Relator Fees and Settlements of Medical Transportation Fraud Cases

A whistleblower received a **Relator Fee** of over **$4.9 million** of the recovery from a **$21 million settlement** in August of 2018, in a case where seven ambulance industry defendants agreed to settle allegations that they offered kickbacks to several municipal entities to secure business. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Ambulance Company and its Municipal Clients Agree to Pay Over $21 Million to Settle Allegations of Unlawful Kickbacks and Improper Financial Relationships (Aug. 27, 2018), https://www.justice.gov/opa/pr/ambulance-company-and-its-municipal-clients-agree-pay-over-21-million-settle-allegations.

In March of 2018, an ambulance services provider agreed to pay **$9 million** to settle allegations that it submitted false or fraudulent claims to Medicare, Medicaid, and TRICARE for ambulance transports that were not medically necessary, that did not qualify as Specialty Care Transports, and that should have been billed to other payers. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Ambulance Company to Pay $9 Million to Settle False Claims Act Allegations (Mar. 28, 2018), https://www.justice.gov/opa/pr/ambulance-company-pay-9-million-settle-false-claims-act-allegations.

In May of 2016, the City of New York agreed to pay **$4.3 million** to resolve claims that between 2008 and 2012, the New York City Fire Department received reimbursement for emergency ambulance transport for Medicare patients that was not medically necessary. *See* Press Release, U.S. Atty's Office for the Southern Dist. of New York, U.S. Dep't of Justice, Manhattan U.S. Attorney Announces $4.3 Million Settlement of False Claims Act Action Based on New York City Fire Department's Receipt of Improper Reimbursements From Medicare (May 5, 2016), https://www.justice.gov/usao-sdny/pr/manhattan-us-attorney-announces-43-million-settlement-false-claims-act-action-based-new.

In a case that began as a *qui tam* lawsuit by a former employee of the ambulance company, the whistleblower received a **Relator Fee** of **$1.2 million** out of the **$7.5 million settlement** proceeds in May of 2015, when nine hospitals and one ambulance company agreed 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 November of 2015, a skilled nursing facility company agreed to pay nearly **$3.2 million** to resolve claims that it violated the AKS by accepting kickbacks from ambulance companies in return for providing rights to the companies for profitable transportation referrals for Medicare and Medicaid. *See* Press Release, U.S. Atty's Office for the Southern Dist. of Texas, U.S. Dep't of Justice, Skilled Nursing Facility Company Agrees to Pay More Than $3 Million to Resolve Kickback Allegations (Nov. 30, 2015), http://www.justice.gov/usao-sdtx/pr/skilled-nursing-facility-company-agrees-pay-more-3-million-resolve-kickback-allegations.

Liberty Ambulance Service, Inc. (Liberty) entered into an FCA settlement agreement to resolve allegations that it submitted false claims to Medicare for transportation services. Specifically, the settlement agreement resolves allegations that, from June 29, 2005, to January 5, 2016, Liberty billed for: (1) Non-Emergency Advanced Life Support (ALS) services when only the less expensive Non-Emergency Basic Life Support (BLS) services were medically reasonable and necessary; (2) emergency services for hospital-to-hospital transports and scheduled transports when only the less expensive Non-Emergency services were medically reasonable and necessary; (3) Non-Emergency BLS or ALS services for ambulance transports that were not medically necessary because transportation by other means was not contraindicated; and (4) emergency transports to residences when only the less expensive Non-Emergency services were medically reasonable and necessary. Liberty agreed to pay **$1.2 million**. *See* 2017 OIG Annual Report.

In January 2017, a previously excluded provider, was sentenced in New Jersey to **18 years in prison** for, among other things, his illegal operation of an ambulance company that billed Medicare and Medicaid. In 2004, the defendant was excluded from participating in Medicare or Medicaid for a minimum of 11 years as a result of a state conviction for Medicaid fraud. From at least 2005-2014 and in violation of the exclusion, the defendant operated K&S Invalid Coach in his brother's name. During this time, Medicare and Medicaid paid over **$9 million** in claims to K&S. The defendant also engaged in tax evasion, paying numerous employees' salaries and all employees overtime "off the books." In response to a Department of Labor audit in 2014, the defendant instructed all of the company's employees to lie to the Department of Labor about the number of hours they worked and instructed certain employees to falsify timekeeping records to match false reports that had been made to the company's payroll accountant. Following a bench trial, during which the defendant attempted to influence a government witness, he was convicted of all 17 counts of the indictment charging him with health care fraud, obstructing a federal audit, tax evasion, and money laundering. The defendant was also ordered to pay $8.8 million in restitution. *See* 2017 OIG Annual Report.

