Relator Fees and Settlements in Unnecessary Lab And Diagnostic Test Cases

In November of 2019, the **whistleblowers received $4.4 Million** as their share of the government's recovery when a laboratory company agreed to pay **$26.7 million** to settle allegations that it violated the AKS and the Stark Law, as well as allegations that it improperly billed claims to the federal government for laboratory testing. The settlement resolved claims that the laboratory agreed to provide laboratory testing for small Texas hospitals in exchange for per-test payments. The physicians involved allegedly referred patients to the Texas hospitals for laboratory testing performed by the company, which were then billed to Medicare, Medicaid, and TRICARE. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Laboratory to Pay $26.67 Million to Settle False Claim Act Allegations of Illegal Inducements to Referring Physicians (Nov. 26, 2019), https://www.justice.gov/opa/pr/laboratory-pay-2667-million-settle-false-claims-act-allegations-illegal-inducements-referring.

In November of 2019, the **whistleblower received $1.9 Million** as her share of the government's recovery when a hospital pharmacy agreed to pay **$10 million** to the federal government to settle claims that it violated the FCA by submitting false claims to Medicare for prescription drugs that did not meet Medicare coverage requirements. The settlement also resolved allegations that the company submitted claims to Medicare that resulted from improper remuneration provided to Medicare beneficiaries in the form of free blood glucose testing supplies and waiver of co-payments and deductibles for insulin. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Kentucky Hospital to Pay over $10 Million to Resolve False Claims Act Allegations (Nov. 20, 2019), https://www.justice.gov/opa/pr/kentucky-hospital-pay-over-10-million-resolve-false-claims-act-allegations.

In October of 2019, an eye doctor group, its former CEO, and several physicians paid the United States and California nearly **$6.7 million** to settle allegations that they billed for medically unnecessary eye exams, improperly waived Medicare co-payments, and violated other regulations. The settlement resolved claims that personnel improperly billed Medicare and Medicaid/Medi-Cal by misclassifying simpler exams as being more complex, and also waived Medicare co-payments and deductibles without proper documentation of patients' financial hardship in an effort to receive referrals. *See* Press Release, U.S. Atty's Office for the C. Dist. of Cal., Eye Doctor Group, Physicians Pay $6.65 Million to Settle Allegations They Submitted Fraudulent Bills to Medicare and Medicaid (Oct. 4, 2019),

https://www.justice.gov/usao-cdca/pr/eye-doctor-group-physicians-pay-665-million-settle-allegations-they-submitted.

In October of 2019, a genetic testing company agreed to pay **$42.6 million** in total to settle claims that they violated the FCA by paying kickbacks to physicians in exchange for laboratory referrals and for providing and billing medically unnecessary tests. The company and its principals allegedly paid the kickbacks to induce orders of pharmacogenetic tests, in return for the physicians' participation in a clinical trial. The federal government also alleged that the company and its principals furnished tests that were not medically necessary and billed Medicare. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Genetic Testing Company and Three Principals Agree to Pay $42.6 Million to Resolve Kickback and Medical Necessity Claims (Oct. 9, 2019), https://www.justice.gov/opa/pr/genetic-testing-company-and-three-principals-agree-pay-426-million-resolve-kickback-and.

In October of 2019, the **whistleblower received 27.5%** of a settlement when Fresenius agreed to pay **$5.2 million** to settle claims that the company tested dialysis patients for Hepatitis B more than medically necessary and then billed Medicare for those tests. The government alleged that the company conducted, and billed Medicare for, tests of patients it knew to be immune to Hepatitis B infection. *See* Press Release, U.S. Atty's Office for the Dist. of Mass., Fresenius Agrees to Pay $5.2 Million to Resolve Allegations that it Overbilled Medicare for Hepatitis B Tests (Oct. 9, 2019), https://www.justice.gov/usao-ma/pr/fresenius-agrees-pay-52-million-resolve-allegations-it-overbilled-medicare-hepatitis-b.

In October of 2019, the whistleblower received **$857,550** when seven clinics and their owners agreed to pay the federal government more than **$7.1 million** to settle allegations that they violated the FCA by submitting false claims to Medicare for medically unnecessary knee injections and knee braces. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Former Osteo Relief Institutes and Their Owners to Pay Over $7.1 Million to Resolve Allegations of Unnecessary Knee Injections and Braces (Oct. 18, 2019), https://www.justice.gov/opa/pr/former-osteo-relief-institutes-and-their-owners-pay-over-71-million-resolve-allegations.

