

Healthcare Audit and Enforcement Risk Analysis

Corporate Integrity
Agreement (CIA)
Summary
Provider-Focused

August 2021



To our Healthcare Management and Compliance Colleagues and Partners:

SunHawk Consulting has produced this free Report in an effort to promote the value of shared learnings, as well as to provide focused insights into healthcare related Corporate Integrity Agreements (CIA) settled over the last couple of years.

The United States Government requires Corporate Integrity Agreements (CIA) for health care Providers, Payers and Life Science companies when settling allegations of false claims related to quality of care or corporate integrity issues, against various Federal health care programs. Under the terms of a CIA, companies agree to various obligations including, in most cases, the engagement of an Independent Review Organization. The CIA summaries provided herein are extracted from published CIAs and US Department of Justice press releases. For your ease the electronic version of this report includes hyperlinks to the original sources.

After your review, we would appreciate any feedback you believe would make this report more helpful to you or others. Should you find you would like to proactively conduct an audit and/or review of activity within your organization to avoid future adverse findings, SunHawk's team of experts are happy to offer our assistance. Visit us at SunHawkConsulting.com and/or [connect with us on LinkedIn](#) for updates to this and other Healthcare Audit and Enforcement Risk Analyses.

Jim Rough
President, SunHawk Consulting, LLC
Jim.Rough@SunHawkConsulting.com

Table of Contents

Hospital	1
Long Term Care	7
Medical Equipment & Supplies	13
Behavioral Health	14
Prescriber and Drug Testing Services	16
Physical and Other Therapies	24
Other Providers and Suppliers.....	25

Contact an Expert

Jan Elezian

602-541-8629

Jan.Elezian@SunHawkConsulting.com

James Rose

502-445-7511

James.Rose@SunHawkConsulting.com

Jim Rough

602-334-5522

Jim@SunHawkConsulting.com



Hospital

[NEW] South Carolina's Largest Urgent Care Provider and its Management Company to Pay \$22.5 Million to Settle False Claims Act Allegations

Company Name: Doctors Care, P.A.; UCI Medical
Affiliates of South Carolina, Inc.
Settlement: \$22,500,000

Issue(s): Billing Credentials

The US Attorney for the District of South Carolina announced that Doctors Care, P.A. (“Doctors Care”) – South Carolina’s largest urgent care provider network – and its management company, UCI Medical Affiliates of South Carolina, Inc. (“UCI”), will pay \$22.5 million and enter [five-year corporate integrity agreement](#) to resolve civil allegations of healthcare fraud in violation of the False Claims Act.

The DOJ alleged that as early as 2013 and continuing to 2018, UCI was unable to secure and maintain necessary billing credentials for most Doctors Care providers. UCI knew that federal insurance programs would deny claims submitted with the billing number of a provider who had not yet received their billing credentials. But instead of solving its credentialing problem – or holding claims while a temporary solution could be found – UCI allegedly submitted the claims falsely, “linking” the uncredentialed rendering providers to credentialed billing providers in order to get the claims paid.

With each “linked” bill, it is alleged that UCI knowingly submitted a false claim for payment. Evidence obtained in support of the allegations includes emails memorializing UCI’s “linking” scheme and well-organized “cheat sheets,” as employees called them, which UCI used to keep track of properly-credentialed billing providers whose names could be substituted on uncredentialed providers’ bills.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 4/6/2021

Entity Location: South Carolina **Government Program(s):** Medicare, Medicaid & TRICARE

Oklahoma City Hospital, Management Company, And Physician Group To Pay \$72.3 Million To Settle Federal And State False Claims Act Allegations Arising From Improper Payments To Referring Physicians

Company Name: Oklahoma Center for Orthopaedic and
Multi-Specialty Surgery
Settlement: \$72,300,000

Issue(s): Stark & Anti-Kickback

The DOJ Office of Public Affairs announced that Oklahoma Center for Orthopaedic and Multi-Specialty Surgery (OCOM), a specialty hospital in Oklahoma City, Oklahoma, its part-owner and management company, USP OKC, Inc. and USP OKC Manager, Inc. (collectively USP), Southwest Orthopaedic Specialists, PLLC (SOS), an Oklahoma City-based physician group, and two SOS physicians, will pay \$72.3 million and enter into a [five-year corporate integrity agreement](#) to resolve allegations under the False Claims Act and the Oklahoma Medicaid False Claims Act of improper relationships between OCOM and SOS, resulting in the submission of false claims to the Medicare, Medicaid and TRICARE programs.

Provider

Hospital

Long Term Care

Medical Equipment and
Supplies

Behavioral Health

Prescriber and Drug
Testing Services

Physical and Other
Therapies

Other Providers and
Suppliers



Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers

The DOJ reported allegations that OCOM and USP provided improper remuneration to SOS and certain of its physicians in exchange for patient referrals to OCOM in the form of (i) free or below-fair market value office space, employees, and supplies, (ii) compensation in excess of fair market value for the services provided by SOS and certain of its physicians, (iii) equity buyback provisions and payments for certain SOS physicians that exceeded fair market value, and (iv) preferential investment opportunities in connection with the provision of anesthesia services at OCOM. The alleged conduct resulted in the submission of claims for services provided to these illegally referred patients, in violation of the False Claims Act and the Oklahoma Medicaid False Claims Act. The settlement also resolves issues arising out of USP's preferential offering of investment opportunities to physicians at four surgery facilities in Texas. As a result of this settlement, USP will pay \$60.86 million to the United States, \$5 million to the State of Oklahoma, and \$206,000 to the State of Texas. SOS and two of its physicians, Anthony L. Cruse, D.O. and R.J. Langerman, Jr., D.O., will pay \$5.7 million to the United States, and \$495,619 to the State of Oklahoma.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 7/7/2020 **Entity Location:** Oklahoma **Government Program(s):** Medicare, Medicaid & TRICARE

Cookeville Hospital Settles False Claims Act Allegations

Company Name: Cookeville Regional Medical Center Authority | **Issue(s):** Stark & Anti-Kickback
Settlement: \$4,100,000

The U.S. Attorney for the Middle District of Tennessee reported that Cookeville Regional Medical Center Authority agreed to pay \$4.1 million and enter into a [five-year corporate integrity agreement](#) to settle allegations that it violated the False Claims Act. The alleged conduct involved payments, between 2012 – 2017, by Cookeville Regional Medical Center (“CRMC”) to physicians in violation of the Anti-Kickback Statute and Stark Law.

These alleged violations related to financial arrangements between CRMC and physicians associated with its wholly owned subsidiary physician practice, CRMC MSO-Sub 1, Inc. d/b/a Tennessee Heart. The original allegations were raised in a qui tam lawsuit filed against CRMC by a former employee, who received \$779,000 as his share of the settlement.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 2/14/2020 **Entity Location:** Tennessee **Government Program(s):** Medicare & Medicaid

Manhattan U.S. Attorney Announces \$12.3 Million Settlement with Lenox Hill Hospital for Submitting Fraudulent Medicare Claims for Urology Procedures and Hospital Services

Company Name: Northwell Health, Inc; Lenox Hill Hospital | **Issue(s):** Stark, Endoscopic Procedures, Robotic Surgeries, Hospital Services, Designated Health Services
Settlement: \$12,300,000

The U.S. Attorney’s Office of the Southern District of New York reported that Lenox Hill Hospital (“Lenox Hill”) and its corporate parent Northwell Health Inc. (“Northwell”) agreed to pay \$12.3 million and enter into a [five-year corporate](#)



[integrity agreement](#) to settle allegations that the Defendants violated the False Claims Act by fraudulently billing Medicare for healthcare services that did not comply with Medicare law.

