

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

UNITED STATES OF AMERICA,	:	CIVIL ACTION
ex. rel. MITCHELL NUDELMAN,	:	
M.D., et. al.	:	
	:	NO. 00-1837
vs.	:	
	:	
INTERNATIONAL REHABILITATION	:	
ASSOCIATES, INC., D/B/A	:	
INTRACORP.	:	

DECISION

JOYNER, J.

April 4, 2006

Presently pending before this Court is the Motion of the United States and the States of California, Delaware, Florida, Illinois, Tennessee and Nevada for Approval of the Settlement which they negotiated with Defendant Intracorp as Fair, Adequate and Reasonable. Following the Fairness Hearing before the undersigned on June 13, 2005 and comprehensive review of the voluminous submissions of the parties, we now make the following:

Findings of Fact

1. Defendant International Rehabilitation Associates, Inc. (Intracorp) is a Delaware corporation and wholly owned subsidiary of CIGNA Corp. with headquarters in Philadelphia, Pennsylvania and offices throughout the United States, including "hub" service centers in Philadelphia and Pittsburgh, Pennsylvania, Atlanta, Georgia, Chicago, Illinois, Dallas, Texas and Chattanooga,

Tennessee. Intracorp is primarily in the business of providing utilization review and health care management services to its base of some 20,000 client-customers which chiefly consists of public and private employers and private group health and worker's compensation insurers. Intracorp's contracts cover approximately 32 million lives. (Appendix 4-9; www.intracorp.com; Relator's Hearing Exhibit 1).

2. The Relator in this case is Mitchell S. Nudelman, M.D., J.D., a Board-certified family practitioner and member of the Georgia Bar who worked as a Physician Advisor at Defendant Intracorp's Southeast Service Center in Norcross (Atlanta), Georgia from 1992 to 2000. (Appendix 874-878; Relator's Hearing Exhibit 1).

3. Utilization management is a set of techniques designed to manage health care costs by influencing clinical decision-making toward the selection of more efficient and efficacious interventions; it is usually applied for or on behalf of the purchasers of health care by utilization management organizations or managed care organizations. (Expert Report of Gary J. Mihalik, M.D., p. 7).

4. Utilization management began in the 1980's and at that time consisted almost exclusively of the retrospective analysis of cases, mostly of hospitalized patients. This retrospective nature gave rise to the term "utilization review." Due to the

growing emphasis on reducing unnecessary health care costs, utilization review has since shifted from retrospective to prospective review of proposed in-patient and outpatient treatments and tests, and has thus evolved from a system of review into a system of management. (Mihalik Report, p. 7; Relator's Hearing Exhibit 19).

5. Given the new-ness of the industry, there was no accreditation¹ of utilization management programs until 1991 when the Utilization Review Accreditation Commission's (URAC) National Utilization Review Standards were approved in June of that year. URAC's accreditation requirements changed significantly over the course of the 1990's as utilization management continued to evolve. (Mihalik Report, p. 8).

6. Intracorp was first accredited by URAC in 1991 and re-accredited in 1994, 1997, 1999, 2001 and 2003. (App. 2137, 2188-2261; Declaration of Susan Goodchild, at ¶18).

7. URAC is an independent, non-profit organization based in Washington, D.C. which has as its stated goal the promotion of health care quality through its accreditation and certification programs. (Declaration of Garry Corneal; www.urac.org).

8. Intracorp policy provides for three levels of review. Nurse reviewers conduct the first level of review by assessing

¹ Dr. Mihalik defines "accreditation" as "the evaluation of an organization's systems, processes and practices against external standards, and assignment of a designation based on the degree of compliance with the standards." (Mihalik Report, p. 8).

whether a proposed surgery, medical procedure, treatment or therapy falls within the written criteria as "medically necessary" for a particular illness or condition and, if they find the criteria to have been satisfied, will certify the case and the UM process is concluded. If the nurse reviewer does not find that the requested service falls within the criteria for medical necessity, the case is then electronically referred to a "call queue" or central area for review by a Physician or "Physician Advisor." Ideally, the cases are routed to an appropriate Physician Advisor ("PA") based upon the reason for the referral, specialty or expertise required and/or jurisdictional mandate (*i.e.* some states require that their residents' cases be reviewed by a physician licensed by that state). A PA then reviews the case and may: contact the referring utilization review specialist or case manager to discuss the case, contact the attending physician or care provider to conduct a peer to peer discussion on the case, negotiate an alternative to the proposed treatment and/or approve or deny the request for certification. If the PA is unable to certify the requested service, the attending physician or care provider may request reconsideration and a peer to peer discussion on the decision. Finally, the non-certification decision may be appealed and the case is then examined by a physician of the same or similar specialty who was not involved

in the initial review and determination. (App. 1580-1585; Relator's Hearing Exhibit 38).

9. Between 1991 and 2000, approximately 90-95% of the cases reviewed were certified by the nurse reviewers. In that time frame, only between 5% and 10% of Intracorp's cases were referred for review by a physician advisor. (App. 1213, 1231-1233, 1248, 1304).

10. There were four different versions of URAC's Health Utilization Management Standards between 1991 and 2001. These were published in 1991, 1994, 1997 and 2001 and were modeled after a pass/fail system. (Carneal Declaration; App. 101-321). These standards are divided into two categories—"shall" standards and "should" standards. To be accredited, 100% of the "shall" standards were expected to be satisfied and at least 60% of the "should" standards were likewise expected to be met. However, URAC did not provide any guidance on how the individual standards and sub-standards were to be scored and aggregated until it published its 2001 standards. Thus, contrary to the common-sense impression that the standards were either satisfied or not and that if only one of the "shall" standards was not met an organization was denied accreditation, surveyors were instructed to score a standard (including "shall" standards) as being in compliance even in the face of some non-compliance so long as the surveyor determined that the non-compliance was not indicative of

a trend. Recently, URAC has been implementing a new, more dynamic scoring system that yields a total numeric score for each applicant (*i.e.*, on a scale of 1 to 100). (Mihalik Report, p. 10; Carneal Declaration; App. 248).

