Relator Awards in Inpatient vs. Out-Patient Billing to Defraud Medicare

Two **whistleblowers** received a **Relator fee** of **$15 million** and **$12.4 million** of the recovery from an over **$260 million settlement** in September of 2018, in which a Florida-based hospital chain agreed to resolve criminal and civil charges for allegedly billing for inpatient services that should have been billed as outpatient services, remunerating physicians for referrals, and inflating claims for emergency department fees. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Hospital Chain Will Pay Over $260 Million to Resolve False Billing and Kickback Allegations; One Subsidiary Agrees to Plead Guilty (Sept. 25, 2018), https://www.justice.gov/opa/pr/hospital-chain-will-pay-over-260-million-resolve-false-billing-and-kickback-allegations-one.

The **whistleblower,** a former director of improvement at one of the California hospitals, **received a Relator fee** of over **$17.2 million** of the recovery from a **$65 million settlement** in August of 2018, in which Prime Healthcare Services agreed to settle allegations that 14 of its California hospitals admitted Medicare patients for unnecessary inpatient treatment and up-coded claims by falsifying information about patient diagnoses. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Prime Healthcare Services and CEO to Pay $65 Million to Settle False Claims Act Allegations (Aug. 3, 2018), https://www.justice.gov/opa/pr/prime-healthcare-services-and-ceo-pay-65-million-settle-false-claims-act-allegations.

The **whistleblower,** a former employee of the company, received a **Relator Fee** of approximately **$3.3 million** of the recovered amount from an over **$18 million settlement** in which Banner Health agreed to resolve allegations that 12 of its hospitals knowingly overcharged Medicare patients for short-stay, inpatient procedures that should have been billed on a less costly outpatient basis. The settlement also resolved claims that the company inflated the number of hours for which patients received outpatient observation in its reports to Medicare. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Banner Health Agrees to Pay Over $18 Million to Settle False Claims Act Allegations (Apr. 12, 2018), https://www.justice.gov/opa/pr/banner-health-agrees-pay-over-18-million-settle-false-claims-act-allegations.

The **relators received** approximately **$4.75 million from a settlement** of **$28 Million in** December of 2015, in a case where 32 hospitals agreed to resolve allegations that the hospitals submitted false claims to Medicare. The hospitals allegedly billed Medicare for inpatient kyphoplasty procedures when the procedures can typically be performed on a less costly outpatient basis. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, 32 Hospitals to Pay U.S. More Than $28 Million to Resolve False Claims Act Allegations Related to Kyphoplasty Billing (Dec. 18, 2015), http://www.justice.gov/opa/pr/32-hospitals-pay-us-more-28-million-resolve-false-claims-act-allegations-related-kyphoplasty.

The ***qui tam* whistleblower** who filed the complaint, a former employee of the hospital system, **received** a **Relator Fee** of about **$6.25 million from a $37 Million settlement** in October 30 of 2014. In that case, Dignity Health agreed to resolve claims that it charged the government for costlier inpatient services when the patients could have been billed on an outpatient basis. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Dignity Health Agrees to Pay $37 Million to Settle False Claims Act Allegations (Oct. 30, 2014), http://www.justice.gov/opa/pr/dignity-health-agrees-pay-37-million-settle-false-claims-act-allegations.

The **whistleblower** that originally filed the case **received $5.95 million** as her **Relator share** in a **$35 million settlement** in August of 2014, when Carondelet Health Network agreed to resolve allegations that its hospitals submitted false bills to Medicare because these hospitals submitted inpatient rehabilitation facility services to Medicare, the Federal Employees Health Benefit Program, and the Arizona Health Care Cost Containment System that were not properly reimbursable under applicable coverage criteria as the patients did not qualify for those services. *See* Press Release, U.S. Attorney's Office, Dist. of Ariz., U.S. Dep't of Justice, Carondelet Health Network to Pay $35 Million to Resolve False Claims Allegations Involving St. Joseph's and St. Mary's Hospitals in Tucson (August 18, 2014),http://www.justice.gov/usao/az/press_releases/2014/PR_08182014_Carondelet.html.

In a case initiated by several *qui tam* lawsuits filed by whistleblowers, in August of 2014, Community Health Systems Inc. agreed to pay a total of **$98.15 million** to settle multiple lawsuits. The government alleged that from 2005 to 2010 the company knowingly billed government health care programs for more expensive inpatient services when it should have billed those services as outpatient or observation services. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Community Health Systems Inc. to Pay $98.15 Million to Resolve False Claims Allegations (August 4, 2014), http://www.justice.gov/opa/pr/community-health-systems-inc-pay-9815-million-resolve-false-claims-act-allegations.

On June 12, 2014, a hospital group agreed to pay **$26 million** to settle allegations that six of its hospitals had submitted inpatient claims for services only billable as outpatient services. An auditing company filed the *qui tam* suit that led to this settlement. *See* Erica Teichert, Shands Settles Remainder of $26M FCA Suit (June 12, 2014), http://www.law360.com/health/articles/547263?nl_pk=e74caebe-c678-4136-8e21
d6fb0277f050&utm_source=newsletter&utm_medium=email&utm_campaign=health.

In July of 2013, the DOJ announced that 55 hospitals, located in 21 states, agreed to pay more than **$34 million** to settle allegations that the settling hospitals billed Medicare for kyphoplasty procedures on an inpatient basis, rather than outpatient basis, to increase Medicare billing. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Fifty-Five Hospitals to Pay U.S. More than $34 Million to Resolve False Claims Act Allegations Related to Kyphoplasty (July 2, 2013), *http://www.justice.gov/opa/pr/2013/July/13-civ-745.html.*

In August of 2013, the DOJ announced that a group of health care providers agreed to settle a *qui tam* lawsuit for **$26 million.** Six of the group's health care facilities were accused of submitting false claims to Medicare, Medicaid, and other federal health care programs for inpatient procedures that should have been billed as outpatient services. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Shands Healthcare to Pay $26 Million to Resolve Allegations Related to Inpatient Stays at Six Florida Hospitals (Aug. 19, 2013), *http://www.justice.gov/opa/pr/2013/August/13-civ-936.html.*

In a ***qui tam*** **lawsuit** filed by a former employee, who received more than **$1.8 million** as her **relator's share from a $10.1 million settlement** in November of 2012, involving a group of Florida hospitals who agreed to resolve allegations that they allegedly overbilled for certain interventional cardiac and vascular procedures as inpatient when they should have been billed as less costly outpatient or observational care matters. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Group of Owned and Affiliated Florida Hospitals Agree to Pay US $10.1 Million to Resolve False Claims Act Allegations (Nov. 20, 2012), *http://www.justice.gov/opa/pr/2012/November/12-civ-1391.html*