In January 2017, Medstar Ambulance, Inc. and its two owners agreed to pay **$12.7 million** to resolve allegations in the District of Massachusetts that from January 2011 through October 2014, Medstar submitted false claims to Medicare for ambulance transport services. Specifically, the United States alleged that Medstar routinely billed for services that did not qualify for reimbursement because the transports were not medically reasonable and necessary, billed for higher levels of services than were required by patients' conditions, and billed for higher levels of services than were actually provided. As part of the settlement agreement, Medstar agreed to enter into a 5-year Corporate Integrity Agreement (CIA) with HHS-OIG. *See* 2017 OIG Annual Report.

In April 2017, the owners of an ambulance company were sentenced to 5 years and 3 months and 4 years and 9 months in prison, respectively, and ordered to pay more than **$2.3 million** in **restitution** in the Southern District of Texas. The defendants owned and operated KMD Healthcare Services Inc. (KMD) from their home in a gated townhouse community in Houston. As part of their guilty pleas, the pair admitted they submitted approximately $6 million in false and fraudulent claims to Medicare, Medicaid and Tricare (another government health program) for ambulance services that were not provided. The defendants admitted they transported Medicare beneficiaries with only one of the two required emergency

medical technicians and in vans instead of ambulances. They also admitted they paid a Houston physician $500 for certificates of medical necessity and paid some of the Medicare beneficiaries to ride in the vans. *See* 2017 OIG Annual Report.

In November 2015, Regent Management Services L.P.—a Galveston, Texas skilled nursing facility company—paid **$2.7 million** to settle civil FCA allegations that it received kickbacks from various ambulance companies in exchange for rights to Regent's more lucrative Medicare and Medicaid transport referrals. Regent manages twelve separately owned and operated nursing facilities. The alleged remuneration included patients at Regent facilities receiving free or heavily discounted ambulance transports that Regent would otherwise have been financially responsible for at higher Medicaid rates. This settlement is the first in the nation to hold accountable the medical institution as opposed to the ambulance in this kind of "swapping" arrangement. *See* 2015 OIG Annual Report.

In June 2016, [in a case in which the Relators were represented by Attorney Rusty Tucker] ten North Texas companies and individuals paid **$1.125 million** to resolve civil FCA allegations that Irving Holdings submitted a false affidavit to the State of Texas that CMS relied upon when paying inflated amounts for transport services. Irving Holdings, Inc. is one of the largest taxicab companies in the United States. *See* 2016 OIG Annual Report.

In May 2015, five Orange County California ambulance companies in San Diego, California agreed to pay a total of more than **$11.5 million** to settle civil False Claims Act (FCA) allegations that they engaged in so-called "swapping" kickback schemes by providing deeply discounted—and often below cost—ambulance services to hospitals and/or skilled nursing facilities (SNFs) in exchange for exclusive rights to the facilities' more lucrative Medicare patient referrals in violation of the AKS. The government alleged that the arrangements resulted in false claims for Medicare Part B transports, which in essence subsidized the discounted trips. The settling defendants were Pacific Ambulance, Inc., Bowers Companies, Inc., Care Ambulance Service, Inc., Balboa Ambulance Service, Inc., and E.R. Ambulance, Inc. *See* 2015 OIG Annual Report.

In June 2015, a general manager and a dispatch supervisor of Mauran Ambulance Inc., an ambulance company in San Fernando, California, were indicted for their roles in a **$28 million** Medicare fraud scheme. The defendants allegedly billed Medicare for medically unnecessary ambulance transportation services, which

primarily were to and from dialysis treatments. In their respective roles at Mauran, the defendants instructed emergency medical technicians who worked at Mauran to conceal the true medical condition of patients they were transporting by altering paperwork and creating false reasons to justify Mauran's ambulance transportation services. A former administrator of a dialysis clinic was also indicted for receiving cash kickbacks from Mauran's general manager in exchange for patient referrals. *See* 2015 OIG Annual Report. *See* 2015 OIG Annual Report.

In November 2013, Filyn Corporation, the owner and operator of California-based Lynch Ambulance, paid more than **$3 million** to resolve civil FCA allegations that from approximately 2001 through 2007, Filyn regularly billed Medicare and TRICARE for non-emergency, basic life support transports of beneficiaries who were not "bed-confined" at the time of transport or whose transports were otherwise not medically necessary. *See* 2013 OIG Annual Report.

In November 2013, Pacific Ambulance, Inc. (Pacific) and Bowers Companies, Inc. (Bowers), both California ambulance companies, agreed to pay **$8 million** to resolve civil FCA allegations that between 2004 and 2011, they entered into numerous below-cost contracts with skilled nursing facilities. The Government alleged that the contracts constituted prohibited "swapping" arrangements, wherein Pacific and Bowers offered prices to the skilled nursing facilities that were below their total costs of providing ambulance transport services in return for referrals of future Medicare business. *See* 2013 OIG Annual Report.