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Connecticut State Court Finds Defunct Pharmacy Liable for $39.2 Million in Damages and Penalties

Article By:

D. Jacques Smith

Randall A. Brater

Michael F. Dearington

Nadia Patel

Hillary M. Stemple

Headlines that Matter for Companies and Executives in Regulated Industries

Connecticut State Court Finds Defunct Pharmacy Liable for $39.2 Million in Damages and Penalties

A Connecticut Superior Court judge found Assured Rx, LLC, a Florida-based pharmacy, liable for violating the Connecticut False Claims Act (FCA), which is modeled after the federal FCA and has many identical provisions, based on the pharmacy's participation in a kickback scheme. The court's opinion comes after a seven-day bench trial in January that involved 180 exhibits, testimony from seven witnesses, and deposition testimony from five witnesses.

The court found that Assured Rx made illegal payments disguised as "marketing payments" to state Department of Corrections employees for costly compound drug prescriptions compounded and distributed by Assured Rx. The Connecticut State Employee and Retiree Pharmacy Benefit Plan bore the costs of the compound drug prescriptions through its pharmacy benefit manager.

Between June 14, 2014, and September 8, 2015, Assured Rx submitted 1,044 claims for compounded drugs, costing the state of Connecticut $10,300,746.45. Because the Connecticut FCA, like the federal FCA, provides for treble damages, the court awarded more than $30 million in damages plus an $8.3 million civil penalty, resulting in a total judgment in excess of $39 million.

The court also concluded that Assured Rx's founder, Nitesh Patel, did not violate the Connecticut

FCA because there was no credible evidence that he had actual knowledge of the scheme.

The case is captioned *State of Connecticut v. Assured Rx LLC et al.*, Case No. HHD-CV18-6101282-S (Connecticut Superior Court, Harford District).

Read the attorney general of Connecticut's press release here.

Additional Health Care Fraud Settlements, Guilty Plea, and Sentencing

An Idaho health care company, KA Health Services, and its owner agreed to pay more than $321,000 to resolve allegations that they submitted false claims to Medicaid. According to the US Department of Justice's (DOJ) press release, KA Health Services allegedly submitted claims for psychotherapy, language interpretation, and other services that were either not provided by a qualified professional or were not provided at all. Relatedly, licensed professional counselor Karen Canfield admitted to knowingly causing KA Health Services to submit false claims by instructing language interpreters to meet with patients who spoke limited English without the presence of a licensed counselor or clinician to provide the clinical services for which KA Health Services was billing. Canfield also consented to a judgment against her that stemmed from the same investigation. Read the DOJ's press release here.

A Washington doctor agreed to pay $65,680 to resolve allegations that he caused the submission of false claims to Medicare. According to the DOJ's press release, the doctor signed durable medical equipment and generic testing orders for Medicare beneficiaries, even though he did not confirm that the orders were medically necessary and reasonable, and, in some cases, did not examine or speak with the patients. Read the DOJ's press release here.

A New York man pleaded guilty to health care fraud for his involvement in the submission of false and fraudulent claims to public and private insurers. While serving as the office manager and health care claims biller for two physicians' practices, the man submitted false claims for services that were not provided and for services that were provided at lower reimbursement rates than the amounts billed. He is scheduled to be sentenced in February 2025. Read the DOJ's press release here.

A New Jersey doctor was sentenced to 15 months in prison for conspiring to commit health care fraud. According to the DOJ's press release, the doctor submitted fraudulent claims for medically unnecessary prescriptions to New Jersey state and local health benefits programs and insurers, resulting in insurers paying more than $5 million for the fraudulent prescriptions. The doctor was also ordered to pay $5.13 million in restitution. Read the DOJ's press release here.

DOJ Continues to Pursue COVID-19 Fraud

A jury convicted a New Jersey man on one count of conspiracy to commit wire fraud following a five-day trial. The man, along with his co-conspirators who previously pleaded guilty, submitted fraudulent applications for COVID-19 unemployment benefits. As a result, the conspirators obtained debit cards totaling more than $570,000 and spent the money on vacations, luxury retail purchases, and cosmetic surgery. Read the DOJ's press release here.

A Missouri man pleaded guilty to one count of filing a false claim and agreed to pay more than $130,000 in restitution to the Internal Revenue Service (IRS). According to the DOJ's press release, the man fraudulently received nearly $1.4 million in COVID-19 relief funds from the government by filing Employer's Quarterly Tax Return forms with the IRS, even though his company did not have

any employees at the time. Read the DOJ's press release here.

Laura Zell also contributed to this article.

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