11. Under the URAC standards and at least since 1994, each utilization review organization ("URO") was required to, *inter alia*:

- have review staff who were properly qualified, trained, supervised and supported by explicit written clinical review criteria and review procedures;
- limit health professionals who are not clinical peers to first level clinical review;
- have second level clinical review conducted by clinical peers who currently hold an unrestricted license to practice medicine or a health profession in the U.S. and who are oriented to the principles and procedures of utilization review and URAC;
- have third level review (appeals) conducted by clinical peers who are board certified and in the same or similar specialty as typically manages the medical condition, procedure or treatment for which review is being sought;
- maintain written policies and procedures that govern all aspects of the utilization review process;
- utilize explicit clinical review criteria, either commercial or proprietary that are evaluated and updated at least annually;
- implement and document a structured professional staff management program that demonstrates a formal program of orientation and training for clinical and peer reviewers, establishes written qualifications and an evaluation/verification process for all clinical and peer reviewers, and includes a periodic formal program for training, ongoing monitoring and evaluation of the performance of all staff involved in all levels of the

review process;

- maintain and document an ongoing Quality Management program which promotes the objective and systematic monitoring and evaluation of all utilization review processes and services. (App. 120-127, 151-154, 156-158, 173-188; Garner Affidavit, ¶6).

12. In addition, the URAC standards required that certification determinations were to be made within two business days of receipt of the necessary information on a proposed admission, procedure or service requiring a review determination and that notification of the certification decision was to be promptly made either by telephone, facsimile transmission or in writing to both the attending physician or other medical provider or facility and patient or enrollee. If the decision was transmitted in writing, it was required to be sent within two business days (App. 131, 162; Garner Affidavit, ¶6). If the decision was to non-certify the procedure or admission, written notification was required to be sent to the patient or enrollee within one business day and telephone notification was to be made to the provider within one business day and was required to include the principal reasons for the determination not to certify and instructions for initiating an appeal. (App. 132, 163; Garner Affidavit, ¶6).

13. Intracorp was reviewed/audited by URAC from time to time in connection with its applications for initial and re-accreditation. Such reviews proceeded in three steps: (1)

desktop review (consisting of a detailed review primarily of policies and procedures related to the applicant's utilization review process to ascertain whether the applicant's services comply with URAC's accreditation standards); (2) on-site review at 50% of the applicant's offices of the policies and procedures for utilization review/management process, orientation and training materials as well as the documentation of staff orientation and ongoing training, regulatory program documentation, clinical review criteria, peer clinical and peer-to-peer records, notification and denial letters and appeal cases; and (3) Accreditation/Executive committee review to determine whether accreditation should be issued/re-issued. Following each such review, Intracorp was found to be compliant. (Carneal Declaration; Goodchild Declaration; App. 2189-2261).

14. Intracorp represented to its existing and potential customers, including the government entities in this case, that it was URAC certified and that it performed utilization review in accordance with URAC standards. (App. 77-88; Defendant's Supplemental Exhibit 1, at p. 3632).

15. URAC accreditation was not a specific requirement or pre-condition to payment of any of the contracts which Intracorp had with any of the States in this case, with the exception of the contract entered into in June, 1997 between Intracorp and the Illinois Department of Central Management services for the State

of Illinois Group Health Program.² (Relator's Hearing Exhibit 3, at p. 11; App. 4-89).

16. By statute, Illinois requires every person or organization conducting a utilization review program in the State to meet URAC's accreditation standards, although such person or program need not be formally accredited by URAC. See, 215 ILCS §134/85.³

17. California, Delaware, Florida, Nevada and Tennessee all statutorily require that utilization review organizations in their states satisfy many of the same requirements as are imposed by URAC to obtain accreditation. See, Nev. Rev. Stat. Ann. §§695G.120, 695G.180, 695G.190; Fla. Stat. §641.512; 16 Del. Code §9120; Cal. H&S Code §1363.5; Tenn. Stat. 56-6-704; Relator's Hearing Exhibit 14). Tennessee expressly exempts a URAC-accredited organization from the requirement that it satisfy the

² At paragraph 2.3 of that contract, the parties agreed that Intracorp would "provide dedicated staffing for the State of Illinois account at the level and with the qualifications as indicated in Appendix B." Appendix B to that contract was an incorporation of Intracorp's Response to Illinois' Request for Proposal, wherein Intracorp represented that it was URAC accredited. See, App. 59-88).

³ Specifically, 215 ILCS §134/85(a) provides,

(a) No person may conduct a utilization review program in this State unless once every 2 years the person registers the utilization review program with the Department and certifies compliance with the Health Utilization Management Standards of the American Accreditation Healthcare Commission (URAC) sufficient to achieve American Accreditation Healthcare Commission (URAC) accreditation or submits evidence of accreditation by the American Accreditation Healthcare Commission for its Health Utilization Management Standards. Nothing in this Act shall be construed to require a health care plan or its subcontractors to become American Accreditation Healthcare Commission (URAC) accredited.

state's statutory standards. Tenn. Stat. 56-6-705(b).

18. Intracorp's nurse and physician reviewers are properly qualified for the positions which they hold⁴ and they receive training in Intracorp's and URAC's policies and procedures regarding the utilization review process at the time of their initial hire. In the case of the physician reviewers, this training consists in large part of one-on-one mentoring from another physician advisor ("PA") whereby the PA trainee sits with an experienced reviewer while they conduct reviews and, using dual headsets, listen in on their conversations with the treating physicians until such time as they are gradually transitioned to independence by first conducting their own reviews with oversight from the training PA and then working completely on their own. Depending upon the work schedule and status (*i.e.*, full time vs. part time) of the trainee, training can take several weeks to complete. (Gross Declaration, ¶7; Loudis Declaration, ¶s6-7; Manfredi Declaration, ¶s7-12; Moore Declaration, ¶7; Silberstein Declaration, ¶s6-8; Stasiuk Declaration, ¶s4-7; Widzer Declaration, ¶s6-10; Feagin Letter, ¶8; App. 879-1164). PA's also received periodic updated training in the form of staff meetings and conferences, in-service education on recent developments in utilization review and medical and/or surgical

⁴ Although most Intracorp in-house PAs are not in active practice, its specialty reviewers or disability contractors are. (Exhibit JJ to Relator's Supplemental Brief in Support of Relator's Objections to Settlement, at BD US 14505.

procedures which result in a high frequency of utilization reviews. (Moore Declaration, ¶10; App. 1056, 1059-1181, 1188-1192, 1201-1207).

