Relator Fees and Settlements in Hospital and Doctor Cases

In November of 2019, the **whistleblower received $5.9 Million** as her share of the government's recovery when the California Health System and Surgical Group agreed to pay the federal government **$46 million** to resolve allegations arising from claims they submitted to Medicare. The settlement resolved allegations that one hospital violated the Stark Law by billing Medicare for services referred by an affiliated physician group, to whom it allegedly paid amounts under a series of compensation agreements that exceeded the fair market value for the services provided. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, California Health System and Surgical Group Agree to Settle Claims Arising from Improper Compensation Agreements (Nov. 15, 2019), https://www.justice.gov/opa/pr/california-health-system-and-surgical-group-agree-settle-claims-arising-improper-compensation.

In October of 2019, the **whistleblowers received $3.4 Million** when Sanford Health hospital entities agreed to pay $**20.25 million** to settle FCA allegations that they submitted false claims to federal health care programs resulting from violations of the AKS and medically unnecessary spinal surgeries. The settlement resolved allegations that the hospital entities received repeated warnings that one of its top neurosurgeons was improperly receiving kickbacks from his use of implantable devices distributed by his physician-owned distributorship and was performing medically unnecessary procedures. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Sanford Health Entities to Pay $20.25 Million to Settle False Claims Act Allegations Regarding Kickbacks and Unnecessary Spinal Surgeries (Oct. 28, 2019), https://www.justice.gov/opa/pr/sanford-health-entities-pay-2025-million-settle-false-claims-act-allegations-regarding.

In November of 2019 Lenox Hill Hospital agreed to pay **$12.3 million** to settle claims that it violated the FCA by submitting false claims to Medicare for procedures only partially performed or supervised by attending surgeons. The settlement resolved allegations that the hospital billed for endoscopic and robotic procedures that were insufficiently supervised by medical residents instead of the attending physician, and that it administered unnecessary and improperly documented treatments. *See* Stipulation and Order of Settlement, *U.S. ex rel. Markelson v. Lenox Hill Hospital et al.*, No. 1:17-cv-07986 (S.D.N.Y. Nov. 8, 2019)

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 **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.

Four whistleblowers received a **Relator fee of approximately $2.8 million** of the recovered funds of a July 2018 **$14.7 million settlement** involving allegations that Health Quest and Putnam Hospital Center submitted inflated or otherwise ineligible claims for payment. As part of the settlement, the hospital system admitted to submitting claims without sufficient documentation to support the level of services billed and submitting claims for home health services without sufficient medical records to support the claims. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Health Quest and Putnam Hospital Center to Pay $14.7 Million to Resolve False Claims Act Allegations (July 9, 2018), https://www.justice.gov/opa/pr/health-quest-and-putnam-hospital-center-pay-147-million-resolve-false-claims-act-allegations.

Three whistleblowers, former employees of one of the nursing facilities, received a **Relator fee of $2 million** of the recovery of a **$10 million settlement** in July of 2018, wherein two consulting companies and nine affiliated skilled nursing facilities in Florida and Alabama agreed to settle allegations that they submitted, or caused the submission of, claims for unnecessary rehabilitation therapy services. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Two Consulting Companies and Nine Affiliated Skilled Nursing Facilities to Pay $10 Million to Resolve False Claims Act Allegations Relating to Medically Unnecessary Rehabilitation Therapy Services (July 18, 2018), https://www.justice.gov/opa/pr/two-consulting-companies-and-nine-affiliated-skilled-nursing-facilities-pay-10-million.

In December of 2018, Coordinated Health and its chief executive officer agreed to pay **$12.5 million** to settle allegations that the health system submitted inflated claims for orthopedic surgeries by unbundling and separately billing for services that were part of the same surgery. *See* Press Release, U.S. Atty's Office for the Eastern Dist. of Pa., Coordinated Health and CEO Pay $12.5 Million to Resolve False Claims Act Liability for

Fraudulent Billing (Dec. 11, 2018), https://www.justice.gov/usao-edpa/pr/coordinated-health-and-ceo-pay-125-million-resolve-false-claims-act-liability.

In December of 2016, South Miami Hospital, Inc. (SMH), entered into a settlement agreement to resolve its civil FCA liability for submitting claims to Medicare, Medicaid, TRICARE, and Federal Employee Health Benefit Programs for medically unnecessary electro physiology studies, echo cardiograms, and other procedures. SMH is an acute care hospital owned and operated by Baptist Health System of South Florida. SMH agreed to pay **$12 million** to resolve its liability under the FCA. *See* 2016 OIG Annual Report.

In February of 2017, TeamHealth Holdings, a successor in interest to IPC Healthcare Inc., f/k/a IPC The Hospitalist Inc. (IPC) agreed to pay **$57.5 million** to settle federal civil FCA allegations that IPC billed federal health care programs for higher and more expensive levels of medical service than were actually performed. The government alleged that IPC encouraged its hospitalists – medical professionals whose primary focus is the medical care of hospitalized patients – to bill for a higher level of service than actually provided. *See* 2017 OIG Annual Report.

