one carrier per region to process  
16 all of the claims originating from region. Administar  
17 Federal is the durable medical equipment regional carrier or  
18 DMERC, D-M-E-R-C, for Region B, and the United Health Care is  
19 the DMERC for Region A, which includes Pennsylvania.

20 Defendant companies supply products to Medicare  
21 beneficiaries in all four regions. Supplying products to  
22 Medicare beneficiaries and submitting claims to carriers  
23 which process the claims, is very complicated and extremely  
24 bureaucratic in nature.

25 Detail and minutia are the order of the day. For

1 example, suppliers must have an updated certificate of  
2 medical necessity for each patient signed by a physician at  
3 least every 90 days.

4           These certificates must be submitted within 30 days  
5 of the date of service. Claims must cover no more than  
6 30-day periods. Product codes required by Medicare to be  
7 used by the suppliers are often changed.

8           The extent of the information collected by the  
9 supplier is daunting. The nature of the patient's wounds and  
10 the size to the centimeter must be recorded. The exact size  
11 and nature of the dressing must also be documented. If the  
12 wounds change in size or condition, all these facts must be  
13 obtained and kept by the supplier for review by the carrier.

14           The defendant companies submitted over 12,500 claims  
15 to Administar and to others from 1994 to 1996 and received  
16 over \$4 million for their product. Clearly with the detail  
17 required and the volume involved, mistakes by the supplier  
18 are inevitable.

19           The supplier may submit claims electronically or by  
20 hard copy, that is on HCFA, H-C-F-A, paper form 1500. For  
21 electronic claims, providers or suppliers enter the data on  
22 their computers and transmit it to Administar's systems, for  
23 example, which analyzes the claim and reimburses or denies  
24 payment accordingly.

25           Administar's employee's play little or no role in

1 the electronic claims processing. While documents are not  
2 attached to electronic claims, providers can supply  
3 additional information on the electronic form.

4 when paper claims are submitted on a HCFA form 1500,  
5 the pertinent data is entered by Administar employees and  
6 supporting documents may be attached. The employees review  
7 the claim forms and documents and reimburse suppliers for  
8 valid claims.

9 In 1994, Administar received complaints from  
10 physicians and families of Medicare beneficiaries about the  
11 billing practices of the defendant companies. The complaints  
12 allege that defendants submitted bills for amounts or types  
13 of surgical dressings which did not match the beneficiaries  
14 needs and the physicians' orders.

15 Mary Beach, Administar's fraud investigation unit  
16 manager, supervised an audit of the defendant companies'  
17 claims. Her staff tried to determine the validity of the  
18 claims by contacting third-parties, such as nursing homes,  
19 physicians, beneficiaries and suppliers to verify whether the  
20 products filled by the defendant companies were appropriate.

21 Ms. Beach's audits revealed some claims for products  
22 which were not medically necessary, were provided in  
23 excessive amounts, were inconsistent with the physicians'  
24 orders and were not received by the beneficiaries.

25 As a result of the audit, Ms. Beach placed the

1 defendant companies on prepayment review, revoked their  
2 electronic billing privileges and instructed the companies to  
3 submit supporting documents with their claim.

4 Janice McNab, Administar's DMERC medical review unit  
5 manager, had her staff conduct a prepayment review of all of  
6 the defendant companies claims during the 1994, 1995 audit  
7 period. The review revealed the following problems.

8 One: Resubmission of claims, that is, resubmitting  
9 repeated claims for the same beneficiary on the same service  
10 date and for the same products after Administar had made a  
11 final decision to either pay or deny the claim.

12 Two: Split line billing, that is, listing each item  
13 on a separate claim form when the products were supplied to  
14 one beneficiary on one service date. This type of billing  
15 makes it easier to hide any inconsistencies in the claim and  
16 provides increased paperwork for the carrier.

17 Three: Over-utilization, that is, submitting claims  
18 for more products than are medically necessary or more  
19 expensive than necessary based on the patients needs.

20 Four: Inconsistent billings. Billing for products  
21 which were not prescribed for the beneficiary by a physician.

22 Five: Inappropriate product combinations, that is,  
23 submitting a claim for products which are contraindicated  
24 according to Medicare or DMRCK policy. Extensive evidence  
25 was presented concerning the appropriateness of

1 simultaneously using Hydrogel and foam bandages.

2           The defendant companies initiated a meeting with  
3 Administar in April 1996 to discuss the high frequency of  
4 claims denials by Administar. At that time, Administar  
5 advised the defendant companies to cease their practices of  
6 resubmitting claims and using split line billing. Even  
7 though these practices are not prohibited by Medicare or  
8 DMRCK policies, the defendant companies acceded to  
9 Administar's request.

10           Pursuant to Title 18, United States Code, Section  
11 1345, the Government seeks a permanent injunction barring  
12 defendants from submitting false and fraudulent Medicare  
13 claims.

14           It also seeks to freeze defendants assets. This  
15 statute as noted above, provides that we may issue an  
16 injunction if a person is violating or about to violate this  
17 chapter or Section 287,371 (insofar as such violation  
18 involves a conspiracy to defraud the United States or any  
19 agency thereof) or Section 1001 of this title. And finally,  
20 an injunction may issue if a party is committing or about to  
21 commit a federal health care offense.

22           The Section 1345 injunction is authorized to prevent  
23 ongoing or future crimes, not punished for past misconduct.  
24 See United States versus CEN, C-E-N, Card Agency, Number  
25 88-5764, a memorandum opinion of the Court of Appeals for the

1 Third Circuit handed down on March 23rd, 1989.

2 If the defendants violate Section 1345(a) 1, we may  
3 issue an injunction or temporary restraining order, freezing  
4 their assets under Section 1345(a)2 and (a)3.

