IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

UNITED STATES OF AMERICA	§	
	§	
	§	
	§	
v.	§	**CIVIL ACTION NO. 6:15-CV-948**
	§	
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	§	
TARIQ MAHMOOD	§	
	§	
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	§	

MEMORANDUM OPINION AND ORDER

Before the Court is the United States' Motion for Summary Judgment (ECF 6). The case was transferred to the undersigned with the consent of the parties pursuant to 28 U.S.C. § 636. For the reasons set forth below, the Court **GRANTS in part** the motion for summary judgment.

BACKGROUND

The United States of America ("the Government") filed this action on October 29, 2015 seeking relief against Defendant Tariq Mahmood ("Defendant") pursuant to the False Claims Act ("FCA"), 31 U.S.C. § 3729(a)(1)(A), (B) and (C). Defendant was a licensed physician who owned multiple hospitals in Texas. The Government alleges that Defendant submitted, or caused to be submitted, false and fraudulent claims to Medicare and Medicaid that resulted in a reimbursement of $578,240.41 paid by Medicare and Medicaid to accounts controlled by Defendant. The Government alleges that Defendant caused his hospital employees to manipulate billing codes to fraudulently increase insurance reimbursements.

On April 11, 2013, a federal grand jury returned an Indictment against Defendant on 1 count of Conspiracy to Commit Health Care Fraud, in violation of 18 U.S.C. § 1349, and 1 count of Health Care Fraud, in violation of 18 U.S.C. §§ 1347 and 2. The grand jury returned a First Superseding Indictment on December 18, 2013, on 1 count of Conspiracy to Commit Health Care Fraud, in violation of 18 U.S.C. § 1349, 7 counts of Health Care Fraud, in violation of 18 U.S.C. §§ 1347 and 2, and 7 counts of Aggravated Identity Theft, in violation of 18 U.S.C. §§ 1028A and 2. The case proceeded to a jury trial on July 21, 2014. At trial, the Government identified 85 claims for reimbursement where Defendant directed an employee to secretly access the coding after another employee had entered the codes, and to resequence the diagnosis codes to increase the reimbursement amount. On the substantive health care fraud counts in the First Superseding Indictment, the Government identified 7 specific patients for whom Defendant fraudulently directed the resequencing of diagnosis codes on Medicare claim forms. On July 24, 2014, the jury returned a verdict finding Defendant guilty on all 15 counts of the First Superseding Indictment.

The Court sentenced Defendant on April 14, 2015 to a total term of imprisonment of 135 months, consisting of 63 months of imprisonment on Counts 1 through 8, and 24 months on each of Counts 9 through 15 of the First Superseding Indictment. The Court ordered Counts 9 through 11 to run consecutive to Counts 1 through 8 and Counts 12 through 15 to run concurrently to Counts 1 through 8, for a total of 135 months. The Court additionally calculated the total loss caused by Defendant's fraud to be $599,128.02—the aggregate amount that Center for Medicare and Medicaid Services, Texas Department of Health & Human Services and BCBS reimbursed Defendant's hospitals—and ordered restitution to be paid in the amount of $599,128.02.

After the Court denied Defendant's motion for a new trial, Defendant appealed his conviction and sentence. On appeal, Defendant challenged the sufficiency of the evidence on his health care fraud and aggravated identity theft convictions, the trial court's failure to conduct an evidentiary hearing on his motion for a new trial, and the calculation of the sentence and restitution order. In an opinion filed on April 14, 2016, the Fifth Circuit Court of Appeals affirmed Defendant's convictions and the new trial ruling. The appellate court vacated Defendant's sentence and the restitution order and remanded the case for resentencing. *U.S. v. Mahmood*, 820 F.3d 177 (5th Cir. 2016). The appellate court held that Defendant "carried his burden at sentencing to show that his hospitals rendered legitimate services to patients and that Medicare would have paid substantial sums for those services had he not fraudulently billed them." *Id*. at 194. As a result, the "district court's refusal, without explanation, to credit Mahmood for the $430,639 that Medicare would have reimbursed his hospitals but for his fraud was a legally unacceptable method of calculating the loss." *Id*. This procedural error affected the applicable sentencing guideline range, requiring resentencing. For the same reasons, the restitution amount was determined based on an erroneous calculation of the victims' actual loss, requiring reconsideration on remand.