In May 2017, hospitals Mercy Hospital Springfield f/k/a St. John's Regional Health Center, and its affiliate, Mercy Clinic Springfield Communities f/k/a St. John's Clinic (collectively, "Mercy") agreed to pay **$34 million** to resolve civil FCA allegations in the Western District of Missouri that they engaged in improper financial relationships with referring physicians. The government alleged that the hospital and clinic submitted false claims to Medicare for chemotherapy services rendered to patients who were referred by oncologists. Allegedly the oncologists' compensation was, in part, determined by a formula that improperly took into account the value of their referrals to defendants. *See* 2017 OIG Annual Report.

In June 2017, PAMC, Ltd. and Pacific Alliance Medical Center Inc., which owns California-based Pacific Alliance Medical Center, agreed to pay **$31.9 million** to settle federal civil FCA allegations that they were involved in improper financial relationships with referring physicians. These relationships allegedly violated the Anti-Kickback Statute and the Stark Law and took the form of (1) arrangements under which the defendants paid above-market rates to rent office space in physicians' offices, and (2) marketing arrangements that provided undue benefit to physicians' practices. In addition to the federal recovery, PAMC and Pacific Alliance Medical Center paid **$10 million** to resolve state Medicaid liability. *See* 2017 OIG Annual Report.

The **relator,** a former employee of the laboratory, **received $1.68 million** of a **$9.35 million settlement** in June of 2016, in which the former owner of a drug testing laboratory and the laboratory agreed to resolve allegations that the company paid kickbacks to physicians in the form of contributions to electronic health records systems purchased by client physician practices. *See* Press Release, U.S. Atty's Office for the Middle Dist. of Tennessee, U.S. Dep't of Justice, Former CEO-Physician and Drug Testing Laboratory Pay $9.35 Million to Settle False Claims Act Allegations (June 1, 2016), https://www.justice.gov/usao-mdtn/pr/former-ceo-physician-and-drug-testing-laboratory-pay-935-million-settle-false-claims.

Federal and state governments paid a combined **relator share** of around **$98 million** from a **settlement of $784.6 million** in April of 2016, when Wyeth admitted that it failed to report, and offer to Medicaid, deep discounts on two of its drugs that it offered to hospitals throughout the United States through bundled sales arrangements. *See* Press Release, U.S. Atty's Office for the Dist. of Massachusetts, U.S. Dep't of Justice, Wyeth and Pfizer Agree to Pay $784.6 Million to Resolve Lawsuit Alleging That Wyeth Underpaid Drug Rebates to Medicaid (Apr. 27, 2016), https://www.justice.gov/usao-ma/pr/wyeth-and-pfizer-agree-pay-7846-million-resolve-lawsuit-alleging-wyeth-underpaid-drug.

In April of 2016, Byram Healthcare and Hollister, Inc. agreed to collectively pay **$20.9 million** to resolve kickback allegations. The government alleged that, from 2007 to 2014, the manufacturer paid the supplier to conduct marketing promotions, conversion campaigns and otherwise refer patients to the manufacturer's products. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Byram Healthcare and Hollister, Inc. to Pay $20.9 Million to Resolve Kickback Allegations (Apr. 29, 2016), https://www.justice.gov/opa/pr/byram-healthcare-and-hollister-inc-pay-209-million-resolve-kickback-allegations.

In March of 2016, the U.S. unit of a global medical equipment company resolved allegations that it paid kickbacks to physicians and hospitals to win new business and reward sales of its endoscopes and other surgical equipment. The company agreed to pay **$646 million, consisting of $310.8 million to resolve civil claims** and $312.4 million in criminal penalties. The case originated with a lawsuit by the **former chief compliance officer of the company**, who **received** more than **$51.1 million** as his **relator's share.** *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Medical Equipment Company Will Pay $646 Million for Making Illegal Payments to Doctors and Hospitals in United Sates and Latin America (Mar. 1, 2016) https://www.justice.gov/opa/pr/medical-equipment-company-will-pay-646-million-making-illegal-payments-doctors-and-hospitals

In March of 2016, a Florida-based physician-led integrated cancer care provider, the largest in the nation, agreed to settle allegations that it improperly billed federal health care programs for performing a certain procedure without a reasonable and necessary medical purpose. The **company agreed to pay $34.7 million**; the **whistleblower**, a former physicist at one of the company's centers, **received more than $7 million.** *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, United States Settles False Claims Act Allegations Against 21st Century Oncology for $34.7 Million (Mar. 8, 2016), https://www.justice.gov/opa/pr/united-states-settles-false-claims-act-allegations-against-21st-century-oncology-347-million.

In March of 2016, the **whistleblower,** a physician who worked for various durable medical equipment companies, **received $5.38 million as the relator** in the case**,** when Respironics agreed to pay **$34.8 million** to resolve allegations that it provided free call center services to durable medical equipment suppliers to induce the suppliers to purchase the company's sleep apnea masks. The company allegedly provided the call center services at no cost as long as its masks were being used, but charged a monthly fee for call center services provided to users of competitors' masks. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Respironics to Pay $34.8 Million for Allegedly Causing False Claims to Medicare, Medicaid and Tricare Related to the Sale of Masks Designed to Treat Sleep Apnea (Mar. 23, 2016), https://www.justice.gov/opa/pr/respironics-pay-348-million-allegedly-causing-false-claims-medicare-medicaid-and-tricare.