The DOJ reported allegations that, in conjunction with Defendants' employment of Lenox Hill's former chair of the Department of Urology, David B. Samadi ("Samadi"), Defendants submitted claims for: (1) endoscopic procedures that were performed, at least in part, by insufficiently supervised medical residents; (2) robotic surgeries for which, at some point during the surgery, Samadi left the patient improperly unattended in order to supervise a different surgery; (3) medically unnecessary hospital services; and (4) designated health services referred to Lenox Hill by Samadi when his compensation arrangement violated the federal Stark Law.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 11/8/2019 **Entity Location:** New York **Government Program(s):** Medicare

Sanford Health Entities to Pay \$20.25 Million to Settle False Claims Act Allegations Regarding Kickbacks and Unnecessary Spinal Surgeries

Company Name: Sanford Health, Sanford Clinic, & Sanford Medical Center **Issue(s):** Anti-Kickback, Spinal Surgeries
Settlement: \$20,250,000

The U.S. Department of Justice reported that hospital entities Sanford Health, Sanford Medical Center, and Sanford Clinic (collectively, Sanford), of Sioux Falls, South Dakota, have agreed to pay \$20.25 million and enter into a [five-year corporate integrity agreement](#) to resolve False Claims Act allegations that they knowingly submitted false claims to federal healthcare programs resulting from violations of the Anti-Kickback Statute and medically unnecessary spinal surgeries.

The DOJ reported allegations that Sanford knew that one of its top neurosurgeons was improperly receiving kickbacks from his use of implantable devices distributed by his physician-owned distributorship (POD). Sanford allegedly received warnings from the neurosurgeon's physician colleagues and others about the alleged kickback scheme and was aware of the heightened compliance risks associated with PODs. In addition, the neurosurgeon's colleagues and others repeatedly warned Sanford that the neurosurgeon was performing medically unnecessary procedures involving the devices in which he had a substantial financial interest. The United States alleged that, despite these repeated warnings, Sanford continued to employ the neurosurgeon, continued to allow him to profit from the devices he used in surgeries performed at Sanford, and continued to submit claims to federal healthcare programs for these surgeries, including procedures that were medically unnecessary.

The settlement resolves allegations originally brought in a lawsuit filed by Drs. Carl Dustin Bechtold and Bryan Wellman, surgeons at Sanford, under the whistleblower, or qui tam, provision of the False Claims Act. The whistleblowers will receive \$3.4 million of the settlement proceeds.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 10/28/2019 **Entity Location:** South Dakota **Government Program(s):** Medicare, Medicaid, and Other Federal Programs

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers



Eagleville Hospital Pays \$2.85 Million to Resolve Allegations of Improper Billing for Detox Treatment

Company Name: Eagleville Hospital | **Issue(s):** Detoxification Treatments
Settlement: \$2,850,000

The U.S. Attorney’s Office of the Eastern District of Pennsylvania announced that Eagleville Hospital, which provides substance use disorder treatment in Eagleville, Pennsylvania, has agreed to pay \$2.85 million to the federal government and enter into a [five-year corporate integrity agreement](#) to resolve allegations that the hospital violated the False Claims Act by submitting claims to Medicare, Medicaid, and the Federal Employees Health Benefits Program (“FEHBP”) for hospital-level detoxification treatment services when the patients were ineligible for admission to receive such services or lacked documentation to support the claims.

The settlement resolves allegations in a complaint filed in federal court in the Eastern District of Pennsylvania by a whistleblower under the qui tam provisions of the False Claims Act. In his qui tam complaint, the whistleblower alleged that Eagleville Hospital admitted certain groups of its substance use disorder treatment patients for the higher-reimbursing hospital-level detoxification treatment, rather than the residential-level treatment, without satisfying the medical necessity requirements to do so. The whistleblower alleged that this practice resulted in false claims to Medicare, Medicaid, and FEHBP. This settlement agreement resolves the allegations for claims from January 2011 through December 2018. The whistleblower here will receive over \$500,000 of the recovery.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 7/24/2019 **Entity Location:** Pennsylvania **Government Program(s):** Medicare, Medicaid & FEHBP

Millcreek Community Hospital Will Pay \$2,451,000 to Settle Claims for Medically Unnecessary Inpatient Rehabilitation Services

Company Name: Millcreek Community Hospital | **Issue(s):** Inpatient Rehabilitation Services
Settlement: \$2,451,000

The U.S. Attorney’s Office for the Western District of Pennsylvania announced that Millcreek Community Hospital has agreed to pay \$2,451,000 and enter into a [five-year corporate integrity agreement](#) to resolve claims that the hospital violated the False Claims Act by billing Medicare and Medicaid for medically unnecessary inpatient rehabilitation services.

The DOJ reported allegations that, between July 1, 2013 and December 31, 2017, Millcreek admitted patients to its inpatient rehabilitation unit who did not qualify for such services and failed to adequately document in the patients’ medical records that the inpatient rehabilitation services were medically necessary and reasonable.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 7/15/2019 **Entity Location:** Pennsylvania **Government Program(s):** Medicare & Medicaid

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers



Anne Arundel Medical Centre to Pay More Than \$3 Million To Settle Federal False Claims Act Allegations

Company Name: Anne Arundel Medical Center | **Issue(s):** E/M Services
Settlement: \$3,154,000

The U.S. Attorney for the District of Maryland announced that Maryland – Anne Arundel Medical Center (“AAMC”), located in Annapolis, Maryland, has agreed to pay the United States \$3,154,000 and enter into a [five-year corporate integrity agreement](#) to settle allegations under the False Claims Act that it submitted false claims to Medicare for services that were not medically necessary.

The DOJ reported allegations that, between January 1, 2010 and December 31, 2013, AAMC submitted false claims to Medicare, TRICARE, and the Federal Employees Health Benefits Program for E/M services that were not medically reasonable and necessary at the same time it submitted and was paid for claims for the blood tests.

The settlement resolves a lawsuit brought by Barbara McHenry, a former AAMC employee, under the qui tam, or whistleblower, provisions of the False Claims Act. As part of the settlement, the whistleblower will receive \$473,100.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 6/27/2019 **Entity Location:** Maryland **Government Program(s):** Medicare, TRICARE & FEHBP

Oklahoma City Hospitals Agree to Pay \$2.8 Million to Settle Allegations of Submitting False Claims to Medicaid

Company Name: Oklahoma Heart Hospital, LLC; Oklahoma Heart Hospital South, LLC | **Issue(s):** Billing for Nonemergency Prescheduled Cardiovascular Stent Procedures
Settlement: \$2,800,000

The U.S. Attorney’s Office of the Western District of Oklahoma reported that Oklahoma Heart Hospital, LLC and Oklahoma Heart Hospital South, LLC, have agreed to pay \$2,800,000 and enter into a [five-year corporate integrity agreement](#) to settle civil claims stemming from allegations that they submitted false claims to Medicaid.