19. Criteria can be implicit or explicit (written). Implicit criteria are decision-making principles based on a physician or other clinician's clinical judgment and is the result of a practitioner's education, training and experience; these principles are deemed implicit because they are not articulated in advance. At no time has explicit or written criteria existed for all diagnoses, medical treatments and/or physical or mental conditions. (Mihalik Report, p. 13).

20. Since at least 1991, Intracorp provided a combination of externally developed criteria (*i.e.*, commercial criteria such as Milliman & Robertson and/or InterQual) and some internally developed clinical review criteria to assist its nurse and most physician reviewers in making UM determinations. Over time, the comprehensiveness of these criteria increased, both because individual internal and external criteria sets evolved and expanded to cover more diagnoses and conditions and because Intracorp added new criteria sets to augment existing criteria, although the frequency with which it updated this criteria is unclear. As a result, the criteria was out-dated from time to time. Additionally there were occasions, particularly in the early to mid-1990's and despite the creation by Intracorp of its

Center for Clinical Outcomes and Guidelines ("CCOG")⁵, when the criteria was issued before sufficient training was provided to the reviewers regarding the proper use of this criteria.

(Relator's Hearing Exhibit 28, pp.7-8, 15, 22-24, 28-33, 39-40; Relator's Hearing Exhibit 32, pp. 44-55; App. 345-364, 385-420, 426-645, 693-717, 872-873; Brenner Declaration, ¶s13-18; Gross Declaration, ¶s13-22; Loudis Declaration, ¶s12-16; Manfredi Declaration, ¶s15-18; Moore Declaration, ¶s12-15; Silberstein Declaration, ¶s18, 21-25; Stasiuk Declaration, ¶s15-18; Woolf Declaration, ¶s5-22; Relator's Hearing Exhibit Nos. 26, 28; Mihalik Expert Report, at p. 17; Exhibits W, CC, DD, EE1, EE2, and FF to Relator's Supplemental Brief in Support of Relator's Objections to the Settlement).

21. In addition to being available in hard copy format, at some point in the early to mid-1990's, many of these various criteria sets (including the Optimal Recovery Guidelines and Procedure Necessity Criteria) became accessible to the nurse and physician reviewers through a computer software program entitled "Toolbox." (App. 652).

22. Despite the existence of clinical criteria for most conditions, there are and always have been occasions when a nurse

⁵ CCOG was created by Intracorp in 1995 to internally develop clinical criteria where commercial criteria were not available, to review Intracorp's existing clinical criteria and to update existing criteria when it was deemed necessary. (App. 713-721). CCOG involved actively practicing physicians in the development of criteria. (App. 806-821; Defendant's Supplemental Exhibit No. 2).

and/or physician reviewer is presented with a case which is not covered by existing criteria or the individual patient's circumstances are so unique that they do not fall within the guidelines. This is due to the fact that medicine is an inexact science and no two patients are precisely the same. In such situations, it is appropriate for the physician reviewer to use his or her own independent medical judgment in deciding whether or not to certify the proposed service. (Woolf Declaration, ¶s24-26; Feagin Letter, ¶9; Relator's Hearing Exhibit 28, pp. 16-18; Relator's Hearing Exhibit 29; Exhibit W to Relator's Supplemental Brief in Support of Objections to Settlement).

23. For a small number of states, Intracorp did not have any or adequate numbers of PA's either on staff or in its approximately 500 physician-contracted reviewer network to meet regulatory requirements. This was particularly problematic and time-consuming when Intracorp was required to have a review conducted by a state-licensed physician of the same specialty as the physician requesting authorization of a service. In order to not have a decision made by a physician who did not meet requirements, to not delay authorization of care and to not fail to meet regulatory requirements for turn-around time on decisions, Intracorp would "administratively certify" those cases. In other words, Intracorp made a business decision to approve cases that did not appear to meet its criteria because it

was not able to satisfy state regulatory requirements. This procedure was also often followed when the backlog of cases was high. It is unclear exactly how many such cases were administratively certified but this procedure was adhered to at least from 1992 until 2000, when Relator's employment was terminated. (Woolf Declaration, ¶s43, 46; Nudelman Affidavit, ¶12; Relator's Hearing Exhibits 17 and 18; Feagin Letter and Proffer, ¶16; Relator's Supplemental Hearing Exhibit A, at BD. 2662, 2666).

24. In or about 1999, Intracorp adopted the "one call policy," governing the manner in which physician advisors gathered the clinical information necessary to make review determinations. Under this policy, PAs were directed to place only one phone call seeking clinical information to a provider who desired to render care under review. If the PA was unable to speak with the provider in that one phone call, he or she was to leave a message advising that if the provider did not return the call and provide all necessary clinical information within 24 hours of the message, the PA would make a decision based upon the information available. Because PAs would only call providers for clinical information when there was insufficient information available to certify the proposed care, the practical effect of this policy was to non-certify all care in cases where the provider did not respond with all necessary information within 24

hours. Thus, when a provider responded to a message within 24 hours, but was unable to reach a PA and instead left a message indicating that the provider would like to discuss the matter with the PA, the case was non-certified even though the provider was attempting to reach the PA to provide additional clinical information. Similarly, when a provider responded to a message within 24 hours, but was unable to reach a PA and instead left a message containing additional clinical information, the case was non-certified if the provider did not leave in the reviewer's opinion the correct or sufficient information. (Woolf Declaration, ¶s40-42; Silberstein Declaration, ¶s38-43; Nudelman Affidavit, ¶11; Relator's Exhibits 18 and 31; App. 1731-1737).

25. Shortly after its implementation, the "one-call" policy was modified to allow for a second call to a provider when a provider returned a message from a PA within 24 hours, but did not leave sufficient additional clinical information. Pursuant to this modification, the PA would now attempt to reach the attending physician a second time, but if the PA did not reach the attending physician on that second try, the attending physician was given only an additional 12 hours to call back, starting over the cycle resulting in an automatic non-certification decision. Such non-certification decisions increased the "impact" of Intracorp on its customers' medical costs, which was one of Intracorp's selling points. (Nudelman

Affidavit, ¶11; Silberstein Declaration, ¶44; Relator's Exhibit 31; App. 1736-1737).