In February of 2016, 51 hospitals in 15 states agreed to pay **$23.75 million** to conclude a nationwide investigation into the implantation of cardiac devices in Medicare patients in violation of coverage requirements. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Fifty-One Hospitals Pay United States More Than $23 Million to Resolve False Claims Act Allegations Related to Implantation of Cardiac Devices (Feb. 17, 2016), https://www.justice.gov/opa/pr/fifty-one-hospitals-pay-united-states-more-23-million-resolve-false-claims-act-allegations.

In January of 2016, the **whistleblower**, a former order entry technician for the pharmacy, **received $1.4 million** when a Nashville-based pharmacy and its majority owner agreed to pay up to $7.8 million to resolve allegations that the pharmacy automatically refilled medications without a physician order, improperly waived co-payments without assessing whether the patient could pay, used manufacturer's co-payment cards to pay for certain patients' co-payments, and billed Medicare for medications dispensed after certain patients' deaths or without a valid prescription. *See* Press Release, U.S. Atty's Office for the Middle Dist. of Tenn., U.S. Dep't of Justice, Nashville Pharmacy Services Settles False Claims Act Lawsuit

(Jan. 5, 2016), https://www.justice.gov/usao-mdtn/pr/nashville-pharmacy-services-settles-false-claims-act-lawsuit.

In January of 2016, two **whistleblowers shared in $24 million of the recovery** when Kindred/Rehabcare and its rehabilitation therapy division agreed to pay **$125 million** to resolve allegations that they caused skilled nursing facility customers to submit claims for services that were not medically necessary or reasonable, or that were never provided. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Nation's Largest Nursing Home Therapy Provider, Kindred/Rehabcare, to Pay $125 Million to Resolve False Claims Act Allegations (Jan. 12, 2016), https://www.justice.gov/opa/pr/nation-s-largest-nursing-home-therapy-provider-kindredrehabcare-pay-125-million-resolve-false.

In January of 2016, Centerlight Healthcare, a managed care company, agreed to pay **$46.7 million** to settle civil claims that it billed Medicaid for services to individuals who attended or were referred by social adult day care centers and who were medically ineligible to participate in its managed long-term care plan. . *See* Press Release, U.S. Atty's Office for the Southern Dist. of N.Y., U.S. Dep't of Justice, Manhattan U.S. Attorney Announces $46.7 Million Settlement of Civil Fraud Claims Against Centerlight Healthcare For Enrollment of Ineligible Individuals in Medicaid Managed Long-Term Care Plan (Jan. 21, 2016), https://www.justice.gov/usao-sdny/pr/manhattan-us-attorney-announces-467-million-settlement-civil-fraud-claims-against.

On December 18, 2015, the **Whistleblower received $3.2 million** from the settlement proceeds as a **Relator Share** when 21st Century Oncology agreed to pay **$19.75 million** to settle allegations that it submitted claims to federal health care programs for medically unnecessary laboratory tests. *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.

In December of 2015, the **relators received** approximately **$4.75 million** from a settlement when 32 hospitals agreed to pay a total of more than **$28 million** 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.

In December of 2015, the **relator received** at least **$1.98 million** from the settlement proceeds when a splint supplier and its founder and president agreed to pay approximately **$10.3 million** to settle claims that they knowingly mischarged Medicare for splints provided to patients staying in skilled nursing facilities. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Splint Supplier and Its President to Pay Over $10 Million to Resolve False Claims Act Allegations (Dec. 18, 2015), http://www.justice.gov/opa/pr/splint-supplier-and-its-president-pay-over-10-million-resolve-false-claims-act-allegations.

In October of 2015, the **relator,** a physician who refused to sign a contract with the health care system, **received $18.1 million** of the settlement proceeds when a health care system agreed to pay **$72.4 million** to resolve claims that it allegedly violated the Stark Law and engaged in illegal Medicare billing practices. The health care system allegedly contracted with physicians to require them to refer their outpatient procedures to the health care system, paying them compensation that was above fair market value. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, United States Resolves $237 Million False Claims Act Judgment against South Carolina Hospital that Made Illegal Payments to Referring Physicians (Oct. 16, 2015), http://www.justice.gov/opa/pr/united-states-resolves-237-million-false-claims-act-judgment-against-south-carolina-hospital.