The DOJ reported allegations that, from January 1, 2010, through December 31, 2016, OHH caused false claims to be submitted to Medicaid for certain nonemergency prescheduled cardiovascular stent procedures under Diagnosis Related Group Codes 247 and 249. The claims were false because OHH billed the procedures as inpatient services to increase its revenue when the procedures should have been billed and reimbursed as outpatient services.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 3/31/2019 **Entity Location:** Oklahoma **Government Program(s):** Medicaid

Avanti Hospitals LLC, and Its Owners Agree to Pay \$8.1 Million to Settle Allegations of Making Illegal Payments in Exchange for Referrals

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers



Company Name: Avanti Hospitals, LLC; Memorial Hospital of Gardena | **Issue(s):** Stark & Anti-Kickback
Settlement: \$8,100,000

The US DOJ announced that Los Angeles-based Avanti Hospitals LLC (Avanti) and six of its owners will pay the federal government \$8.1 million and enter into a [five-year corporate integrity agreement](#) to settle claims that they violated the False Claims Act by submitting, or causing Avanti’s subsidiary, Memorial Hospital of Gardena (Gardena Hospital), to submit false claims to the Medicare and Medicaid programs for medical services referred by a physician who received kickbacks and other improper payments from Gardena and other Avanti affiliates. This agreement resolved the allegations that Avanti, Gardena Hospital and at least two other Avanti affiliates provided compensation to a physician they engaged as a medical director that (1) exceeded fair market value for his services, and (2) was an attempt to incentivize him to refer patients to Gardena Hospital.

The settlement partially resolves allegations originally brought in a lawsuit filed under the qui tam, or whistleblower, provisions of the False Claims Act by Dr. Joshua Luke, the former C.E.O. of Gardena Hospital. Dr. Luke will receive approximately \$1.6 million from the federal government.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 1/28/2019 **Entity Location:** California **Government Program(s):** Medicare & Medicaid

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers

Long Term Care

[NEW] SavaSeniorCare LLC Agrees to Pay \$11.2 Million to Resolve False Claims Act Allegations

Company Name: SavaSeniorCare LLC
Settlement: \$11,200,000

Issue(s): Rehabilitation Therapy Services

The US DOJ announced that SavaSeniorCare LLC and related entities (Sava), based in Georgia, have agreed to pay \$11.2 million, plus additional amounts if certain financial contingencies occur, as well as enter into a [five-year corporate integrity agreement](#), to resolve allegations that Sava violated the False Claims Act by causing its skilled nursing facilities (SNFs) to bill the Medicare program for rehabilitation therapy services that were not reasonable, necessary or skilled, and to resolve allegations that Sava billed the Medicare and Medicaid programs for grossly substandard skilled nursing services. Sava currently owns and operates SNFs across the country.

The US DOJ alleged that, in 2015, the government filed a consolidated False Claims Act complaint against Sava, alleging that between October 2008 and September 2012, Sava knowingly submitted false claims for rehabilitation therapy services as a result of a systematic effort to increase its Medicare billings. The United States' complaint alleged that, through corporate-wide policies and practices, Sava exerted significant pressure on its SNFs to meet unrealistic financial goals, resulting in the provision of medically unreasonable, unnecessary or unskilled services to Medicare patients. Sava allegedly set these aggressive, prospective corporate targets for the highest Medicare reimbursement rates without regard for its patients' actual clinical needs and then pressured its staff to meet those targets. Sava also allegedly sought to increase its Medicare payments by delaying the discharge of patients from its facilities, even though the patients were medically ready to be discharged.

This settlement also resolves allegations that between October 2008 and September 2012, Sava knowingly submitted false claims to Medicaid for coinsurance amounts for rehabilitation therapy services for beneficiaries eligible for both Medicare and Medicaid and for whom Sava also allegedly submitted or caused the submission of false claims to Medicare for those services.

In addition, this settlement resolves allegations that between January 2008 and December 2018, Sava knowingly submitted false claims for payment to Medicare and Medicaid for grossly and materially substandard and/or worthless skilled nursing services. The government alleged that some of the nursing services provided by Sava failed to meet federal standards of care and federal statutory and regulatory requirements, including failing to have sufficient staffing in certain facilities to meet certain residents' needs. The government also alleged that in certain skilled nursing facilities, Sava failed to follow appropriate pressure ulcer protocols and appropriate falls protocols, and failed to appropriately administer medications to some of the residents.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 5/21/2021

Entity Location: Georgia

Government Program(s): Medicare & Medicaid

Provider

Hospital

Long Term Care

Medical Equipment and
Supplies

Behavioral Health

Prescriber and Drug
Testing Services

Physical and Other
Therapies

Other Providers and
Suppliers



Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers

Hope Hospice Agrees to Pay \$3.2 Million To Settle False Claims Act Liability

Company Name: Hope Hospice
Settlement: \$3,200,000

Issue(s): Hospice and Palliative Care Services

The US Attorney for the Middle District of Florida announced that Hope Hospice has agreed to pay the United States \$3.2 million and enter into a [five-year corporate integrity agreement](#) to resolve allegations that it knowingly submitted false claims to Medicare, Medicaid, and TRICARE for hospice care provided to beneficiaries who did not qualify for the service.

The DOJ reported allegations that from July 1, 2012 to June 30, 2016, Hope Hospice billed Medicare for four or more years of hospice care for certain patients who were not terminally ill for at least a portion of their greater than four-year hospice stay. Additionally, it was alleged that Hope Hospice knowingly submitted false claims to Medicare, Medicaid, and TRICARE for general inpatient (“GIP”) hospice care in circumstances where that higher level of care was not medically necessary. According to the settlement agreement, the United States alleged that Hope Hospice knowingly submitted false claims from January 1, 2011 to June 30, 2016, to Medicare, Medicaid and TRICARE for unnecessary GIP hospice care for certain patients for whom Hope Hospice billed for over two weeks of GIP care.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 7/8/2020

Entity Location: Massachusetts

Government Program(s): Medicare, Medicaid & TRICARE

Nursing Home Chain Saber Healthcare Agrees to Pay \$10 Million to Settle False Claims Act Allegations

Company Name: Saber Healthcare Holdings, LLC and related companies
Settlement: \$10,000,000

Issue(s): Rehabilitation Therapy Services

The US DOJ Office of Public Affairs announced that Saber Healthcare Group LLC and related entities have agreed to pay \$10 million and enter into a [five-year corporate integrity agreement](#) to resolve allegations that Saber violated the False Claims Act by knowingly causing some of its skilled nursing facilities (SNFs) to submit false claims to Medicare for rehabilitation therapy services that were not reasonable, necessary, or skilled.

The DOJ reported allegations that Saber improperly established general goals that all patients should be provided with the Ultra High level of therapy, regardless of the patients’ individual therapeutic needs, and enforced that expectation by pressuring therapists to provide Ultra High therapy to each patient at nine facilities. The United States further contended that Saber established uniform expectations for Ultra High therapy in facility budgets, pressured facility directors in weekly or daily calls to ensure therapists provided the Ultra High therapy to each patient, prevented therapists from providing lower levels of therapy minutes if, in the therapists’ clinical judgment, a lower amount was warranted, caused therapists to report time spent on initial evaluations as therapy time in violation of Medicare policy, and caused therapists to report time spent providing unskilled services as time spent on skilled therapy.