26. It is not at all uncommon for Intracorp PAs to review cases which fall outside their area of specialization. In such instances, PAs typically consult the criteria and other reference sources available to them or another PA who does specialize in the area in question ("curbside consultation") for guidance in making their certification decisions. In the event that the PA is not comfortable in rendering a decision, they may return the case to the call queue for handling by another physician reviewer, who may or may not be a specialist in the given area. Thus at Intracorp, highly specialized or unusual medical treatments or procedures may be certified by a PA who is not a specialist and who has little knowledge about a particular medical condition and the appropriate means of treating it. (Stasiuk Declaration, ¶23, Widzer Declaration, ¶s28-29; Silberstein Declaration, ¶s 47-48; Moore Declaration, ¶s19-22; Manfredi Declaration, ¶21-23; Brenner Declaration, ¶19, 26; Relator's Hearing Exhibits 25, 29; Relator's Supplemental Hearing Exhibit A, BD. 2905, 2910; Exhibit OO to Relator's Supplemental Brief in Support of Objections to Proposed Settlement).

27. The result of the repeated return of certain, usually complex, cases to the call queue for review by a PA of the same specialty was a delay in the decision to certify or non-certify

the proposed medical intervention. Such delays could be for as long as a week or longer. (Relator's Hearing Exhibits 25, 30, 32).

28. In or about 1999, Intracorp issued a directive to its PAs to refer those cases which fell within their own specialties and which they had already reviewed and decided to non-certify, to another PA for review, thereby permitting the original PA to be used for an appeal of that same case. (Relator's Supplemental Hearing Exhibit A, at BD 3174.)

29. Since at least the early 1990's, Intracorp had a quality management program in place to evaluate its utilization review services. In the early to mid-1990's, quality control was focused primarily on the production of monthly metric reports which tracked outcome measurements such as the number of calls received and answered, number of referrals to PAs, timeliness of reviews and the percentage of cases non-certified and/or negotiated by PAs and was handled primarily at the local service center level, with each service center having a different individual in charge of quality assurance. (Richmond Declaration, ¶s6-7; Feagin Letter, ¶5; Woolf Declaration, ¶34; Silbertstein Declaration, ¶27; App. 1208-1264). These reports provided data that allowed the establishment of norms against which individual physician advisor certification, negotiation, and non-certification rates could be compared and could be

employed in quality improvement counseling. (Feagin Letter, ¶7).

30. Peer-to-peer case audits were also periodically conducted during this time frame and continue to be done at Intracorp. Auditors assess, among other things, (1) whether a case was properly documented by the nurse reviewer and, where necessary, the PA; (2) whether the appropriate written criteria were adhered to and applied; (3) the consistency of decisions, and (4) whether calls were made to treating providers and notification letters were sent. (Moore Declaration, ¶s 34-35; Richmond Declaration, ¶8; App. 1210-1211, 1251-1260; Feagin Letter, ¶7).

31. In late 1996, Intracorp charged Dr. Feagin with advancing the oversight of the quality of the physician advisors' decisions by consolidating the efforts nationally as opposed to the local medical director audits that had been in place in various forms in the individual service centers. Dr. Feagin created an appeals database that allowed tracking of the appeals along with characterizations of the rationale for any decisions overturned in the appeals process, although little to no computer programming support was provided such that the program was only minimally functional by the time he left Intracorp in May, 1999. (Feagin Letter, ¶s 5, 7; App. 1570).

32. Also in late 1996 and/or early 1997, Intracorp established the Quality Management Oversight Committee and the

Medical Management Quality Team to oversee the design and implementation of a comprehensive quality management program centralized at the corporate level to be known as the National Quality Management Program. Also created were several subcommittees, such as the Utilization Management Quality Subcommittee, the Criteria and Guideline Quality Subcommittee and the Compliance and Risk Management Quality Subcommittee. (App. 1268-1297; Richmond Declaration, ¶11; Silberstein Declaration, ¶29;) "Quality Management Councils" also were put into place in the various service centers to further facilitate oversight of quality control issues, among other things. (App. 1423-1562; Richmond Declaration, ¶11; Woolf Declaration, ¶s34, 36-38; Exhibit A to Relator's Brief in Support of Proposed Findings of Fact and Conclusions of Law at BD 1866-1869).

33. Intracorp's quality management program continues to evolve and is now conducted on a company-wide basis through the use of a computer program and Excel spreadsheet. (Widzer Declaration, ¶s30-32; Woolf Declaration, ¶38; App. 1673, 1684-1685, 1707-1715, 1722-1724).

34. The Relator faces a substantial risk that he would be unable to prove his allegations regarding Intracorp's (1) lack of adequate physician reviewer training, (2) lack of a quality assurance program, and (3) the harm caused by the lack of sufficient and currently-updated written clinical review

criteria. Relator would likely succeed in demonstrating that Intracorp did not always (1) have PA reviewers who were in active clinical practice or licensed in every state in which it did business, (2) render its certification decisions in the time frame required, (3) inform treating providers and/or patients of their appeal rights or, (4) provide its PAs with complete and/or current written clinical criteria.

35. Although Intracorp had shortcomings in the areas of administrative certifications, second and third level reviews, timeliness of decisions, and criteria development and updating such that there was and is room for improvement in these areas, Intracorp was substantially in compliance with the requirements of URAC, the United States and the States of Nevada, Florida, California, Delaware, Illinois and Tennessee for providing utilization review services under the contracts which it had with each of those government entities.

36. The manner in which Intracorp performed utilization review services for the government entities in this case did not pose any danger or threat to the 32 million lives covered under the contracts at issue here.

37. Between 1990 and 2003, the State of Delaware, through its Employee Benefits Office paid a total of \$3,590,133 to Intracorp for medical utilization review services for the State Employee Benefits Program. (Exhibit H to Relator's Supplemental

Brief in Support of Objections to Proposed Settlement; N.T. 6/13/05, 38-41).

38. Between 1990 and 2003, the State of Florida, pursuant to a three-year contract between its Department of Insurance, Division of Risk Management executed in September, 1997, paid a total of \$699,218 to Intracorp for utilization review services. (Relator's Hearing Exhibit 16; N.T. 6/13/05, 20-21)

39. Between 1990 and 2003, the State of Illinois, through its Department of Central Management Services, paid more than \$20 million to Intracorp for utilization review services. (Exhibit J to Relator's Supplemental Brief in Support of Objections to Proposed Settlement; N.T. 6/13/95, 12-13).