In October of 2015, the *qui tam* **relators received a $30.35 million share** from the urine drug testing portion of the settlement and $1.48 million from the genetic testing portion of the settlement when Millennium Health agreed to pay **$256 million** to settle claims that the company violated the FCA by billing federal health care programs for unnecessary drug and genetic tests, and for violating the Stark Law and the AKS by providing free testing equipment to physicians. The $256 million includes $227 million to resolve claims related to allegedly unnecessary drug testing and $10 million to resolve allegations relating to 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 October of 2015, **two relators shared more than $38 million of the settlement proceeds** when the DOJ announced 70 settlements with 457 hospitals spanning 43 states, for a total settlement of **over $250 million**. Each of the settling hospitals allegedly implanted cardiac devices into Medicare patients during a prohibited time period in violation of Medicare requirements. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Nearly 500 Hospitals Pay United States More Than $250 Million to Resolve False Claims Act Allegations Related to Implantation of Cardiac Devices (Oct. 30, 2015), http://www.justice.gov/opa/pr/nearly-500-hospitals-pay-united-states-more-250-million-resolve-false-claims-act-allegations.

In September of 2015, a Georgia hospital system and a physician employee agreed to pay more than $25 million to settle allegations that they submitted false claims to federal health care programs and also violated the Stark Law. The health system agreed to pay **$25 million, as well as contingent payments of up to $10 million,** and the physician agreed to pay $425,000. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Georgia Hospital System and Physician to Pay More than $25 Million to Settle Alleged False Claims Act and Stark Law Violations (Sept. 4, 2015), http://www.justice.gov/opa/pr/georgia-hospital-system-and-physician-pay-more-25-million-settle-alleged-false-claims-act-and.

In September of 2015, Adventist Health System agreed to pay a total of **$118.7 million** to federal and state governments to settle allegations that it submitted false claims to federal health care programs by providing illegal financial incentives to referring physicians and also miscoding certain claims submitted to Medicare. The federal government received $115 million, with the remainder going to the states. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Adventist Health System Agrees to Pay $115 Million to Settle False Claims Act Allegations (Sept. 21, 2015), http://www.justice.gov/opa/pr/adventist-health-system-agrees-pay-115-million-settle-false-claims-act-allegations.

In August of 2015, the whistleblowers **shared in $1.1 million** of settlement proceeds**.** Pediatric Services of America and related entities agreed to pay **$6.88 million** to settle claims that the company knowingly submitted false claims to federal health care programs that overstated the length of services provided, knowingly failed to disclose and return overpayments from federal health care programs, and knowingly submitted false claims to the Georgia Pediatric Program. *See* Press Release, U.S. Atty's Office for the Northern Dist. of Ga., U.S. Dep't of Justice, Pediatric Services of America and Related Entities to Pay $6.88 Million to Resolve False Claims Act Allegations (Aug. 3, 2015), http://www.justice.gov/usao-

ndga/pr/pediatric-services-america-and-related-entities-pay-688-million-resolve-false-claims.

In July of 2015, the whistleblowers **received** approximately **$2.2 million of the settlement proceeds** when NuVasive Inc. agreed to pay **$13.5 million** to settle allegations that the company marketed a product for uses that were not approved by the Food and Drug Administration, thereby causing health care providers to submit alleged false claims to federal health care programs for surgeries that were not eligible for reimbursement. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Medical Device Manufacturer NuVasive Inc. to Pay $13.5 Million to Settle False Claims Act Allegations (July 30, 2015), http://www.justice.gov/opa/pr/medical-device-manufacturer-nuvasive-inc-pay-135-million-settle-false-claims-act-allegations.

In June of 2015, DaVita (a national kidney-dialysis company) agreed to pay **$450 million** to settle allegations in a declined *qui tam* lawsuit that it allegedly created unnecessary waste of its drugs when administering the drugs to patients and then charged the federal government for the wasted drug amounts. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, DaVita to Pay $450 Million to Resolve Allegations that it Sought Reimbursement for Unnecessary Drug Wastage (June 24, 2015), http://www.justice.gov/opa/pr/davita-pay-450-million-resolve-allegations-it-sought-reimbursement-unnecessary-drug-wastage.

In June of 2015, the whistleblower **received nearly $1.9 million** of the settlement proceeds when Children's Hospital and its affiliated entities agreed to pay **$12.9 million** to settle allegations that they submitted false cost reports and applications to HHS and to the Virginia and District of Columbia Medicaid Programs, leading to overpayment by these programs. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Children's Hospital to Pay $12.9 Million to Settle False Claims Act Allegations (June 15, 2015), http://www.justice.gov/opa/pr/childrens-hospital-pay-129-million-settle-false-claims-act-allegations.

In June of 2015, the **whistleblower,** the facility's former Chief Financial Officer, **received $4.25 million** of the settlement proceeds when a Florida skilled nursing facility, its subsidiaries and affiliates, along with its former president and executive director agreed to pay **$17 million** to settle claims that the facility hired physicians for allegedly fake positions as medical directors and then paid the physicians for patient referrals, rather than for performing the duties for their positions. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Florida Skilled Nursing Facility Agrees to Pay $17 Million to Resolve False Claims Act Allegations (June

16, 2015), http://www.justice.gov/opa/pr/florida-skilled-nursing-facility-agrees-pay-17-million-resolve-false-claims-act-allegations.