The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 4/14/2020

State: Ohio

Government Program(s): Medicare

Diversicare Health Services Inc. Agrees to Pay \$9.5 Million to Resolve False Claims Act Allegations Relating to the Provision of Medically Unnecessary Rehabilitation Therapy Services

Company Name: Diversicare Healthcare Services, Inc.
Settlement: \$9,500,000

Issue(s): Rehabilitation Therapy Services

The US DOJ Office of Public Affairs announced that Diversicare Health Services Inc. has agreed to pay \$9.5 million and enter into a [five-year corporate integrity agreement](#) to resolve allegations that it violated the False Claims Act by knowingly submitting false claims to Medicare for rehabilitation therapy services that were not reasonable, necessary, or skilled. The settlement also resolves allegations that Diversicare submitted forged pre-admission evaluations of patient need for skilled nursing services to TennCare, the state of Tennessee's Medicaid Program.

The DOJ reported allegations that Diversicare submitted claims for Ultra High therapy levels despite evidence that (1) the frequency and duration of physical or occupational therapy were not reasonable or necessary for the patient, (2) the intensity of the physical or occupational therapy was inappropriate for the patient and not reasonable or necessary, (3) services did not require the skills of a therapist to perform them, and (4) speech therapy was medically unnecessary. This included specific instances of improper co-treatment in order to achieve minute thresholds, repetitive and unskilled exercises that did not match plan of care goals to obtain additional minutes, engaging patients in activities contraindicated by underlying medical conditions, inflating ADL scores, extending patient lengths of stay beyond what was medically indicated, billing for services that were not provided, using budgets, goals, and quotas to ensure Ultra High therapy was maximized, and threatening or undertaking adverse actions against employees if they failed to meet the budgets, goals, or quotas.

The settlement resolves allegations originally brought in lawsuits filed under the qui tam, or whistleblower, provisions of the False Claims Act by Mary Haggard and Bryant Fitzmorris, former Diversicare employees. Ms. Haggard will receive approximately \$1.4 million and Mr. Fitzmorris will receive approximately \$145,350.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 2/28/2020

State: Tennessee

Government Program(s): Medicare & Medicaid

Guardian Elder Care Holdings and Related Entities Agree to Pay \$15.4 Million to Resolve False Claims Act Allegations for Billing for Medically Unnecessary Rehabilitation Therapy Services

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers



Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers

Company Name: Guardian Elder Care Holdings Inc. and related companies
Settlement: \$ 15,466,278

Issue(s): Rehabilitation Therapy Services, Excluded Professionals

The US DOJ Office of Public Affairs announced that Guardian Elder Care Holdings Inc. and related companies Guardian LTC Management Inc., Guardian Elder Care Management Inc., Guardian Elder Care Management I Inc., and Guardian Rehabilitation Services Inc., (Guardian) agreed to pay \$15,466,278 and enter into a [five-year corporate integrity agreement](#) to resolve False Claims Act allegations that they knowingly overbilled Medicare and the Federal Employees Health Benefits Program (FEHBP) for medically unnecessary rehabilitation therapy services.

The DOJ reported allegations that Guardian caused certain facilities in Pennsylvania, West Virginia, and Ohio to bill for patients at the highest level of Medicare reimbursement, when services at that level were not medically necessary and were influenced by financial considerations rather than resident needs. The settlement also resolves allegations voluntarily disclosed by Guardian that it had employed two people who were excluded from federal healthcare programs. As a result of its employment of these two excluded individuals, Guardian inappropriately received payment for ineligible services.

These allegations were originally brought by two former Guardian employees, Phillipa Krause and Julie White, under the whistleblower, or qui tam, provisions of the False Claims Act. The whistleblowers in this case will receive approximately \$2.8 million.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 2/19/2020 **State:** Pennsylvania **Government Program(s):** Medicare & FEHBP

Medical Doctor Settles Civil Fraud Allegations in Adult Homes Investigation

Company Name: New York Otolaryngology & Aesthetic Surgery, P.C.
Settlement: \$ \$1,109,000

Issue(s): Anti-Kickback, Allergy Testing

The US Attorney for the Eastern District of New York announced that Dr. Rajendra Bhayani, an otolaryngologist, has agreed to pay the United States \$1,109,000 and enter into a [three-year corporate integrity agreement](#) to resolve civil allegations that he and his practice – New York Otolaryngology & Aesthetic Surgery, P.C. in Brooklyn and Queens – paid kickbacks and submitted false claims to federal healthcare programs for services provided to residents in adult homes in violation of the False Claims Act.

The DOJ reported allegations that, from 2012 through 2016, Bhayani allegedly paid cash tips, excessive rent and other improper remuneration to medical management companies in adult homes in the Eastern District of New York to obtain exclusive access to bill for allergy testing and other medical services to residents in violation of the Anti-Kickback Statute. Bhayani then obtained payment for these services from Medicare and the Federal Employees' Health Benefits Program (FEHBP), although the services were actually performed by his nurse practitioner, and some of the services performed were medically unnecessary.



The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 1/21/2020

State: New York

Government Program(s): Medicare & FEHBP

Louisiana Department of Health to Pay \$13.42 Million to Settle Alleged False Medicaid Claims for Nursing Home and Hospice Care

Company Name: Louisiana Department of Health
Settlement: \$13,420,550

Issue(s): Nursing Home and Hospice Services

The US DOJ Office of Public Affairs announced that the Louisiana Department of Health has agreed to pay \$13,422,550 and enter into a [three-year corporate integrity agreement](#) to resolve allegations that it submitted false and inflated Medicaid claims for long-term nursing home and hospice care.

The DOJ reported allegations that the Louisiana Department of Health knew that the rates determining the federal share of Louisiana’s Medicaid payments were set to decrease following the months of December 2010, March 2011, June 2011, and September 2013. To receive the higher Federal share percentage rates in effect during these months, the Louisiana Department of Health fraudulently caused its healthcare contractor, Molina Medical Solutions, to prepare, submit, and pay claims for nursing home and hospice services in these months, before the providers had submitted to Louisiana any claims for them. Louisiana then claimed Federal reimbursement for those premature payments. As a result, the Louisiana Department of Health received a Federal share based upon the higher percentage rate in effect in those months, rather than the lower percentage rate in effect the following months when the providers actually submitted their claims to Louisiana.

The claims resolved by this settlement are allegations only, and there has been no determination of liability.

Date: 11/13/2019

State: Louisiana

Government Program(s): Medicaid

Skilled Nursing Facility Management Company Agrees to Settle False Claims Act Allegations

Company Name: Tennessee Health Management, Inc
Settlement: \$9,764,108

Issue(s): Nursing Facility Services

The US Attorney for the Middle District of Tennessee announced that Tennessee Health Management, Inc. (“THM”) has agreed to pay \$9,764,108 and enter into a [five-year corporate integrity agreement](#) to settle allegations that it violated the False Claims Act.

The DOJ reported allegations that THM submitted pre-admission evaluations with photocopied or pre-signed physician signatures on the required certifications for claims rendered to TennCare beneficiaries at its associated Tennessee skilled nursing and rehabilitation facilities.

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers



The claims resolved by this settlement are allegations only, and there has been no determination of liability.

Date: 2/5/2019

State: Tennessee

Government Program(s): Medicaid

Provider

Hospital

Long Term Care

Medical Equipment and
Supplies

Behavioral Health

Prescriber and Drug
Testing Services

Physical and Other
Therapies

Other Providers and
Suppliers

Medical Equipment and Supplies

Shreveport Prosthetics, Inc. Agrees to Pay \$1.6 Million to Resolve False Claims Act Allegations

Company Name: Shreveport Prosthetics, Inc.
Settlement: \$1,600,000

Issue(s): Supplier Billings

The US Attorney for the Western District of Louisiana announced that Shreveport Prosthetics, Inc. (“SPI”) has agreed to pay \$1.6 million, plus interest, and enter into a [three-year corporate integrity agreement](#) to the federal government to resolve allegations that it violated the False Claims Act for false supplier billings to the Medicare program.