The **whistle-blower,** a former senior quality control analyst at the subsidiary, **received a Relator Fee of approximately $5.6 million** of the recovered amount from an approximately **$33.2 million Settlement** in March of 2018, in a case involving a medical device manufacturer with Alere agreeing to resolve claims that

its subsidiary caused hospitals to submit false claims to government health care programs by knowingly selling materially unreliable point-of-care diagnostic testing devices. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Alere to Pay U.S. $33.2 Million to Settle False Claims Act Allegations Relating to Unreliable Diagnostic Testing Devices (Mar. 23, 2018), https://www.justice.gov/opa/pr/alere-pay-us-332-million-settle-false-claims-act-allegations-relating-unreliable-diagnostic.

The **whistle-blower** received a **Relator Fee** of approximately **$1.6 million** as part of the settlement when in April of 2018, Rotech (a respiratory equipment supplier) agreed to pay approximately **$9.7 million** to settle allegations that it knowingly submitted false claims for portable oxygen contents to Medicare between January 2009 and March 2012. The government alleged that the company billed Medicare without verifying that beneficiaries used or needed the oxygen, and without obtaining the requisite proof of delivery. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Rotech Agrees to Pay $9.68 Million to Settle False Claims Act Liability Related to Improper Billing for Portable Oxygen (Apr. 12, 2018), https://www.justice.gov/opa/pr/rotech-agrees-pay-968-million-settle-false-claims-act-liability-related-improper-billing.

In April of 2018 a diagnostics laboratory agreed to pay **$2 million** to settle claims that it submitted and caused the submission of false claims to Medicare for Breast Cancer Index tests that were not reasonable and necessary. The government alleged the company promoted and performed the tests for patients who had not been in remission for five years and who had not been taking tamoxifen. The government claimed performing tests under such circumstances is medically unnecessary based on published clinical trial data and clinical practice guidelines. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, San Diego Laboratory Agrees to Pay $2 Million to Settle False Claims Act Allegations Related to Unnecessary Breast Cancer Testing (Apr. 19, 2018), https://www.justice.gov/opa/pr/san-diego-laboratory-agrees-pay-2-million-settle-false-claims-act-allegations-related.

In February of 2017, a pain management physician agreed to the entry of a **$20 million** consent judgment to settle claims brought by three whistleblowers in two lawsuits that the physician billed for medically unnecessary diagnostic tests and surgical monitoring services that were never performed. *See* Press Release, U.S. Atty's Office for the Eastern Dist. of Ky., U.S. Dep't of Justice, Pain Management Physician Resolves False Claims Act Allegations (Feb. 1, 2017), https://www.justice.gov/usao-edky/pr/pain-management-physician-resolves-false-claims-act-allegations.

In July of 2016, a federal district court judge ordered two New Jersey-based diagnostic imaging companies and their owners to pay **$7.75 million** for submitting falsified diagnostic test reports, underlying tests, and claims for neurological tests conducted without physician supervision. *See* Press Release, U.S. Atty's Office for the Eastern Dist. of N.J., U.S. Dep't of Justice, New Jersey Couple And Two Diagnostic Companies Ordered To Pay $7.75 Million For Falsifying Diagnostic Test Reports And Failing To Properly Supervise Tests (July 12, 2016), https://www.justice.gov/usao-nj/pr/new-jersey-couple-and-two-diagnostic-companies-ordered-pay-775-million-falsifying.

In January of 2016, the former owner of Bostwick Laboratories agreed to pay up to **$3.75 million** for reimbursements for cancer detection tests that allegedly were not medically necessary or performed without a treating physicians' consent or order. In addition, the government asserted that the laboratory offered various discounts and billing arrangements to induce physicians to conduct business with the laboratory. The settlement provided for a guaranteed $2.6 million payment, with up to an additional $1.125 million to be paid within the next five years for certain financial contingencies. For his role in the two settlements, a **whistleblower received more than $2.5 million.** *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Former Owner of Bostwick Laboratories Agrees to Pay Up to $3.75 Million to Resolve Allegations of Unnecessary Testing and Illegal Remuneration to Physicians (Jan. 8, 2016), https://www.justice.gov/opa/pr/former-owner-bostwick-laboratories-agrees-pay-375-million-resolve-allegations-unnecessary.