In May of 2015, the **whistleblower** in the case **received $2,667,300 from the settlement** when sixteen separate hospitals and their respective parent companies agreed to collectively pay **$15.69 million** to settle claims that the hospitals billed Medicare for unnecessary services. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Sixteen Hospitals to Pay $15.69 Million to Resolve False Claims Act Allegations Involving Medically Unnecessary Psychotherapy Services (May 7, 2015), http://www.justice.gov/opa/pr/2015/May/15-civ-569.html.

In May of 2015, Davita, Inc announced in public filings that it had set aside **$495 million** to settle a seven-year old whistleblower suit under the FCA. DaVita Healthcare Partners, Inc., Form 8-K, Ex-99.1 (May, 4, 2015) (announcing "a settlement amount of $450 million and attorney fees and other costs of $45 million"). Notably, the government did not intervene in the suit, making the settlement one of the largest ever without government intervention. *See* Order, *United States ex rel. Vainer v. Davita, Inc.*, No. 1:07-cv-02509, Dkt. No. 33 (N.D. Ga. Apr. 01, 2011) (reflecting government decision not to intervene).

In May of 2015, the whistleblower **received $1.2 million** out of the settlement proceeds when nine Jacksonville, Florida hospitals and one ambulance company agreed to pay **$7.5 million** to settle allegations that they billed for allegedly unnecessary basic life support and nonemergency transports. *See* Press Release, U.S. Attorney's Office, Middle Dist. of Fla., U.S. Dep't of Justice, United States Settles False Claims Act Allegations Against Multiple Jacksonville Hospitals And An Ambulance Company For $7.5 Million (May 8, 2015), http://www.justice.gov/usao-mdfl/pr/united-states-settles-false-claims-act-allegations-against-multiple-jacksonville.

In April 9of 2015, a laboratory agreed to pay **$47 million** 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 two laboratories, along with a third lab, routinely waived patient co-pays and deductibles and paid doctors a "processing and handling fee" of between $10 and $17 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 April of 2015, the whistleblowers collectively **received $5,981,250** out of the settlement proceeds when a Texas-based, county-owned hospital agreed to pay **$21.75 million** to settle claims that it illegally took referrals into account when paying doctors their bonuses. According to the government, the hospital also allegedly paid certain cardiologists more than fair market value for their services in exchange for referrals. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Texas-Based Citizens Medical Center Agrees to Pay United States $21.75 Million to Settle Alleged False Claims Act Violations (Apr. 21, 2015), http://www.justice.gov/opa/pr/2015/April/15-civ-485.html.

In April of 2015, a Georgia hospital agreed to pay **$20 million** to settle claims that it overbilled federal health care programs. The government alleged that between 2004 and 2008, the hospital provided outpatient or observation services while routinely billing Medicare for more expensive inpatient services. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Georgia Hospital to Pay $20 Million to Resolve False Claims Act Allegations (Apr. 27, 2015), http://www.justice.gov/opa/pr/2015/April/15-civ-514.html.

In March of 2015, a Pennsylvania-based heart monitoring company agreed to pay **$6.4 million** to settle claims that its subsidiary overbilled federal health programs for unnecessary cardiac monitoring services. The government alleged that the company knew it could not receive reimbursements for the services at issue when patients had only mild heart palpitations. According to the government, the company billed for the more expensive procedure while providing inaccurate diagnostic codes to cover up the true conditions of the patients it treated. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Cardiac Monitoring Company to Pay $6.4 Million for Alleged Overbilling of Government Health Care Programs (Mar. 19, 2015), http://www.justice.gov/opa/pr/2015/March/15-civ-344.html.

In March of 2015, a health systems company agreed to pay **$10 million** to resolve allegations that it signed sham management agreements with two physicians groups to induce referrals to the company. The government alleged that the company violated both the Anti-Kickback Statute and Stark Law by engaging in these financial relationships with the doctors. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Ohio-Based Health System Pays United States $10 Million to Settle False Claims Act Allegations (Mar. 31, 2015), http://www.justice.gov/opa/pr/2015/March/15-civ-395.html.

In February of 2015, the **relator received** slightly more than **$18.6 million** from the settlement proceeds when Community Health Systems Professional Services Corporation agreed to pay **$75 million** to settle claims that the hospitals made illicit donations to three county governments. The DOJ alleged that the local governments used these donations to illegally fund New Mexico's share of Medicaid payments. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Community Health Systems Professional Services Corporation and Three Affiliated New Mexico Hospitals to Pay $75 Million to Settle False Claims Act Allegations (Feb. 2, 2015), http://www.justice.gov/opa/pr/2015/February/15-civ-119.html.

In October 2014, Dignity Health, the fifth largest health system in the country formerly known as Catholic Healthcare West, agreed to pay **$36.7 million** to settle civil FCA allegations that 13 of its hospitals in California, Nevada, and Arizona knowingly submitted false claims to Medicare and TRICARE by admitting patients who could have been treated on a less costly, outpatient basis. *See* 2014 OIG Annual Report.

In February 2015, Community Health Systems Professional Services Corporation (CHS), a nationwide hospital management company, and three of its affiliated New Mexico hospitals agreed to pay **$75 million** to settle civil FCA allegations that they made illegal donations to county governments that were used to fund the state share of Medicaid payments to the hospitals. *See* 2015 OIG Annual Report.