The DOJ reported allegations that when SPI’s supplier number was deactivated, SPI funneled its claims to Medicare through a supplier in Texas for services that were rendered by SPI in Louisiana. SPI also routinely waived patient coinsurance amounts over a three-year period, resulting in Medicare being overcharged for the billed services. This lawsuit was initiated by former office administrator/billing specialist Kimberly Throgmorton under the qui tam, or whistleblower provisions, of the False Claims Act. Ms. Throgmorton will receive over a quarter of a million as her share of the government’s recovery.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 10/14/2020

Entity Location: Louisiana

Government Program(s): Medicare

Resmed Corp. to Pay the United States \$37.5 Million for Allegedly Causing False Claims Related to the Sale of Equipment for Sleep Apnea and Other Sleep-Related Disorders

Company Name: ResMed Corp.
Settlement: \$37,500,000

Issue(s): Anti-Kickback, Sleep Labs, Home Sleep Testing

The DOJ Office of Public Affairs announced that ResMed Corp., a manufacturer of durable medical equipment (DME) based in San Diego, California, has agreed to pay more than \$37.5 million and enter into a [five-year corporate integrity agreement](#) to resolve allegations that ResMed; (a) provided DME companies with free telephone call center services and other free patient outreach services that enabled these companies to order resupplies for their patients with sleep apnea, (b) provided sleep labs with free and below-cost positive airway pressure masks and diagnostic machines, as well as free installation of these machines, (c) arranged for, and fully guaranteed the payments due on, interest-free loans that DME supplies acquired from third-party financial institutions for the purchase of ResMed equipment, and (d) provided non-sleep specialist physicians free home sleep testing devices referred to as “ApneaLink.”

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 1/15/2020

Entity Location: California

Government Program(s): Medicare & Medicaid

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers

Behavioral Health

Universal Health Services, Inc. And Related Entities to Pay \$122 Million To Settle False Claims Act Allegations Relating to Medically Unnecessary Inpatient Behavioral Health Services and Illegal Kickbacks

Company Name: Universal Health Services, Inc., Turning Point Care Center, LLC
Settlement: \$122,000,000

Issue(s): Anti-Kickback, Inpatient Behavioral Health Services

The US DOJ Office of Public Affairs announced that Universal Health Services, Inc., UHS of Delaware, Inc. (together UHS), and Turning Point Care Center, LLC (Turning Point), have agreed to pay a combined total of \$122 million and enter into a [five-year corporate integrity agreement](#) to resolve alleged violations of the False Claims Act for billing for medically unnecessary inpatient behavioral health services, failing to provide adequate and appropriate services, and paying illegal inducements to federal healthcare beneficiaries.

The DOJ reported allegations that, between January 2006 and December 2018, UHS's facilities admitted federal healthcare beneficiaries who were not eligible for inpatient or residential treatment because their conditions did not require that level of care, while also failing to properly discharge appropriately admitted beneficiaries when they no longer required inpatient care. The government further alleged that UHS's facilities billed for services not rendered and improper and excessive lengths of stay, failed to provide adequate staffing, training, and/or supervision of staff, and improperly used physical and chemical restraints and seclusion. In addition, UHS's facilities allegedly failed to; (1) develop and/or update individual assessments and treatment plans for patients, (2) provide adequate discharge planning, and (3) provide required individual and group therapy services in accordance with federal and state regulations.

The government's settlement with UHS resolves 18 cases pending in the Eastern District of Pennsylvania, Western District of Michigan, the Eastern District of Michigan, and Northern District of Georgia under the qui tam, or whistleblower, provision of the False Claims Act. The whistleblower share of the federal portion of the settlement will be \$15,862,457. The settlement with Turning Point resolves an additional qui tam lawsuit filed in the Northern District of Georgia. The whistleblower in that suit will receive \$861,853, from the federal share of the Turning Point settlement.

The claims resolved by the settlements are allegations only, and there has been no determination of liability.

Date: 7/10/2020

Entity Location: Pennsylvania

Government Program(s): Medicare, Medicaid, TRICARE, Department of Veteran Affairs, Federal Employee Health Benefit Programs (FEHBP)

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers



Ashland Physician and Substance Abuse Treatment Center Agree to Pay \$1.4 Million to Resolve Civil Claims

Company Name: Ultimate Care Medical Services, LLC
Settlement: \$1,400,000

Issue(s): E&M Services and prescription of controlled substances

The US Attorney for the Eastern District of Kentucky announced that an Ashland addiction treatment specialist, Dr. Rose O. Uradu, and her substance abuse treatment center, Ultimate Care Medical Services, LLC d/b/a Ultimate Treatment Center, have agreed to pay \$1.4 million and enter into a [three-year corporate integrity agreement](#) to resolve civil allegations that that Ultimate Treatment Center, at the direction of Dr. Uradu, sought and received payments from Medicare and Kentucky Medicaid for services that were not actually provided to patients.

The DOJ reported allegations that, between January 2013 and September 2014, defendants billed these government programs for “evaluation and management” services, purportedly provided to patients who visited the clinic to receive daily methadone doses. The United States alleged that Ultimate Treatment Center did not actually perform these services when patients received their methadone doses, but falsely documented the performance of these services, in the patients’ medical records, to create the false appearance that the reimbursement was justified. The United States further alleged that, during the period July 2013 to December 2014, defendants billed Medicare and Kentucky Medicaid for complex urine drug testing that the clinic’s equipment was incapable of performing.

The United States also alleged that Dr. Uradu issued buprenorphine prescriptions to more patients than permitted by law for a three-month period in 2014. Buprenorphine is marketed under the brand names Suboxone and Subutex, and is used medically in the treatment of opioid addiction. Because buprenorphine has the potential for diversion and abuse by recreational users, it is a controlled substance regulated by law. Dr. Uradu was only permitted to treat 100 patients with buprenorphine drug products, but repeatedly exceeded her patient limit.

The claims resolved by the settlements are allegations only, and there has been no determination of liability.

Date: 8/16/2019

Entity Location: Kentucky

Government Program(s): Medicare & Medicaid

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers

Prescribers and Drug Testing Services

United States Attorney Mike Stuart Announces Healthcare Fraud Settlement for Over \$1.2 Million

Company Name: Great Lakes Medical Laboratory, Inc. | **Issue(s):** Laboratory Services
Settlement: \$1,200,738

The US Attorney for the Southern District of West Virginia announced that Great Lakes Medical Laboratory, Inc. (Great Lakes) will pay \$1,200,738 and enter into a [three-year corporate integrity agreement](#) to resolve allegations that the Michigan laboratory engaged in a billing scheme that defrauded Medicare and the United Mine Workers of America 1992 Benefit Plan, the 1993 Benefit Plan, and the Combined Benefit Fund (UMWA Funds) of \$600,369.

The DOJ reported allegations that, in or about January 4, 2016 continuing into or about May 12, 2017, Great Lakes presented at least 21,732 claims to Medicare and the UMWA Funds which included separate claims for reimbursement for services which were already included in bills submitted for other laboratory services. Moreover, investigators learned that the fraudulent claims were for services that were not specifically ordered by the referring physicians and determined that there was no indication that the services billed were performed. These false claims resulted in a loss to Medicare and the UMWA Funds in the amount of \$600,369. As a result of the \$1,200,738 settlement, which represents twice the actual loss suffered by Medicare and the UMWA Funds, both federal programs will be made whole.