Following remand, the Court conducted a resentencing hearing on September 14, 2016. In a judgment entered on September 15, 2016, the Court sentenced Defendant to 135 months of imprisonment, consisting of 63 months on Counts 1 through 8 of the First Superseding Indictment and 24 months on Counts 9 through 15 of the First Superseding Indictment. Counts 9, 10 and 11 of the First Superseding Indictment were ordered to run consecutively to the 63-month term of imprisonment, for a total term of 135 months. In addition, the Court ordered the payment of restitution in the amount of $145,358.23.

Prior to the decision of the appellate court, the Government filed the motion for summary judgment that is currently before the Court. In its motion, the Government seeks an award of $2,091,480.82 against Defendant, plus costs and interest. The Government asserts that Defendant is estopped from denying FCA liability as a result of his conviction. The award requested by the Government includes $1,156,480.82 in compensatory damages and $935,000.00 in civil penalties. The Government calculated the compensatory damages amount by trebling the "amount of the claims paid by government payors as a result of Mahmood's fraud" and then subtracting the amount of restitution ordered by the Court.[1] The requested civil penalty of $935,000.00 represents $11,000 for each of 85 claims that were wrongfully submitted to Medicare and Medicaid.

In response, Defendant filed a Combined Rule 56(d) Motion for Continuance; Alternative Motion to Stay Proceedings Pending Outcome of Criminal Appeal; and Response to the Government's Motion for Summary Judgment (ECF 7). In the response, filed prior to the resolution of Defendant's appeal, Defendant asserts the Court should stay this case pending resolution of his appeal in the interest of judicial economy. He also argues that he is not estopped from denying liability as to all 85 fraudulent claims forming the basis of the restitution award because estoppel only applies to claims for the 7 patients identified in the health care fraud counts. Defendant seeks a Rule 56(d) continuance to obtain medical records pertinent to the other 78 patients and have them reviewed by the coding expert that reviewed the medical records of the 7 patients forming the basis for the substantive counts of conviction. Defendant concedes that, unless his convictions are reversed on appeal or in a post-conviction § 2255 motion, he is liable under the FCA for the claims made with respect to the 7 patients identified in the substantive counts of the First Superseding Indictment. As a result of the restitution order and

[1] *See* The United States' Motion for Summary Judgment, ECF 6, at *11–12.

criminal forfeiture provisions, Defendant argues that the Government has been more than made whole in this matter.

After the appellate court issued its April 14, 2016 opinion, the Government filed a Notice of Additional Authority Supporting Summary Judgment (ECF 21). The Government asserts that the holding that the Court must credit Defendant for the $430,639 that Medicare would have reimbursed his hospitals but for his fraud when calculating the amount of restitution due does not affect the amount of damages and civil penalties in this FCA case. The Government submits that its calculation of $1,156,480.82 in damages already includes a credit for restitution.

Defendant responds that the Government's actual damages are only $143,608—the amount of overpayment. If the amount is trebled, the compensatory damages are $430,924. With regard to civil penalties, the possible range is $467,500 to $935,000, representing a penalty of not less than $5,500 and not more than $11,000 for each false claim. Defendant argues that the restitution amount of $143,608 should be deducted from the final amount due.

SUMMARY JUDGMENT STANDARD

The Court may only grant a motion for summary judgment when there is no genuine dispute of material fact and the moving party is entitled to summary judgment as a matter of law. FED. R. CIV. P. 56(a). A genuine dispute as to a material fact exists "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). A "material fact" is one that might affect the outcome of the suit under governing law. *Id*. The party seeking summary judgment always bears the initial responsibility of informing the district court of the basis for its motion and identifying those portions of the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, which it believes demonstrate the

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