In April of 2015, The Medical Center of Central Georgia, Inc. (MCCG) agreed to pay **$20 million to resolve civil FCA** allegations that it submitted false claims to Medicare for medically unnecessary inpatient admissions, including zero-day stays, one-day stays, cardiac stays with a procedure, and cardiac stays without a procedure. Specifically, these services should have been billed as outpatient or observation services due to the absence of medical necessity for inpatient services. *See* 2015 OIG Annual Report.

In April of 2015, Citizens Medical Center, a county-owned hospital in Victoria, Texas, agreed to pay **$21.7 million to settle civil FCA** allegations that it engaged in improper financial relationships with referring physicians. The settlement resolved allegations that the hospital provided compensation to several cardiologists that exceeded the fair market value of their services and that the hospital paid bonuses to emergency room physicians that improperly took into account the value of their cardiology referrals in violation of the Stark Law. *See* 2015 OIG Annual Report.

In June of 2015, Children's Hospital in Washington, DC, Children's National Medical Center Inc., (CNMC) and its affiliated entities agreed to pay **$12.9 million to resolve civil FCA allegations** that they submitted false cost reports and other applications to the components and contractors of HHS, as well as to Virginia and District of Columbia Medicaid programs. The settlement resolved allegations that CNMC misstated information regarding its available bed count and overhead costs on cost reports and applications that were used by HHS and Medicaid programs to calculate reimbursement rates to CNMC. *See* 2015 OIG Annual Report.

In June of 2015, Community Health Network (CHN), an Indiana-based non-profit health system, agreed to **pay over $20 million to resolve allegations** that it submitted false claims to the Medicare and Medicaid programs. CHN contracted with free-standing ambulatory surgery centers (ASCs) to provide outpatient surgical services to CHN patients. When billing Medicare and Medicaid, however, CHN allegedly represented that the surgery was performed in the outpatient department of CHN's hospitals, rather than in an ASC. Based on this prohibited practice, CHN allegedly received a higher reimbursement from the Medicare and Medicaid programs than it was entitled. *See* 2015 OIG Annual Report.

In September of 2015, North Broward Hospital District, a special taxing district of the state of Florida that operates hospitals and other health care facilities, agreed to pay **$69.5 million to settle civil FCA allegations** that it engaged in improper financial relationships with referring physicians. The settlement resolved allegations that the hospital district provided compensation to nine employed physicians that exceeded the fair market value of their services in violation of the Stark Law. *See* 2015 OIG Annual Report.

In September of 2015, Columbus Regional Healthcare System (Columbus Regional) and a physician agreed to pay more than $25 million to settle civil FCA allegations that they submitted claims to federal health care programs that violated the Stark Law and that misrepresented the level of services they provided. The government alleged that Columbus Regional provided excessive salary and directorship payments to the physician that violated the Stark Law, submitted claims for services at higher levels than supported by the documentation, and submitted claims for radiation therapy at higher levels than the therapy that was provided. Under the settlement agreement, Columbus Regional agreed to pay **$25 million, plus additional contingent payments not to exceed $10 million, for a maximum settlement amount of $35 million;** the physician has agreed to pay $425,000. *See* 2015 OIG Annual Report.

In September of 2015, Adventist Health Care System, a non-profit healthcare organization that operates hospitals and other healthcare facilities in 10 states, agreed to pay **$115 million to settle civil FCA allegations** that they submitted false claims to Medicare and Medicaid. Adventist allegedly paid bonuses to its employed physicians based on the number of tests and procedures they ordered and billed Medicare for its employed physicians' professional services using improper coding modifiers. *See* 2015 OIG Annual Report.

On November 12, 2014, the *qui tam* **whistleblower** who filed the lawsuit **received more than $3.9 million** of the recovery when Careall Companies, a home health agency, agreed to pay **$25 million** to the United States and Tennessee to settle claims that it allegedly upcoded billings for home health care. The government alleged that the agency exaggerated the severity of patients' conditions to increase billings and billed for medically unnecessary services to patients who were not homebound. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Careall Companies Agree to Pay $25 Million to Settle False Claims Act Allegations (Nov. 12, 2014), http://www.justice.gov/opa/pr/careall-companies-agree-pay-25-million-settle-false-claims-act-allegations.

In October of 2014, a leading dialysis services provider agreed to pay **$350 million** to resolve allegations that it paid kickbacks for patient referrals. It was alleged that the provider offered physicians joint venture opportunities in return for referrals. The settlement involved a *qui tam* lawsuit filed by a former analyst of the provider. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, DaVita to Pay $350 Million to Resolve Allegations of Illegal Kickbacks (Oct. 22, 2014), http://www.justice.gov/opa/pr/davita-pay-350-million-resolve-allegations-illegal-kickbacks.