40. Between 1998 and 2005, the Nevada Department of Prisons Medical Division and Nevada Public Employees' Benefits Program had contracts for utilization review services with Intracorp totaling \$4,258,719. (Exhibit K to Relator's Supplemental Brief in Support of Objections to Proposed Settlement; Relator's Hearing Exhibit 16).

41. Between 1990 and 2003, Tennessee, through its Access MedPlus program paid a total of \$10,450,546 to Intracorp for utilization review services. (Exhibit L to Relator's Supplemental Brief in Support of Objections to Proposed Settlement; Relator's Hearing Exhibit 16).

42. The State of California could locate only one contract

in the 1990 to 2005 time-frame between Intracorp and Octagon Risk Services, the third-party administrator for the University of California covering an eight-year period for some \$12 million. (N.T. 6/13/05, 30-33; Relator's Hearing Exhibit 16).

43. Intracorp had contracts with the United States through its Government Employee Health Administration and a portion of the funds paid to Intracorp from the State of Tennessee originated with Medicaid. Although the United States did not undertake to do a calculation of the total amount paid by it to Intracorp, it appears that these funds were well in excess of \$4 million and may have been in excess of the Relator's estimated figure of \$12 million. (Relator's Hearing Exhibits 16, 18; Exhibit M to Relator's Supplemental Brief in Support of Objections to Proposed Settlement).

44. Although the investigations which each of the government entities undertook into the Relator's allegations against Intracorp in this case were not extensive and could have been more thorough, they were sufficient to permit an objective and accurate assessment as to the veracity of Relator's claims, the likelihood of successfully proving Relator's claims to a jury, the risks of establishing liability and damages, the complexity, expense and likely duration of the litigation, and the range of reasonableness of a settlement fund to a possible recovery in light of the best recovery possible. (Exhibits G-Q

of Relator's Supplemental Brief in Support of Objections to Proposed Settlement).

45. In or about mid-2003 after multiple mediation sessions before United States Magistrate Judge Thomas Rueter, the government entities entered into a settlement agreement with Intracorp. Under the terms of that agreement, Intracorp agreed to pay the total sum of \$1,650,000 to be divided among the states and the United States as follows: \$406,250 to the United States, \$100,000 each to Delaware, California, Florida and Nevada, \$625,000 to Illinois and \$218,750 to Tennessee. In addition, Intracorp agreed to a three-year monitoring agreement to be overseen by the United States through Health Advocate, Inc., an independent monitor. (Exhibit A to Defendant's 12/31/03 Response to Relator's Objections to Proposed Settlement).

46. Under the monitoring agreement, Intracorp is required to provide a report on 1005 of its cases to Health Advocate on a quarterly basis detailing Intracorp's compliance with URAC standards relating to timeliness, application of appropriate guidelines by its Health Service Specialists, Registered Nurses and Associate Medical Directors and appropriate jurisdictional requirements. Health Advocate shall determine the process for selecting the 1005 cases that Intracorp shall include in its report and the criteria for selection of these 1005 cases shall change every quarter. From these 1005 cases, Health Advocate

will audit Intracorp's compliance using URAC's 80% rule.

(Relator's Hearing Exhibit 34, ¶s2, 3).

47. The monitoring agreement further provides that Health Advocate will conduct two on-site reviews of Intracorp per year, during which time it will conduct side-by-side monitoring of Intracorp's review personnel. Health Advocate will thereafter report its findings to the United States Department of Justice. Intracorp will be given the opportunity to comment on such reports and will be afforded a period of thirty days to bring itself into compliance in the event it is found non-compliant. Should Intracorp fail to bring itself into compliance within this time period, it is subject to penalties of \$1,000 per day until such time as it becomes compliant. (Relator's Hearing Exhibit, ¶s 4-7).

48. Via Order dated May 12, 2005, this Court granted the Motion of the Realtor to set the value of the monitoring agreement at \$1.5 million, giving the proposed settlement a total value of \$3,150,000.

Discussion

The gravamen of Relator's cause of action in this case is that Intracorp submitted false claims to the United States and to the States of California, Delaware, Florida, Illinois, Nevada and Tennessee in excess of \$100 million as the result of improperly performed contracts and fraudulent representations concerning the

manner in which it performed utilization review ("UR") services. Relator further avers that Intracorp's UR practices pose a danger to the general public in that the defendant's conduct may have resulted in individuals not receiving appropriate and necessary medical care. (See, e.g., Relator's Supplemental Brief in Support of Relator's Objections to Proposed Settlement, at pp. 2-3).

In making these assertions, Relator invokes the False Claims Acts of the United States and the enumerated states. Specifically, the United States' False Claims Act, 31 U.S.C. §3729, provides in relevant part:

(a) Liability for certain acts.-Any person who-

(1) knowingly presents, or causes to be presented, 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;

(2) 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;

(3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;

(4) has possession, custody, or control of property or money used, to be used, by the Government and, intending to defraud the Government or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt;

(5) authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(6) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or

(7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,

is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person, except that if the court finds that-

(A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;

(B) such person fully cooperated with any Government investigation of such violation; and

(C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation;

the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of the person. A person violating this section shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

(b) Knowing and knowingly defined.-For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information-

(1) has actual knowledge of the information;

(2) acts in deliberate ignorance of the truth or falsity

of the information; or

(3) acts in reckless disregard of the truth or falsity of the information,

and no proof of specific intent to defraud is required.

(c) Claim defined.—For purposes of this section, “claim” includes 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 the United States Government provides any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

...

The False Claims Acts of California, Delaware, Florida, Illinois, Nevada and the Tennessee Medicaid False Claims Act read similarly and are substantively the same as the FCA under the United States Code. See, Cal. Gov. Code §§12650, 12651 and 12652; 6 Del. Code §§1201-1208; Fla. Stat. §§68.081-68.092; 740 Ill. Comp. Stat. §175/1-§175/5; Nev. Rev. Stat. §357.040, *et. seq.* and Tenn. Code Ann. §71-5-181, *et. seq.* Accordingly, our analysis of the federal claims shall apply equally to the states’ claims. See, e.g., United States ex. rel. Bannon v. Edgewater Hospital, Inc., Civ. A. No. 00 C 7036, 2005 U.S. Dist. LEXIS 8109 (N.D. Ill. April 14, 2005)(“Both the FCA and the Illinois Whistleblower Reward and Protection Act require that EMC have knowingly submitted, made, brought, authorized or received a false claim...”); Pfingston v. Ronon Engineering Co., 284 F.3d 999, 1003, n.2 (9th Cir. 2002)(noting concession that there is no

material difference between federal False Claims Act and California False Claims Act); United States ex. rel. Humphrey v. Franklin-Williamson Human Services, Inc., 189 F.Supp.2d 862, 867 (S.D.Ill. 2002)(noting that the Illinois Whistleblower Act tracks the relevant provisions of the federal False Claims Act almost word for word).