The claims resolved by this settlement are allegations only, and there has been no determination of liability.

Date: 10/23/2020 **Entity Location:** Michigan **Government Program(s):** Medicare

DOJ settles False Claims Act allegations against drug testing lab with operations in Tacoma and Denver

Company Name: Cordant Health Solutions | **Issue(s):** Anti-Kickback, Urine Testing Services
Settlement: \$11,942,913

The US Attorney for the Western District of Washington announced that Cordant Health Solutions (Cordant) settled a civil suit alleging Cordant illegally paid kickbacks to generate urine testing business from government insured consumers. Cordant has agreed to pay various government healthcare programs \$11,942,913 and enter into a [five-year corporate integrity agreement](#) to settle the allegations. Twenty percent of the settlement will go to the relator who first filed a qui tam case regarding the conduct in 2015, alerting the government to the misconduct.

The DOJ reported allegations that Cordant paid millions of dollars in remuneration to Northwest Physicians Laboratories, LLC (“NWPL”), and Genesis Marketing Group (“Genesis”) in exchange for referrals of urine drug tests paid for by federal healthcare programs in violation of the Anti-Kickback Statute and the False Claims Act. The kickbacks were paid to NWPL for claims that were filed between January 1, 2013, and July 31, 2015, and to Genesis from August 7, 2013, through March 31, 2015.

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers



The claims resolved by this settlement are allegations only, and there has been no determination of liability.

Date: 7/20/2020

Entity Location: Colorado

Government Program(s): Medicare & TRICARE

Associated Pain Specialists, P.C. Of Knoxville Enters into Settlement Resolving False Claims Act Allegations

Company Name: Associated Pain Specialists, P.C.
Settlement: \$400,000

Issue(s): Heart Rate Variability, Pulse Wave Velocity and Sudomotor Function Tests

The US Attorney for the Eastern District of Tennessee announced that, on June 26, Associated Pain Specialists, P.C., of Knoxville agreed to pay \$400,000 and enter into a [three-year corporate integrity agreement](#) to resolve allegations of violating the False Claims Act.

The DOJ reported allegations that Associated Pain Specialists, P.C. performed tests on patients whose medical records did not support a medical diagnosis for the tests and the associated billing codes. The government also alleged the Vital System Assessment Tests (VSAT) did not benefit patients because the test results were not used in the treatment subsequently provided and Associated Pain Specialists, P.C. knowingly submitting false claims to federal health care programs for payment for VSATs that were not reasonable or medically necessary. Allegations were brought in a lawsuit filed under the qui tam, or whistleblower, provisions of the False Claims Act.

The claim settled by this agreement are allegations only, and there has been no determination of liability.

Date: 7/11/2020

State: Tennessee

Government Program(s): Medicaid

Milwaukee Pain Management Clinic and Physician Agree to Pay At Least \$1.35 Million to Resolve Allegations They Violated the False Claims Act and Anti-Kickback Statute

Company Name: Center for Pain Management, S.C.
Settlement: \$1,350,000

Issue(s): Anti-Kickback, Urine Drug Tests

The US Attorney for the Eastern District of Wisconsin announced that Center for Pain Management, S.C. (“CPM”), and its owner, Dr. Nosheen Hasan, agreed to pay at least \$1.35 million and entered into a [three-year corporate integrity agreement](#) to resolve allegations that they received kickbacks from a urine drug testing laboratory in exchange for ordering medically unnecessary tests for Medicare and Medicaid patients.

According to the allegations in the Complaint-in-Intervention filed by the United States in the case, CPM and Dr. Hasan received illegal remuneration from Midwest Laboratory Sales & Consulting, LLC (“Midwest”), and its owner, Matthew Samuelson, in exchange for ordering urine drug tests performed by Midwest. The government further alleged that CPM and Dr. Hasan ordered these tests despite knowing that they were not medically necessary. Over the course of the more

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers

than five-year-long arrangement, CPM and Dr. Hasan ordered thousands of unnecessary tests that were paid for by Medicare and Medicaid and received over \$1 million in illegal kickbacks from Midwest for ordering the tests.

The claim settled by this agreement are allegations only, and there has been no determination of liability.

Date: 5/1/2020

State: Wisconsin

Government Program(s): Medicare & Medicaid

Reference Laboratory, Pain Clinic, and Two Individuals Agree to Pay \$41 Million to Resolve Allegations of Unnecessary Urine Drug Testing

Company Name: Tampa Pain Relief Centers Inc; Logan Laboratories, LLC; Surgery Partners Inc.
Settlement: \$41,000,000

Issue(s): Urine Drug Testing Services

The US DOJ Office of Public Affairs announced that Logan Laboratories Inc. (Logan Labs), a reference laboratory in Tampa, Florida, Tampa Pain Relief Centers Inc. (Tampa Pain), a pain clinic also based in Tampa Florida, and two of their former executives, Michael T. Doyle and Christopher Utz Toepke (collectively, Defendants) have agreed to pay a total of \$41 million and enter into a [five-year corporate integrity agreement](#) to resolve alleged violations of the False Claims Act for billing Medicare, Medicaid, TRICARE, and other federal health care programs for medically unnecessary Urine Drug Testing (UDT).

The DOJ reported allegations that the defendants knowingly submitted or caused the submission of false claims to federal health care programs for presumptive and definitive UDT, in circumstances where such testing was not medically reasonable or necessary. The government alleged that Defendants developed and implemented a policy and practice of automatically ordering both presumptive and definitive UDT for all patients at every visit, without any physician making an individualized determination that either test was medically necessary for the particular patients for whom the tests were ordered. The allegations that are the subject of the settlement were originally alleged in two cases filed under the whistleblower, or qui tam, provision of the False Claims Act. The whistleblowers will receive approximately \$7.79 million of the settlement.

The claims resolved by this settlement are allegations only, and there has been no determination of liability.

Date: 4/15/2020

Entity Location: Florida

Government Program(s): Medicare, Medicaid, TRICARE

Jacksonville-Area Doctor pays \$850,000 To Settle Allegations She Received Illegal Kickbacks to Prescribe the Fentanyl Drug Subsys

Company Name: Parveen Khanna, M.D.
Settlement: \$850,000

Issue(s): Anti-Kickback

The U.S. Attorney's Office of the Middle District of Florida reported that Dr. Parveen Khanna paid the United States \$850,000 and entered into a [three-year corporate integrity agreement](#) to resolve allegations that, for many years, Insys Pharmaceuticals, Inc. ran a wide-ranging scheme to increase the sales of its signature drug Subsys, a sublingual fentanyl spray that is a powerful, but highly addictive, opioid painkiller. In 2012, Subsys was approved by the Food and Drug

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers



Administration for the breakthrough treatment of persistent pain in adult cancer patients who were already receiving, and tolerant to, around-the-clock opioid therapy.

The DOJ reported allegations that Insys used “speaker programs” to increase brand awareness of Subsys through peer-to-peer educational lunches and dinners. However, the programs were used as a vehicle to pay bribes and kickbacks to targeted practitioners in exchange for increased Subsys prescriptions to patients and for increased dosage of those prescriptions.

The claim settled by this agreement are allegations only, and there has been no determination of liability.