5 See United States v. Brown, 988 F.2d 658, 662 (Sixth  
6 Circuit 1993) and United States New Frontiers Real Estate Co,  
7 Civil Action Number 89-2585, 1989 WESTLAW 49, 519, decision  
8 of the Eastern District of Pennsylvania dated May 8th, 1989.

9 As the predicates for the injunction, the Government  
10 alleges that the defendant companies are committing and will  
11 continue to commit mail fraud and wire fraud, and are  
12 engaging in the submission of false and fraudulent claims  
13 against the United States. See Title 18, United States Code,  
14 Section 1341, 1343 and 287.

15 The essential elements of mail or wire fraud are as  
16 follows. One, that there was a scheme to defraud. Two, that  
17 there was use of the mails or wires in furtherance of the  
18 fraudulent scheme, and three, the defendants knowingly  
19 devised or participated in the scheme with intent to defraud.

20 To prove that defendants made false or fictitious  
21 claims, the Government must prove that they made a claim  
22 against a department or agency of the United States. The  
23 claim was false, fraudulent or fictitious, they knew the  
24 claim was false, fraudulent or fictitious, and they submitted  
25 the claim with intent to defraud the United States.

1           The Court of Appeals for the Third Circuit has not  
2 ruled on the standard for the burden of proof which applies  
3 to the injunctions against fraud statute. The parties  
4 contend and we agree that the Third Circuit would hold that  
5 the Government must prove its claims by a preponderance of  
6 the evidence. See Brown, 988 F.2d 663. This means that it  
7 is more likely than not that the defendants are committing or  
8 will continue to commit fraud.

9           Of the 12,500 claims submitted by the defendant  
10 companies in 1994, 1995 and 1996, the Government provided  
11 evidence of allegedly fraudulent billing practices in fewer  
12 than two dozen instances.

13           Furthermore, virtually every claim presented by the  
14 Government was submitted before the meeting between the  
15 defendant companies and Administar which occurred in April  
16 1996.

17           It is common knowledge that resubmitted claims also  
18 never result in double payments because the carriers computer  
19 systems are programmed to deny such claims. In fact, the  
20 defendant companies did not benefit from resubmitting claims.

21           They were paid twice only in a few resubmitting  
22 claims, and where it occurred, the defendant companies  
23 voluntarily refunded the monies. In fact, the defendants  
24 have voluntarily refunded over \$400,000 to the four DMERCs  
25 for 1994 to 1998.

1                   Finally, after the April of 1996 meeting with  
2 Administar, the defendant companies have resubmitted claims  
3 only when there was a code change instituted by the Health  
4 Care Financing Administration. These facts do not establish  
5 an intent or scheme to defraud.

6                   The defendant companies also stopped submitting  
7 split line billing claims as a matter of course. They now  
8 transmit multiple forms for a single patient for the same  
9 service date only when items are supplied that cannot fit on  
10 the six lines provided on a single HCFA 1500 form.

11                   There were a few instances when the defendant  
12 companies provided larger bandages than required by the wound  
13 size because however it was requested by the physician on the  
14 certificate of medical necessity.

15                   If anyone is to blame for over-utilization by  
16 ordering inappropriately sized bandages, it seems it should  
17 be the physician signing the certificate of medical  
18 necessity, not the supply company complying with the order.

19                   We also note that there were instances when the  
20 defendant companies down coded to smaller, cheaper bandages  
21 when appropriate. At the very least, this evidence of  
22 over-utilization is inclusive regarding any scheme or intent  
23 to defraud.

24                   The Government presented a few instances when the  
25 product billed by the defendant companies was inconsistent

1 with the one identified in the corresponding certificate of  
2 medical necessity.

3           The defendant companies provided logical  
4 explanations for these inconsistencies. One provider  
5 requested a bandage in a size which was not manufactured, so  
6 the company billed for the next closest size.

7           In other instances, the defendant companies admitted  
8 they made a data entry mistake. As we noted previously, with  
9 the with the high volume of claims submitted, numerous  
10 products' codes used and the detail of information required,  
11 it is reasonable to expect that mistakes will occur from time  
12 to time. These few inconsistencies or billing errors do not  
13 amount to a scheme to defraud the United States.

14           While the Government presented evidence of billing  
15 mistakes and disputes over the way forms should be completed,  
16 it fell far short of meeting its burden to prove by a  
17 preponderance of the evidence that defendants engaged in a  
18 scheme to defraud the Government, or that they submitted  
19 claims with intend to defraud an agency of the United States.

20           Based on the above findings of fact and conclusions  
21 of law, we will enter judgment in favor of the defendants and  
22 against the Government. The Court today will enter the  
23 following order.

24           And now this 18th day of September 1998 based on the  
25 findings of fact and conclusions of law announced in open

1 court, it is hereby ordered one, that the temporary  
2 restraining order of August 20th, 1998 and the stipulation to  
3 amend and extend the temporary restraining order of August  
4 26th, 1998 are vacated.

5 And two, judgment is entered in favor of the  
6 defendants, Alan Rose, Core Care Health Systems, Inc., Health  
7 Care Technology Services, Inc., Priority Medical Systems,  
8 Inc. and Progress Health Care, Inc. and against the  
9 plaintiff, the United States of America.

10 Thank you very much.

11 ALL: Good afternoon, your Honor.

12 (Proceedings concluded at 3:15 o'clock p.m.)

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CERTIFICATION

Every effort has been made in proofing that the foregoing is a correct transcript from the electronic sound recordings of the proceedings in the above-captioned matter.

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