To establish a *prima facie* claim under 31 U.S.C. §3729(a)(1), a plaintiff must show that: "(1) the defendant presented or caused to be presented to an agent of the United States a claim for payment; (2) the claim was false or fraudulent; and (3) the defendant knew the claim was false or fraudulent." United States ex. rel. Schmidt v. Zimmer, Inc., 386 F.3d 235, 242 (3d Cir. 2004), quoting Hutchins, 253 F.3d at 182. See Also, United States ex. rel. Hartman v. Allegheny General Hospital, Civ. A. No. 02-1948, 2005 U.S. Dist. LEXIS 18321 (W.D.Pa. Aug. 26, 2005). In order to make out a *prima facie* case under §3729(a)(2), known as the false statements prong of the FCA, a plaintiff must also show that the defendant made or used (or caused someone to make or use) a false record in order to cause the false claim to be actually paid or approved. United States ex. rel. Schmidt v. Zimmer, Inc., Civ. A. No. 00-1044, 2005 U.S. Dist. LEXIS 15648 at *4 (E.D.Pa. July 29, 2005), citing Schmidt, 386 F.3d at 242. In addition, in order to establish the requisite knowledge, a plaintiff must demonstrate that the

alleged offender had actual knowledge that it submitted a false or fraudulent claim for payment, or acted in deliberate ignorance or reckless disregard of the truth or falsity of the claim for payment. United States ex. rel. Watson v. Connecticut General Life Insurance Company, No. 03-1639, 87 Fed. Appx. 257, 260, 2004 U.S. App. LEXIS 1736 at *6 (3d Cir. Jan. 16, 2004).

Of course, "not all false statements made to the federal government are claims within the meaning of the False Claims Act; only actions which have the purpose and effect of causing the government to pay out money are clearly 'claims' within the purpose of the Act." Hutchins, 253 F.3d at 183, quoting, *inter alia*, United States v. Greenberg, 237 F.Supp. 439, 442 (S.D.N.Y. 1965) and United States v. Lawson, 522 F.Supp. 746, 750 (D.N.J. 1981). In other words the False Claims Act at least requires the presence of a claim, a call upon the government fisc, for liability to attach. United States ex. rel. Atkinson v. Pennsylvania Shipbuilding Co., 255 F.Supp.2d 351, 365 (E.D.Pa. 2002). In this way, the False Claims Act reaches "all fraudulent attempts to cause the Government to pay out sums of money." United States ex. rel. Quinn v. Omnicare, Inc., 382 F.3d 432, 438 (3d Cir. 2004), quoting United States ex. rel. Clausen v. Laboratory Corporation of America, 290 F.3d 1301, 1311 (11th Cir. 2002). It is, however, noteworthy that the statute adds that no proof of specific intent to defraud is required. United

States ex. rel. Cantekin v. University of Pittsburgh, 192 F.3d 402, 411 (3d Cir. 1999).

An action under the False Claims Acts can be commenced in one of two ways. The United States Department of Justice (or the states' attorneys general under the state Acts) can file suit, or, alternatively, a private plaintiff can institute a qui tam action on behalf of the United States (or the individual State) to recover damages incurred due to fraudulent claims. United States of America ex. rel. Drescher v. Highmark, Inc., 305 F.Supp.2d 451, 453 n.1 (E.D.Pa. 2004), citing 31 U.S.C. §3730(b)(1) and Hutchins v. Wilentz, Goldman & Spitzer, 253 F.3d 176, 181 (3d Cir. 2001), *cert. denied*, 536 U.S. 906 (2002). When suit is brought by a private plaintiff in this fashion, the government can elect to intervene. Id., citing 31 U.S.C. §3730(b)(2). The private plaintiff, known as the relator, will receive up to 25% of the recovered funds if the qui tam suit proves successful. Id., citing 31 U.S.C. §3730(d).

If, however, the government proceeds with the action, it shall have the primary responsibility for prosecuting the action and shall not be bound by an act of the person bringing the action, although that person has the right to continue as a party to the action subject to certain limitations. 31 U.S.C. §3730(c)(1). The government also has the right to dismiss and to settle the action notwithstanding the relator's objection. 31

U.S.C. §3730(c)(2)(A) and (B). In the case of a settlement, Section 3730(c)(2)(B) provides,

The Government may settle the action with the defendant notwithstanding the objections of the person initiating the action if the court determines, after a hearing, that the proposed settlement is fair, adequate and reasonable under all the circumstances. Upon a showing of good cause, such hearing may be held in camera.

In our Order of May 13, 2004, we observed that although no court has yet to define what the statute meant by "fair, adequate and reasonable," the legislative history of the 1986 Amendments to the False Claims Act suggested that the test to be employed in ascertaining whether a settlement under the FCA was "fair, adequate and reasonable under all the circumstances," was the same as that used in reviewing class action settlements.⁶ Thus, applying the well-settled Third Circuit precedent for evaluation of class action settlements first articulated in Girsch v. Jepson, 521 F.2d 153, 156 (3d Cir. 1975), we concluded that the following factors would be utilized in our determination of whether the settlement in this case was fair, adequate and reasonable: (1) the complexity, expense and likely duration of the litigation, (2) the reaction of the class to the settlement,

⁶ This is undoubtedly because "[w]hen Congress borrows language from one statute and incorporates it into a second statute, the language of the two acts ordinarily should be interpreted the same way." In Re Community Bank of Northern Virginia, 418 F.3d 277, 295-296 (3d Cir. 2005), citing Morales v. Trans World Airlines, Inc., 504 U.S. 374, 383-384, 112 S.Ct. 2031, 119 L.Ed.2d 157 (1992); Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 144-145, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990); Oscar Mayer & Co. v. Evans, 441 U.S. 750, 756, 99 S.Ct. 2066, 60 L.Ed.2d 609 (1979).