In July of 2016, Preferred Imaging, LLC agreed to pay **$3.51 million** to resolve alleged federal and Texas Medicaid Fraud and Prevention Act violations. The government alleged that independent diagnostic facilities operated by the company performed certain procedures without required physician supervision on-site. *See* Press Release, U.S. Atty's Office for the Northern Dist of Tex., U.S. Dep't of Justice, Preferred Imaging, LLC to Pay $3,510,000 to Resolve False Claims Act Allegations (July 22, 2016), https://www.justice.gov/usao-ndtx/pr/prefered-imaging-llc-pay-3510000-resolve-false-claims-act-allegations.

In November of 2016, Zwanger & Pesiri Radiology Group, LLP, and Zwanger Radiology, P.C., entered into a settlement agreement to resolve allegations that they billed Medicare and Medicaid for radiology testing performed or

supervised by physicians who were not properly credentialed with Medicare and Medicaid programs, or which were performed at an unauthorized practice location. The defendants agreed to pay **$8.1 million** to resolve their federal and state civil FCA liability. *See* 2016 OIG Annual Report.

In April 2017, Valley Tumor Medical Group (Valley Tumor) in California paid **$3 million** to resolve federal FCA allegations that from January 2006 through November 2015, it billed Medicare, Medi-Cal (California's Medicaid program), and TRICARE for radiation treatments at the Ridgecrest location without the requisite physician supervision. Specifically, radiation therapists employed by Valley Tumor allegedly regularly administered radiation treatments when no doctor was present on-site and, thus, physically available to supervise such treatments. *See* 2017 OIG Annual Report.

In June 2017, AMI Monitoring Inc., also known as Spectocor, Spectocor's owner, Medi-Lynx Cardiac Monitoring LLC, and Medicalgorthmics SA agreed to pay approximately **$13.5 million** to resolve civil FCA allegations that they billed Medicare for higher and more expensive levels of cardiac monitoring services than requested by the ordering physicians. *See* 2017 OIG Annual Report.

In October 2016, NeuroScience, Inc., its founder, and Pharmasan Labs, Inc. (collectively, "defendants"), entered into a settlement agreement to resolve allegations that they submitted false claims to Medicare and TRICARE for urinary transmitter testing. The defendants agreed to pay **$6.1 million** to resolve their liability under the civil FCA. *See* 2016 OIG Annual Report.

In April 2017, Quest Diagnostics agreed to pay **$6 million** to settle civil FCA allegations that Berkeley HeartLab Inc. made payments to physicians and patients to induce the use of Berkeley for blood testing services for medically unnecessary tests in violation of the Anti-Kickback Statute. The government alleged that Berkeley paid kickbacks to referring physicians disguised as "process and handling" fees. *See* 2017 OIG Annual Report.

On August 31, 2016, a health services provider agreed to pay **$7.4 million** to resolve allegations that it sought reimbursement for medically unnecessary drug screening procedures in violation of the FCA. The government alleged that the company performed expensive "quantitative drug tests" on all patients

in its care, even though these are generally only to be performed when there is reason to doubt the results of less expensive "qualitative drug tests." *See* Press Release, U.S. Atty's Office for the Middle Dist. of Fla., U.S. Dep't of Justice, United States Settles False Claims Act Allegations Against Coastal Spine And Pain For $7.4 Million (Aug. 31, 2016), https://www.justice.gov/usao-mdfl/pr/united-states-settles-false-claims-act-allegations-against-coastal-spine-and-pain-74.

In April 2016, a psychiatrist at Riverside General Hospital (Riverside) in Texas was sentenced to 12 years in prison and ordered to pay **$6.3 million** in restitution. A jury convicted the psychiatrist of conspiracy to commit health care fraud, health care fraud, and making false statements relating to health care matters. According to evidence presented at trial, from 2006 until 2012 the psychiatrist and others engaged in a scheme to defraud Medicare by submitting through Riverside approximately $158 million in false claims for partial hospitalization program (PHP) services, an intensive outpatient treatment for severe mental illness. **Six defendants** involved in the scheme were previously sentenced to a combined **120 years in prison** and ordered to pay **$46.7 million** in **restitution**, joint and several. *See* 2016 OIG Annual Report.

In October of 2015, Millennium Health, LLC (Millennium)—formerly Millennium Laboratories of San Diego, California—paid **$205.6 million** to resolve civil FCA allegations that it billed federal health care programs for medically unnecessary urine drug testing and genetic testing, and paid physicians kickbacks in exchange for referrals for those tests. Millennium allegedly caused physicians to order unnecessary urine drug tests (in some instances, dozens per patient) and unnecessary genetic testing without an individualized assessment of each patient's needs for those tests. To further propagate its urine drug testing scheme, Millennium allegedly provided free urine drug test cups to physicians, expressly conditioned on the physicians' agreement to return the urine specimens to Millennium for additional testing. *See* 2015 OIG Annual Report.

