# Relator Fees and Settlements in Home Health Care Cases

In August of 2019, a **$339.4 Million Judgment** was obtained against 4 individuals in one of the largest recoveries for home health care fraud in the history of the United States. The allegations included the fact that two doctors signed certification or recertifications for patients being classified as homebound without ever seeing the patient, and that many of the patients did not qualify for homebound status. The government's investigation also revealed that on many occasions, the doctors would bill Medicare for over 100 hours per day, and over 200 per day on at least one occasion. Per an agreement reached with the government, the **Relator/Whistleblower** is entitled to **23% of the recovery** from a related criminal case resulting in forfeiture of hundreds of millions of dollars by the Defendants. *U.S. ex. rel. Bachman v. Healthcare Liasons, et. al.*, Civil Action No. 3:13-cv-0023 (N.D. TX Judgment dated August 14, 2019). ***Note—This Judgment was obtained by Attorney Rusty Tucker. For a Texas Lawbook article describing the case, click here.**

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.

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 up-coded 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 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.