(3) the stage of the proceedings and the amount of discovery completed, (4) the risks of establishing liability, (5) the risks of establishing damages, (6) the risks of maintaining the class action through trial, (7) the ability of the defendants to withstand a greater judgment, (8) the range of reasonableness of the settlement fund to a possible recovery in light of the best possible recovery and (9) the range of reasonableness of the settlement fund to a possible recovery in light of all the attendant risks of litigation. See also, In re Warfarin Sodium Litigation, 391 F.3d 516, 534-535 (3d Cir. 2004); In re Prudential Insurance Co. Of America Sales Litigation, 148 F.3d 283, 317 (3d Cir. 1998).

Applying the first and third of the foregoing factors to the case at hand⁷, we first note that this case, which was initiated six years ago and has already had a long and protracted history of legal wrangling including the filing of numerous motions and disputes over discovery and exchange of documents, is a complex and expensive one that could conceivably take several more years and many more dollars in legal fees to resolve.⁸ Although

⁷ Given that this is not a class action, we shall not discuss the sixth factor, *i.e.*, the risks of maintaining the class action through trial and will modify our examination of the second factor to consider the reaction of the Relator to the proposed settlement rather than consider the reaction of the class thereto.

⁸ As the Third Circuit has observed, the first Girsch factor "captures the probable costs in time and money of continued litigation." In re Warfarin Sodium Antitrust Litigation, *supra.*, 391 F.3d at 535-536.

significant discovery has already been exchanged, no depositions have been taken to date and the Relator has suggested and the government entities have not disputed, that still more discovery would need to be taken before the case would be trial-ready. We therefore find that these factors militate in favor of settlement.

The second factor, that of the reaction of the Relator to the settlement, clearly favors rejection of the proposed settlement. Indeed, the Relator strenuously opposes the proposed settlement as grossly inadequate given what he believes to be the strength of the evidence of Intracorp's intentional wrongdoing and knowing failures with respect to the provision of adequate written criteria, training and quality assurance programs and controls. He further opposes the proposed settlement as not sufficiently protective of his interests and as not properly considering the hardships which he has endured generally and at the hands of Intracorp specifically, in bringing this action. See, e.g., United States ex. re. Dunleavy v. County of Delaware, 123 F.3d 734, 739 (3d Cir. 1997). However, while we find that Intracorp had obvious deficiencies in its operations, we cannot find that the record evidence supports a conclusion that Intracorp was anything more than negligent with respect to those deficiencies. In short, we cannot and do not draw the same conclusions from the evidence before us that the Relator does.

Furthermore, while it is clear that Dr. Nudelman has endured both emotional and financial hardships and has significantly invested time, money and energy in pursuing this case and although the statutes provide that he would be entitled to a larger share of the proceeds if he were to prosecute it, as discussed below, we find that a question exists as to how much more he would be able to recover if he were to take this matter to a jury trial.

Turning next to the fourth and fifth factors, we note that Dr. Nudelman brought this action in April, 2000 by filing his complaint under seal pursuant to the FCA. After numerous extensions of the seal at the request of the United States, the case was eventually unsealed in its entirety in August, 2003. Relator here advances two theories in support of his contention that Intracorp violated the False Claims Acts: (1) Intracorp falsely certified that it was URAC-accredited when it in fact was out of compliance with URAC's standards, and/or (2) Intracorp fraudulently procured URAC-accreditation by misrepresenting the manner in which it actually conducted utilization review. As a result, Relator submits that the utilization review services which Intracorp did provide were worthless.

Although the Third Circuit has yet to formally adopt it, the "false certification theory" of FCA liability is based on a false representation of compliance with a contract term, statute or regulation--when payment is conditioned on compliance with that

requirement. Omnicare, 382 F.3d at 441. See Also, United States ex. rel. Cooper v. Gentiva Health Services, Inc., Civ. A. No. 01-508, 2003 U.S. Dist. LEXIS at *6-*9 (W.D.Pa. Nov. 4, 2003). It is thus axiomatic that a false certification of compliance with applicable law creates liability under the FCA only when certification is a prerequisite to obtaining a government benefit. Schmidt, 386 F.3d at 243, citing, *inter alia*, United States ex. rel. Hopper v. Anton, 91 F.3d 1261, 1266 (9th Cir. 1996) and Harrison v. Westinghouse Savannah River Co., 176 F.3d 776, 787 (4th Cir. 1999). See Also, United States ex. rel. Hunt v. Merck-Medco Managed Care, LLC, 336 F.Supp.2d 430, 439 (E.D.Pa. 2004) ("Medco was required to submit certifications of its performance which were used to assess contractual penalties and to determine whether its contract with Blue Cross would be renewed. To the extent that these certifications were false, they could have fraudulently induced Blue Cross to renew its contract with Medco.")

Case law in the area of "worthless services" under the FCA addresses instances in which either services literally are not provided or the service is so substandard as to be tantamount to no service at all and is not predicated upon the false certification theory. In Re: Genesis Health Ventures, Inc., No. 03-2313, 112 Fed. Appx. 140, 2004 U.S. App. LEXIS 21170 (3d Cir. Oct. 12, 2004), citing United States ex. rel. Mikes v. Straus,

274 F.3d 687, 702 (2d Cir. 2001) and United States ex. rel. Lee v. Smithkline Beecham, Inc., 245 F.3d 1048, 1053 (9th Cir. 2001).

In this case, although the states did statutorily require that utilization review organizations in their states satisfy many of the same requirements as are imposed by URAC to obtain accreditation, satisfaction of all of URAC's standards was not statutorily mandated and URAC accreditation was not a specific requirement or pre-condition to payment of any of the contracts which Intracorp had with the U.S. or any of the States in this case, with the exception of the contract entered into in June, 1997 between Intracorp and the Illinois Department of Central Management Services. In any event, Intracorp was at all times relevant here, fully accredited by URAC, having first received accreditation in 1991 and having been re-accredited in 1994, 1997, 1999, 2001 and 2003. The record further evinces that Intracorp was periodically audited by URAC and although various deficiencies were at times noted, URAC nevertheless found Intracorp to be sufficiently compliant with its standards to be re-accredited. Thus, regardless of whether Intracorp was or was not in full compliance at all times with URAC's standards, URAC nevertheless found its compliance sufficient to warrant re-accreditation.