In October of 2014, the *qui tam* **whistleblower** who filed the complaint, a former employee of the hospital system, **received** about $**6.25 million**, when Dignity Health to pay **$37 million** to resolve claims that it charged the government for costlier inpatient services when the patients could have been billed on an outpatient basis. The hospital system also entered into a corporate integrity agreement with HHS OIG that required reviews from an independent review organization. *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.

In October of 2014, Extendicare Health Services, Inc. and its subsidiary agreed to pay **$38 million** to the United States and eight states to settle claims that it allegedly improperly billed Medicare and Medicaid. The firm allegedly billed the government for purportedly worthless nursing services, and medically unnecessary physical, speech, and occupational rehabilitation services. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Extendicare Health Services, Inc. Agrees to Pay $38 Million to Settle False Claims Act Allegations Relating to the Provision of Substandard Nursing Care and Medically Unnecessary Rehabilitation Therapy (Oct. 10, 2014), http://www.justice.gov/opa/pr/extendicare-health-services-inc-agrees-pay-38-million-settle-false-claims-act-allegations.

In August of 2014, the **whistleblower** that originally filed the case **received $5.95** million as her share in the settlement when Carondelet Health Network agreed to pay **$35 million** to resolve allegations that its hospitals submitted false bills to Medicare as well as other federal and state health care programs. The government alleged that these hospitals submitted inpatient rehabilitation facility services to Medicare, 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 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. The settlement resolved several *qui tam* lawsuits filed by whistleblowers. *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.

In July of 2014, a hospital system, two hospital-affiliated clinics, and a physicians' group consented to pay **$24.5 million** 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. **The whistleblower in this case, a physician formerly employed by the physicians' group, received $4.41 million as his share of the settlement.** *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 June of 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. The company became aware of the claims through audits commissioned by its own corporate compliance department. In 2008, the 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 May of 2014, a Kentucky-based hospital 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. The government further alleged that the hospital violated the Stark Law by paying certain cardiologists salaries that exceeded fair market value. *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.

In April of 2014, in a case that resolved **seven** pending *qui tam* suits by **relators** who **split $26 million** of the settlement funds, Amedisys Home Health Companies agreed to pay **$150 million** to settle claims that some offices of the company billed Medicare for ineligible patients and services. The violations allegedly occurred because of pressure from management to focus on the financial health of the company rather than the needs of the patients. The settlement also resolves allegations that the company violated the Anti-Kickback Statute and the Stark Law by maintaining improper financial relationships with referring physicians. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Amedisys Home Health Companies Agree to Pay $150 Million to Resolve False Claims Act Allegations (Apr. 23, 2014), http://www.justice.gov/opa/pr/2014/April/14-civ-422.html.

In March of 2014, the **relator received $20.8 million** when a hospital system agreed to pay **$85 million** to resolve allegations that it violated the Stark Law by billing Medicare for services referred to the hospital by physicians with a financial relationship with the hospital. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Florida Hospital System Agrees to Pay the Government $85 Million to Settle Allegations of Improper Financial Relationships with Referring Physicians (Mar. 11, 2014), http://www.justice.gov/opa/pr/2014/March/14-civ-252.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. Allegedly, the clinics referred patients to the clinical laboratory for tests that were either medically unnecessary or more expensive than those that were necessary. The government also alleged violations of the Stark Law, which forbids a laboratory from billing Medicare and Medicaid for services referred by physicians having a financial relationship with the laboratory. *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.

In February of 2014, the **three whistleblowers** in the case **received a total of $2.9 million** when a group that operates a chain of diagnostic imaging facilities agreed to pay **$15.5 million** 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 January of 2014, the **whistleblower received a $5.7 million share of the recovery** when a group of nationwide contract therapy providers agreed to pay **$30 million** to settle claims that they engaged in a kickback scheme for referrals of nursing home business. The therapy provider allegedly paid six-figure amounts for referrals and allowed referrers to keep a portion of the revenue generated by the referrals. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Nationwide Contract Therapy Providers to Pay $30 Million to Resolve False Claims Act Allegations (Jan. 17, 2014), http://www.justice.gov/opa/pr/2014/January/14-civ-060.html.

In January of 2014, the **whistleblowers received $2.46 million of the settlement funds** when an operator of numerous hospitals in Kentucky agreed to pay **$16.5 million** to settle allegations that it submitted false claims to the Medicare and Kentucky Medicaid programs for medically unnecessary cardiac procedures. settlement. *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 January 2014, St. Joseph Health System, Inc., of London, Kentucky, agreed to pay **$16.5 million** to resolve civil FCA allegations that it submitted false claims to federal health care programs for medically unnecessary cardiac procedures, including stents, pacemakers, and catheterizations. The settlement also resolved allegations of Anti-Kickback Statute (AKS) and Stark Law violations arising out of contractual relationships between the hospital and the owners of Cumberland Clinic, the physicians' practice group alleged to have performed the unnecessary services. *See* 2014 OIG Annual Report.

In March 2014, Halifax Hospital Medical Center, which operates a hospital and outpatient clinics in the Daytona Beach, Florida area, agreed to pay **$85 million** to resolve civil FCA allegations that Halifax entered into certain prohibited contracts with oncologists and neurosurgeons in violation of the Stark Law. *See* 2014 OIG Annual Report.