Date: 3/20/2020

State: Florida

Government Program(s): Medicare & TRICARE

Lexington Laboratory Agrees to Pay \$2.1 Million to Resolve Allegations of False Claims for Urine Drug Testing Services

Company Name: LabTox, LLC
Settlement: \$2,101,335

Issue(s): Urine Drug Testing, Specimen Validity Testing

The US Attorney for the Eastern District of Kentucky announced that LabTox, LLC, a clinical laboratory in Lexington, has agreed to pay \$2,101,335 and enter into a [three-year corporate integrity agreement](#) to resolve allegations related to urine drug testing services LabTox provided to Medicare and Kentucky Medicaid beneficiaries.

According to allegations in the settlement agreement, from January 2014 to March 2015, LabTox billed Medicare and Kentucky Medicaid for qualitative urine drug screens completed by a high complexity method. The United States alleged that these claims were false because LabTox misrepresented the complexity of its testing method and the method was low complexity, not high complexity, as LabTox claimed. By billing the screens as high complexity, LabTox secured higher reimbursements to which it was not entitled.

The United States further alleged that LabTox billed Medicare for specimen validity testing, a quality control process used to analyze a urine specimen to ensure that it has not been diluted or adulterated. Since January 2014, Medicare’s guidance has been explicit that specimen validity testing should not be separately billed to Medicare. The United States alleged that LabTox nonetheless submitted claims to Medicare for specimen validity testing during the period January 2014 to February 2016.

The claims resolved by this settlement are allegations only, and there has been no determination of liability.

Date: 11/19/2019

Entity Location: Kentucky

Government Program(s): Medicare & Medicaid

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers



United States Files Suit Against Pharmacy, Pharmacy Owner, and Pharmacist-in-Charge for Alleged False Billing

Company Name: G&A Somerton Pharmacy LLC

Settlement: \$1,300,000

Issue(s): Prescription Drugs

The U.S. Attorney's Office of the Eastern District of Pennsylvania reported that G&A Somerton Pharmacy LLC ("Somerton"), its owner Polina Khodak, and its pharmacist-in-charge, Inessa Lerner, have agreed to pay nearly \$1.3 million and enter into a [three-year corporate integrity agreement](#).

The DOJ reported allegations that G&A Somerton Pharmacy, LLC, Polina Khodak, and Inessa Lerner violated the False Claims Act when they knowingly billed Medicare for over \$1 million worth of prescription drugs that were never actually dispensed to beneficiaries. These medications included but were not limited to Lidoderm, Advair Diskus, Omeprazole, Solaraze, Nexium, Donepezil, Novolog, Meclizine, Lidocaine, and Januvia. Somerton and Khodak will also have to agree to a 10-year healthcare exclusion, which will prohibit them from receiving payments from any federally funded health care insurer such as Medicare.

The claim settled by this agreement are allegations only, and there has been no determination of liability.

Date: 9/23/2019

State: Pennsylvania

Government Program(s): Medicare

Middle Georgia Compounding Pharmacy Agrees to Pay \$365,000 to Resolve Fraud Claims

Company Name: Lake Country Pharmacy and Compounding Center

Settlement: \$ 365,000

Issue(s): Compounded Medications

The US Attorney's Office of the Middle District of Georgia reported that a civil settlement has been reached with Lake Country Pharmacy and Compounding Center (Lake Country) and its principals Chris and Carey Vaughan. Lake Country agreed to pay to the United States and the State of Georgia \$365,000 and enter into a [three-year corporate integrity agreement](#) to resolve allegations that it violated the False Claims Act and the Georgia False Medicaid Claims Act.

The DOJ reported allegations that Lake Country submitted bills for compounded medications dispensed to Medicare, Medicaid, and TRICARE beneficiaries that were made with non-reimbursable bulk powders but were billed as if they were made from reimbursable tablets. The settlement marks the end of a 36-month investigation into Lake Country's compounding pharmacy business that began with a lawsuit filed by a former pharmacist employed at Lake Country, under the whistleblower provisions of the False Claims Act and the Georgia False Medicaid Claims Act.

The claim settled by this agreement are allegations only, and there has been no determination of liability.

Date: 6/12/2019

State: Georgia

Government Program(s): Medicare, Medicaid & TRICARE

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers

Florida Doctor Agrees to Pay \$911,137 to Settle Alleged False Claims Act Violations Arising from Improper Financial Relationship with Drug Testing Laboratory

Company Name: Dr. Nathan Hanflink
Settlement: \$ 911,137

Issue(s): Stark Law & Anti-Kickback, Drug Testing Services

The US Attorney's Office of the Western District of Pennsylvania reported that Dr. Nathan Hanflink of Mt. Dora, Florida, agreed to pay \$911,137 and enter into a [three-year corporate integrity agreement](#) to settle allegations that he received improper payments for making referrals to Greensburg, Pennsylvania drug testing lab Universal Oral Fluid Laboratories, and caused false claims to be submitted to Medicare for drug testing services.

The DOJ reported allegations that Dr. Hanflink referred Medicare patients to Universal Oral Fluid Laboratories (UOFL) for lab tests while engaged in a financial relationship with UOFL. Specifically, UOFL paid Dr. Hanflink to refer patients to the lab for drug tests and UOFL then submitted claims to Medicare for the drug testing services.

The claim settled by this agreement are allegations only, and there has been no determination of liability.

Date: 6/6/2019

State: Florida

Government Program(s): Medicare

Pentec Health, Inc. to Pay \$17 Million to Settle False Claims Act Allegations

Company Name: Pentec Health, Inc.
Settlement: \$17,000,000

Issue(s): Renal & Specialized Drug Compounding

The US Attorney's Office of the Eastern District of Pennsylvania reported that Pentec Health, Inc. ("Pentec") agreed to pay the United States \$17 million and enter into a [five-year corporate integrity agreement](#) to settle allegations that Pentec submitted false claims to Medicare and other government healthcare programs.

The DOJ reported allegations that, from 2007 to 2018, Pentec billed Medicare and other federal healthcare programs for excessive amounts of product wasted during the compounding of Proplete. Additionally, Pentec routinely waived patient copayments and deductible obligations to induce the prescription and use of Proplete. Pentec also submitted duplicate and improperly coded claims to the Federal Employee Health Benefits Program.

The claim settled by this agreement are allegations only, and there has been no determination of liability.

Date: 2/4/2019

State: Pennsylvania

Government Program(s): Medicare & FEHBP

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers



Walgreen Co. Agrees to Pay \$3.5 Million to Settle Allegations Under the False Claims Act

Company Name: Walgreen Co.
Settlement: \$ 3,500,000

Issue(s): Stimulant Medications

The US Attorney's Office of the Eastern District of Wisconsin reported that Walgreens Co. has agreed to pay \$3.5 million and enter into a [five-year corporate integrity agreement](#) to settle allegations that Walgreens violated the False Claims Act by submitting claims to Medicaid for stimulant medications without complying with Medicaid rules designed to ensure that stimulants are dispensed for appropriate medical treatment.

The DOJ reported allegations that, from 2011 through 2014, Walgreens violated Wisconsin Medicaid rules by dispensing routinely stimulant medications to Wisconsin Medicaid beneficiaries without first verifying that the prescribing physician ordered the medication for medically appropriate treatment. The United States and the State of Wisconsin further allege that, by failing to verify that medications were prescribed for appropriate treatment, Walgreens dispensed and billed Wisconsin Medicaid for medically unnecessary medications.