In August 2016, the two owners and operators of Biosound Medical Services Inc. and Heart Solutions (collectively, "Biosound"), of Parsippany, New Jersey, were **sentenced to 100 and 78 months** respectively in prison for health care fraud. In July 2016 they were also ordered to pay the United States **$5 million in damages and $2.8 million** in civil monetary penalties. Biosound provided mobile diagnostic testing, including ultrasounds, echocardiograms and nerve conduction studies that were used to diagnose heart defects, blood clots, abdominal aortic aneurysms and other serious medical conditions. Both owners admitted to falsely representing to Medicare that the neurological testing performed by Biosound was being supervised by a licensed neurologist. *See* 2016 OIG Annual Report.

In a case began as a *qui tam* lawsuit filed by a former medical assistant for the provider, the **whistleblower** received a **Relator Fee of $3.2 million** from the **$19.75 million settlement** proceeds from a settlement in December of 2015, when 21st Century Oncology agreed to settle allegations that it submitted claims to federal health care programs for medically unnecessary laboratory tests. The provider also allegedly incentivized four doctors to order the unnecessary tests by providing bonuses that were partially based on the number of tests referred to the provider's laboratory. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, 21st Century Oncology To Pay $19.75 Million to Settle Alleged False Claims For Unnecessary Laboratory Tests (Dec. 18, 2015), http://www.justice.gov/usao-mdfl/pr/21st-century-oncology-pay-1975-million-settle-alleged-false-claims-unnecessary.

The *qui tam* relators received a **Relator Fee** of approximately **$32 million** share from a **$256 million settlement** in October of 2015, when Millennium Health agreed to settle claims that the company violated the FCA by billing federal health care programs for unnecessary drug and genetic testing performed without a determination of medical necessity. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Millennium Health Agrees to Pay $256 Million to Resolve Allegations of Unnecessary Drug and Genetic Testing and Illegal Remuneration to Physicians (Oct. 19, 2015), http://www.justice.gov/opa/pr/millennium-health-agrees-pay-256-million-resolve-allegations-unnecessary-drug-and-genetic.

In a case that began as three related *qui tam* actions filed by four individuals, in April of 2015, a laboratory agreed to pay **$47 million** to settle allegations that the labs paid remuneration to doctors in exchange for their referrals and for billing for unnecessary procedures. According to the government, the laboratories routinely waived patient co-pays and deductibles and paid doctors a "processing and handling fee" per referral for blood testing. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Two Cardiovascular Disease Testing Laboratories to Pay $48.5 Million to Settle Claims of Paying Kickbacks and Conducting Unnecessary Testing (Apr. 9, 2015), http://www.justice.gov/opa/pr/2015/April/15-civ-431.html.

In February of 2014, a chain of addiction clinics, a clinical laboratory, and their owners agreed to pay **$15.75 million** to resolve allegations that they submitted false claims to Medicare and Kentucky's Medicaid program for tests that were either medically unnecessary or more expensive than those that were necessary. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Government Settles False Claims Act Allegations Against Kentucky Addiction Clinic, Clinical Lab and Two Doctors for $15.75 Million (Feb. 10, 2014), http://www.justice.gov/opa/pr/2014/February/14-civ-138.html.

The **three whistleblowers** in the case **received a Relator Fee of $2.9 million** from a **$15.5 Million Settlement** in February of 2014, when a group that operates a chain of diagnostic imaging facilities agreed to resolve allegations that it paid kickbacks to physicians and submitted false claims to Medicare and the New Jersey and New York Medicaid programs. The group allegedly required medically unnecessary tests to be performed by bundling tests together on the facilities' order forms. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Diagnostic Imaging Group to Pay $15.5 Million for Allegedly Submitting False Claims to Federal and State Health Care Programs (Feb. 25, 2014), http://www.justice.gov/opa/pr/2014/February/14-civ-200.html.

The **whistleblower**, a physician formerly employed by the physicians' group, **received** a **Relator Fee** of **$4.41 million** as his share of the **$24.5 million settlement** in July of 2014, when a hospital system and a physicians' group consented to settle allegations that they violated the FCA by paying or receiving financial inducements in connection with Medicare claims. The government alleged that the two hospital-affiliated clinics agreed to pay the

physicians' group a percentage of Medicare payments for tests and procedures referred by the group's physicians**.** *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Alabama Hospital System and Physicians Group Agree to Pay $24.5 Million to Settle Lawsuit Alleging False Claims for Illegal Medicare Referrals (July 21, 2014), http://www.justice.gov/opa/pr/alabama-hospital-system-and-physician-group-agree-pay-245-million-settle-lawsuit-alleging.