In March 2014, Memorial Hospital, an Ohio nonprofit corporation that operates an acute care hospital in Fremont, Ohio, agreed to pay **$8.5 million** to settle civil FCA allegations that it engaged in improper financial relationships with referring physicians in violation of the AKS and Stark Law. The settlement involved self-disclosed allegations that financial relationships that Memorial had with two physicians – a joint venture between Memorial and a pain management physician and an arrangement under which an ophthalmologist purchased intraocular lenses and then resold them to Memorial at inflated prices - violated statutory requirements. *See* 2014 OIG Annual Report.

In May 2014, Ashland Hospital Corporation d/b/a King's Daughters Medical Center (KDMC), a Kentucky corporation based in Ashland, Kentucky, agreed to pay **$40.9 million** to resolve civil FCA allegations that it billed for medically unnecessary coronary stents and diagnostic catheterizations performed on Medicare and Medicaid patients. The settlement also resolves allegations that KDMC violated the

Stark Law by paying certain cardiologists' salaries that exceeded fair market value. *See* 2014 OIG Annual Report.

In July 2014, Community Health Systems, Inc., based in Franklin, Tennessee, and its affiliated hospitals (collectively, CHS) agreed to pay a total payment of **$98.2 million** to resolve allegations that: (1) CHS knowingly admitted patients who presented to CHS hospital emergency departments as inpatients when they should have been treated as outpatients or provided observation care; (2) a CHS hospital, Laredo Medical Center, presented false claims to Medicare for certain inpatient procedures that should have performed on an outpatient basis; and (3) CHS improperly billed Medicare for services referred to Laredo Medical Center by a physician who was offered a medical directorship at the hospital in violation of the Stark law. *See* 2014 OIG Annual Report.

In August 2014, Arizona non-profit corporation Carondelet Health Network, d/b/a Carondelet St. Mary's Hospital and Carondelet St. Joseph's Hospital, agreed to pay $35 million to resolve civil FCA allegations that the hospitals billed federal health care programs for inpatient rehabilitation facility services when an inpatient setting was not appropriate. *See* 2014 OIG Annual Report.

In November 19, 2013, a California-based operator of nursing homes agreed to pay **$48 million** to resolve allegations that it knowingly submitted false Medicare claims for medically unnecessary rehabilitation therapies. According to the government, the operator provided physical, occupational, and speech therapy to patients whose conditions did not require such treatment. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Nursing Home Operator to Pay $48 Million to Resolve Allegations That Six California Facilities Billed for Unnecessary Therapy (Nov. 19, 2013), http://www.justice.gov/opa/pr/2013/November/12-civ-1235.html.

In July of 2013, Dubuis Health System and Southern Crescent Hospital for Specialty Care, Inc. paid **$8 million** to settle allegations that they submitted false claims to Medicare. The DOJ announced that the settlement resolved allegations that between 2003 and 2009 the health care system and hospital knowingly kept patients hospitalized beyond the time considered medically necessary to increase their Medicare reimbursements and to maintain the hospital's classification as a long-term acute care facility. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Dubuis Health System and Southern Crescent Hospital for Specialty Care, Inc. to Pay U.S. $8 Million to Resolve False Claims Act Allegations (July 26, 2013), http://www.justice.gov/opa/pr/2013/July/13-civ-851.html.

In January of 2013, the **relator received over $2.6 million from the settlement.** when American Sleep Medicine agreed to pay **$15.3 million** to resolve allegations that it submitted false claims to federal healthcare programs by misrepresenting the credentials of its technicians. Federal programs require that technicians be licensed or certified by a state or national credentialing body for claims to be eligible for reimbursement; the government contends 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.*

In January of 2013, a major New Jersey hospital system agreed to pay **$12.6 million** to resolve allegations that it had violated the FCA by billing Medicare and Medicaid for services resulting from tainted referrals. The allegations stemmed from a *qui tam* suit that accused the hospital of making improper payments to physicians in return for patient referrals and which was brought by a physician whom the hospital allegedly attempted to recruit for that purpose. *See* Press Release, U.S. Attorney's Office, D.N.J., Office of Pub. Affairs, Major New Jersey Hospital Pays $12.5 Million to Resolve Kickback Allegations (Jan. 24, 2013), *http://www.justice.gov/usao/nj/Press/files/Cooper%20Settlement%20PR.html*.

In July of 2013, the **whistleblower** who brought the lawsuit, a former employee of the medical firm, **received $2.7 million of the settlement**, when a medical firm agreed to pay **$14.5 million** to settle allegations that it overbilled Medicare and other federal health care programs. The government alleged that the firm, which provides physicians to hospitals and other medical facilities, submitted inflated claims to federal health benefits programs on behalf of its physicians for higher and more expensive levels of service than were documented. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Tacoma, Wash., Medical Firm to Pay $14.5 Million to Settle Overbilling Allegations (July 3, 2013), *http://www.justice.gov/opa/pr/2013/July/13-civ-758.html.*