Department of Justice

U.S. Attorney's Office

Middle District of Tennessee

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Mail-Order Diabetic Testing Supplier And Its Parent Company Agree To Pay $160 Million To Resolve Alleged False Claims To Medicare

Whistleblower Case Brought by Former Employee at Antioch, Tennessee Call Center Largest False Claims Act Settlement in Middle Tennessee

NASHVILLE – Arriva Medical, LLC (Arriva), at one point the nation's largest Medicare mail-order diabetic testing supplier, and its parent, Alere Inc. (Alere), have agreed to pay $160 million to resolve allegations that they violated the False Claims Act. Until it ceased business operations in December 2017, Arriva was a mail-order diabetic testing supply company based in Coral Springs, Florida and one of the largest such mail order diabetic supply companies in the nation. Alere is a medical device company now based in Abbott Park, Illinois, which acquired Arriva in November 2011. The settlement resolves allegations that Arriva and Alere made, or caused, claims to Medicare that were false because of kickbacks to Medicare beneficiaries, because patients were ineligible to receive meters, or because patients were deceased.

"The False Claims Act and related statutes exist to protect the public fisc and to ensure companies do not benefit from unfair competition by gaining an illegal advantage over competitors," said Acting U.S. Attorney Mary Jane Stewart. "When companies engage in such practice, they can expect to be held accountable for their actions."

"Paying illegal inducements to Medicare beneficiaries in the form of free items and routine copayment waivers can result in overutilization and waste taxpayer funds," said Acting Assistant Attorney General Bryan M. Boynton for the Justice Department's Civil Division. "We will continue to protect the integrity of the Medicare program by pursuing fraudulent claims arising from violations of the Anti-Kickback Statute or other applicable reimbursement requirements.

The United States alleged that, from April 2010 until the end of 2016, Arriva, with Alere's approval, paid kickbacks to Medicare beneficiaries by providing them "free" or "no cost" glucometers and by routinely waiving, or not collecting, their copayments for these meters and other diabetic testing supplies. Specifically, the United States alleged that Arriva advertised that glucometers would be "free," and then during intake calls offered Medicare beneficiaries a "no cost guarantee," under which Arriva would provide the meters at "no cost" if Medicare denied payment, which typically happened because the beneficiaries were not yet entitled to a new glucometer paid for by Medicare. Arriva also allegedly offered and provided existing customers "free" additional meters to induce them to reorder testing supplies from Arriva.

Arriva also allegedly routinely waived, and failed to make reasonable efforts to collect, Medicare copayments. It allegedly failed to send invoices to beneficiaries, and failed to take other basic steps, like sending collection letters or making phone calls, to collect copayments. Specifically, Arriva allegedly systematically waived "small" dollar copayments without informing beneficiaries of their copayment obligations by sending them an invoice, and allegedly automatically waived other unpaid copayments after sending no more than three invoices seeking payment and making no other collection efforts. Arriva also allegedly waived copayments when customers complained that Arriva had advertised and otherwise indicated that their supplies would be free or at no cost.

"Engaging in activities that result in the submission of false claims to Medicare diverts funding from the necessary treatment and medical supplies beneficiaries need," said Special Agent in Charge Derrick L. Jackson, U.S. Department of Health and Human Services Office of Inspector General. "We will continue working with our law enforcement partners to hold accountable those who seek to enrich themselves by submitting false claims to federal healthcare programs."

"The TBI is diligent in pursuing false claims allegations such as these," said Director David Rausch of the Tennessee Bureau of Investigation. "The partnership we have with our federal counterparts is key in combating healthcare fraud."

The settlement also resolves allegations that Arriva and Alere caused the submission of false claims to Medicare for glucometers because Arriva, with Alere's approval, allegedly systematically provided to all of its new patients, and billed Medicare for, a meter without regard to the patients' eligibility for one. Medicare beneficiaries are only eligible to seek reimbursement for a new meter once every five years. Arriva also allegedly repeatedly billed Medicare for new meters for existing patients where Arriva itself had previously billed Medicare for meters for those patients within the five-year window.

Finally, the settlement resolves claims that Arriva submitted false claims to Medicare on behalf of deceased beneficiaries. In November 2016, the Medicare program revoked Arriva's Medicare supplier number for doing so.

The civil settlement includes the resolution of claims brought under the *qui tam* or whistleblower provisions of the False Claims Act by Gregory Goodman, a former employee at an Arriva call center in Antioch, Tennessee. Under those provisions, a private party can file an action on behalf of the United States and receive a portion of any recovery. The Act also permits the United States to intervene and take over the litigation of such actions, as the United States did here. Mr. Goodman will receive $28,548,748.98 as his share of the recovery. The *qui tam* case is captioned *United States ex rel. Goodman v. Arriva Medical LLC et al.*, Case No. 3:13-cv-00760 (M.D. Tenn.).

Arriva's founders, David Wallace and Timothy Stocksdale, previously paid $1 million to resolve allegations that they participated in the kickback scheme. Ted Albin and Albin's Florida-based company, Grapevine Billing and Consulting Services, Inc., are not parties to the settlement and remain defendants in the ongoing litigation. The United States filed suit against Albin and Grapevine shortly after it intervened in the *qui tam* action against Arriva and Alere.

The settlement of this case is the largest single False Claims Act settlement by the U.S. Attorney's Office for the Middle District of Tennessee and one of the largest settlements for allegations of kickbacks involving durable medical equipment in the United States.

The resolution obtained in this matter was the result of a coordinated effort between the U.S. Attorney's Office for the Middle District of Tennessee, the Justice Department's Civil Division, Commercial Litigation Branch, Fraud Section, the U.S. Department of Health and Human Services Office of Inspector General, and the Tennessee Bureau of Investigation.

The investigation and resolution of this matter illustrates the government's emphasis on combating healthcare fraud. One of the most powerful tools in this effort is the False Claims Act. Tips and complaints from all sources

about potential fraud, waste, abuse, and mismanagement can be reported to the Department of Health and Human Services at 800-HHS-TIPS (800-447-8477).

The matter was handled by Assistant U.S. Attorney Ellen Bowden McIntyre of the Middle District of Tennessee and Trial Attorney Jake M. Shields of the Civil Division.

The claims resolved by the settlement are allegations only and there has been no determination of liability.

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Topic(s):
Health Care Fraud

Component(s):
Civil Division
USAO - Tennessee, Middle

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