However, even assuming the truth of the Relator's allegations that Intracorp falsely represented the manner in

which it performed UR services, there is no evidence that it was required to certify that it was URAC-compliant as a pre-condition to its receiving payment or other government benefit.

Additionally, even accepting as true that what Intracorp was doing by performing UR services which were out-of-compliance with URAC standards constituted the submission of false claims to the government entities for payment, we do not find there to be sufficient evidence that it knew that the claims it was submitting were false or that it recklessly disregarded or was deliberately indifferent to the likelihood that its UR activities equated to false claims. Rather, what the record evidence suggests to this Court is that while Intracorp was aware that the manner in which it performed its services was not always in complete compliance with URAC's standards and that there was room for improvement in its overall operations, Intracorp was consistently trying to correct the known deficiencies and make system-wide improvements in the manner in which it provided services. For these reasons, we find that the government entities and/or the Relator would have significant difficulty in establishing liability under the False Claims Acts against Intracorp.

Furthermore, the services in this matter cannot be said to be completely worthless and we therefore also believe that the governments and/or the Relator would have a difficult time

establishing that the amount of damages to which they are entitled are in the range which Relator claims. For one, the Relator is not challenging the manner in which Intracorp's nurse reviewers performed the first level UM case reviews and he does not dispute that between 90 and 95% of the cases reviewed in the 1991-2000 time frame were certified by the nurse reviewers, with no involvement from the PA's. Consequently, at issue here are only between 5 and 10% of Intracorp's cases in that period of time. *A fortiori*, the services provided in the vast majority of Intracorp's cases clearly had value.

In addition, while there is evidence that Intracorp did not *always*: have PA reviewers in active clinical practice or licensed in every state, timely make its certification decisions, notify treating providers or patients of their appeal rights or provide its PA's with complete or current written clinical review criteria, the record also reflects that it oftentimes did. Thus, although Intracorp's operations were less than perfect 100% of the time, we do not believe that a jury could find that its system of providing utilization management services was so flawed as to be completely worthless. We therefore find that the risks of establishing damages in the amounts urged by Relator also weigh in favor of the settlement brokered here.

We next consider the ability of the defendant to withstand a greater judgment than the settlement amount at issue here,

\$3,150,000.

There is little evidence on this record as to Intracorp's financial ability to withstand a greater judgment, although Relator's counsel has argued and Intracorp has not disputed that Intracorp certainly could withstand a greater judgment given that its parent corporation, CIGNA makes a billion dollars in profit each year. Indeed, Intracorp does advertise on its web site that it reports its earnings under the Life and Disability segment of the CIGNA Corporation and as of December 31, 2005, CIGNA reported \$16.7 billion in revenue. (See, www.intracorp.com). Accordingly, we find that a greater judgment than the amount settled upon in this case would pose no hardship for Intracorp and thus this factor would weigh against approval of the proposed settlement.

In next evaluating the range of reasonableness of the settlement fund to a possible recovery in light of the best possible recovery, we consider the polar-opposite arguments advanced by the Relator and Intracorp. According to the Relator, the best possible recovery would be in excess of \$229 million. Relator bases this figure on his assertion that Intracorp received at least \$76 million over the time period in question from the government entities (accepting that the appropriate measure of damages is the full value of the contracts at issue for the allegedly completely worthless services which Intracorp

provided) and that that figure should be trebled. In contrast, Intracorp asserts that since 95% to 98% of its cases were certified by nurse reviewers and 5% of \$70 million is \$3.5 million, then the settlement is clearly reasonable. While we would agree with Relator that a \$3.15 million settlement would indeed be paltry under his scenario, we have previously rejected Relator's argument that the services which Intracorp provided were wholly without value. Similarly, although we do not wholeheartedly adopt Intracorp's calculations either, its analysis has more logical appeal given that the traditional measure of damages in a false claims act case is the difference between the market value of what the government was promised and what it actually received. See, United States v. Bornstein, 423 U.S. 303, 316, n. 13, 96 S.Ct. 523, 531, n. 13, 46 L.Ed.2d 514, 525 (1976). In consideration of these premises, we believe that the best possible recovery in this case would be in the range of \$6-10 million. Thus, we conclude that resolution of this matter for \$3.15 million would be still be reasonable and that this factor militates in favor of approval of the proposed settlement.

Finally, looking at the range of reasonableness of the proposed settlement to a possible recovery in light of all the attendant risks of litigation and in light of our earlier conclusions that Relator and/or the government entities would have significant difficulties in establishing both liability

under the federal and state false claims acts and that the amount of damages sustained was in excess of \$6 million, we find the settlement brokered here to be a fair, reasonable and adequate one.

Accordingly, this Court having now carefully considered and weighed all of the above-prescribed factors, we enter the following:

Conclusions of Law

1. This Court has jurisdiction over the parties and subject matter of this litigation pursuant to 28 U.S.C. §1331 and 31 U.S.C. §3729 and §3730.

2. The settlement which the government entities have entered into with Defendant Intracorp in this matter is fair, adequate and reasonable under all the circumstances of this case.

3. The settlement which the government entities have entered into with Defendant Intracorp in this matter is properly approved by the Court.

An order follows.

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

UNITED STATES OF AMERICA,	:	CIVIL ACTION
ex. rel. MITCHELL NUDELMAN,	:	
M.D., et. al.	:	
	:	NO. 00-1837
vs.	:	
	:	
INTERNATIONAL REHABILITATION	:	
ASSOCIATES, INC., D/B/A	:	
INTRACORP.	:	

ORDER

AND NOW, this 4th day of April, 2006, upon consideration of the Motion of the United States and the States of California, Delaware, Florida, Illinois, Nevada and Tennessee for Approval of their Proposed Settlement with Defendant International Rehabilitation Associates, Inc., d/b/a Intracorp and following the Fairness Hearing in this Matter on June 13, 2005 and examination of all of the evidence presented by the parties, it is hereby ORDERED that the Motion is GRANTED and the Proposed Settlement of this matter for the total sum of \$3,150,000 is APPROVED.

BY THE COURT:

s/J. Curtis Joyner

J. CURTIS JOYNER, J.