In May of 2014, King's Daughters Medical Center agreed to pay **$40.9 million** to settle allegations that physicians working for the hospital falsified medical records to justify medically unnecessary coronary stents and diagnostic catheterizations. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, King's Daughters Medical Center to Pay Nearly $41 Million to Resolve Allegations of False Billings for Unnecessary Cardiac Procedures and Kickbacks (May 28, 2014), http://www.justice.gov/opa/pr/2014/May/14-civ-567.html.

The three **whistleblowers** in the case received a **Relator Fee** of a total of **$2.9 million** from a **$15.5 million settlement** in February of 2014, when a group that operated a chain of diagnostic imaging facilities agreed to resolve allegations that it paid kickbacks to physicians and submitted false claims to Medicare and the New Jersey and New York Medicaid programs. The group allegedly required medically unnecessary tests to be performed by bundling tests together on the facilities' order forms. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Diagnostic Imaging Group to Pay $15.5 Million for Allegedly Submitting False Claims to Federal and State Health Care Programs (Feb. 25, 2014), http://www.justice.gov/opa/pr/2014/February/14-civ-200.html.

In a case that began with *qui tam* suits by three cardiologists, the **Relators received $2.46 million** of the **$16.5 million settlement funds** in January of 2014,when an operator of numerous hospitals in Kentucky agreed to settle allegations that it submitted false claims to the Medicare and Kentucky Medicaid programs for medically unnecessary cardiac procedures. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Kentucky Hospital Agrees to Pay Government $16.5 Million to Settle Allegations of Unnecessary Cardiac Procedures (Jan. 29, 2014), http://www.justice.gov/opa/pr/2014/January/14-civ-095.html.

In April of 2015, two cardiovascular testing laboratories—Health Diagnostics Laboratory Inc. (HDL), of Richmond, Virginia, and Singulex Inc., of Alameda, California—agreed to resolve civil FCA allegations that they paid physicians kickbacks in exchange for patient referrals and billed federal health care programs for medically unnecessary testing. The laboratories allegedly induced physicians to refer patients for blood tests by paying them processing and handling fees of between $10 and $17 per referral and by routinely waiving patient co-pays and deductibles. Under the settlements, HDL will pay **$47 million** and Singulex will pay $1.5 million. *See* 2015 OIG Annual Report.

In April of 2015, Health Management Associates, Inc. (HMA) in Naples, Florida, and 14 hospitals formerly owned and operated by HMA agreed to pay **$15 million** to resolve allegations that they billed Medicare for intensive outpatient psychotherapy (IOP) services that did not meet the conditions for payment, including services provided to patients whose condition did not qualify for IOP. *See* 2015 OIG Annual Report.

In February of 2014, two physicians who owned a chain of addiction treatment clinics and a clinical laboratory agreed to pay **$15.8 million** to resolve civil FCA allegations relating to fraudulent urine testing. The government alleged that the lab (PremierTox 2.0 LLC) submitted false claims to federal health care programs for medically unnecessary quantitative urine drug tests referred to it by the treatment clinic (Addixxion Recovery of Kentucky, LLC (d/b/a SelfRefind)). *See* 2014 OIG Annual Report.

In February of 2014, Diagnostic Imaging Group and its subsidiary, Doshi Diagnostic Imaging Service, P.C., agreed to pay **$15.5 million** to resolve civil FCA allegations that the defendants billed federal health care programs for diagnostic tests that were not performed and/or not medically necessary and paid kickbacks to physicians in exchange for referrals. *See* 2014 OIG Annual Report.

The **relator** received over **$2.6 million** from a **$15.3 million settlement** in January of 2013, when American Sleep Medicine agreed to resolve allegations that it submitted false claims to federal healthcare programs by misrepresenting the credentials of its technicians because the government

contended that the company knew that it was violating the law when it submitted claims for testing done by uncertified technicians. *See* Press Release, U.S. Dep't of Justice, Office of Pub. Affairs, Florida-Based American Sleep Medicine to Pay $15.3 Million for Improperly Billing Medicare and Other Federal Healthcare Programs (Jan. 3, 2013*), http://www.justice.gov/opa/pr/2013/January/13-civ-006.html.*