The claim settled by this agreement are allegations only, and there has been no determination of liability.

Date: 1/23/2019

State: Wisconsin

Government Program(s): Medicaid

Manhattan U.S. Attorney Announces \$269.2 Million Recovery from Walgreens In Two Civil Healthcare Fraud Settlements

Company Name: Walgreen Co.
Settlement: \$269,200,000

Issue(s): Insulin Pens & Days-of-Supply Reporting

The US Attorney's Office of the Southern District of New York reported that Walgreens will pay a total of \$269.2 million and enter into a [five-year corporate integrity agreement](#) to resolve two different settlements. The first settlement requires Walgreens to pay \$209.2 million to settle allegations that it improperly billed Medicare, Medicaid, and other federal healthcare programs for hundreds of thousands of insulin pens it knowingly dispensed to program beneficiaries who did not need them. The second settlement requires Walgreens to pay \$60 million to resolve allegations that it overbilled Medicaid by failing to disclose to and charge Medicaid the lower drug prices that Walgreens offered the public through a discount program. In both settlements, Walgreens admitted and accepted responsibility for conduct the Government alleged in its complaints under the False Claims Act.

Insulin Pens Settlement

The United States' complaint alleges that Walgreens routinely submitted false days-of-supply data to federal healthcare programs when it sought federal reimbursement for insulin pens it dispensed to federal beneficiaries who did not need them. Specifically, Walgreens engaged in two practices that resulted in the fraudulent submissions. First, Walgreens configured its electronic pharmacy management system to prevent its pharmacists from dispensing less than a full box of five insulin pens, even when patients did not need that much insulin. Second, when a full box of insulin pens exceeded the federal healthcare program's limit on the total days of supply (i.e., the total number of daily doses) that could be dispensed

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers



and reimbursed at that time, Walgreens evaded this restriction by falsely stating in its reimbursement claims that the total days of supply did not go over the limit. As a result, federal healthcare programs paid Walgreens millions of dollars for insulin that many beneficiaries did not actually need, and substantial quantities of valuable medication were wasted.

Discount Drug Pricing Settlement

The United States’ complaint in this case alleges that Walgreens operated a program called the Prescription Savings Club (the “PSC”), under which customers received discounts when they ordered drugs from Walgreens. Medicaid regulations directed Walgreens to seek Medicaid reimbursement only at the lowest of certain drug price points, including the “usual and customary price” (“U&C price”). Medicaid rules of many states defined the U&C price as the price offered through discount programs like the PSC. Contrary to these requirements, Walgreens did not disclose to Medicaid the discount drug prices it offered customers through the PSC when it sought reimbursement from Medicaid. As a result, Medicaid programs paid Walgreens more in reimbursements than they would have paid had Walgreens disclosed the lower PSC prices.

The claim settled by this agreement are allegations only, and there has been no determination of liability.

Date: 1/22/2019

State: New York

Government Program(s): Medicare & Medicaid

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers

Physical and Other Therapies

New York Physical Therapy Providers Settle Civil Healthcare Fraud Allegations

Company Name: Williamsburg Physical Therapy, P.C. and Euro Physical Therapy, P.C.
Settlement: \$4,000,000

Issue(s): Physical Therapy Services

The US Attorney for the Eastern District of New York announced that Williamsburg Physical Therapy, P.C. and Euro Physical Therapy, P.C. have agreed to pay the United States and the State of New York \$4 million and enter into a [three-year corporate integrity agreement](#) to resolve civil allegations that they falsely billed Medicare, Medicaid, the Federal Employees' Compensation Act Program (FECA) and the Federal Employees' Health Benefits Program (FEHBP) for physical therapy services from 2008 to 2018. The settlement also resolves claims against the owners of the two physical therapy practices, Alex Klurfeld and Diana Klurfeld, and First Plus Services, Inc., a management company associated with the practices.

The DOJ reported allegations that the defendants submitted false claims to federal healthcare programs for physical therapy services provided or supervised by someone other than the licensed physical therapist identified on the claim, including unlicensed aides. The settlement also resolves claims that the defendants wrongfully backdated services after treatment authorizations had expired.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 10/2/2020

Entity Location: New York

Government Program(s): Medicare, Medicaid, (FECA),(FEHBP)

Contract Rehab Provider to Pay \$4 Million to Resolve False Claims Act Allegations Relating to the Provision of Medically Unnecessary Rehabilitation Therapy Services

Company Name: Encore Rehabilitation Services, LLC
Settlement: \$4,030,000

Issue(s): Rehabilitation Therapy Services

The US DOJ Office of Public Affairs reported that Encore Rehabilitation Services LLC (Encore) agreed to pay \$4.03 million and enter into a [five-year corporate integrity agreement](#) to resolve allegations that Encore violated the False Claims Act by knowingly causing three Michigan skilled nursing facilities to submit false claims to Medicare for rehabilitation therapy services that were not reasonable, necessary or skilled.

The DOJ reported allegations that Encore's policies and practices at three Michigan skilled nursing facilities resulted in the provision of unreasonable, unnecessary, or unskilled rehabilitation therapy or the recording of therapy minutes as individual therapy when concurrent or group therapy was actually provided.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 4/10/2020

Entity Location: Michigan

Government Program(s): Medicare

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Supplies

Other Providers and Suppliers

[NEW] EEG Testing and Private Investment Companies Pay \$15.3 Million to Resolve Kickback and False Billing Allegations

Company Name: Alliance Family of Companies LLC; Ancor Holdings LP
Settlement: \$15,300,000

Issue(s): Anti-Kickback, electroencephalography (EEG) testing

The US DOJ announced that two Texas companies have agreed to pay a combined \$15.3 million and enter into a [five-year corporate integrity agreement](#) to resolve allegations of kickbacks and other misconduct resulting in the submission of false claims to federal health care programs. Alliance Family of Companies LLC (Alliance), a national electroencephalography (EEG) testing company based in Texas, will pay \$13.5 million to resolve allegations that it submitted or caused to be submitted false claims to federal health care programs that resulted from kickbacks to referring physicians or that sought payment for work not performed or for which only a lower level of reimbursement was justified. The settlement also resolves allegations against Texas-based private investment company Ancor Holdings LP (Ancor), which will pay over \$1.8 million for causing false billings resulting from the kickback scheme through its management agreement with Alliance.

The United States alleged that Alliance induced physicians to order the company's EEG testing by providing kickbacks in the form of free EEG test-interpretation reports, thereby enabling primary care physicians who were not neurologists to bill the government as if they had interpreted the tests. The government also alleged that Alliance used an inaccurate billing code for certain EEG testing to generate higher reimbursements and billed for a specialized digital analysis that it did not actually perform. The United States alleged that Ancor learned of the kickbacks based on due diligence it performed prior to investing in Alliance and then caused false claims by allowing that conduct to continue once it entered into an agreement to manage Alliance.

The claims resolved by this agreement are allegations only, and there has been no determination of liability.

Date: 2/11/2021

Entity Location: Texas

Government Program(s): Medicare & Medicaid

Cardiologist Dinesh Shah Pays \$2 Million To Resolve False Claims Act Allegations Relating To Excessive Testing

Company Name: Michigan Physicians Group, P.C. (MPG)
Settlement: \$2,000,000

Issue(s): Diagnostic Testing

The US Attorney's Office for the Eastern District of Michigan announced that an Oakland County Cardiologist, Dinesh M. Shah, M.D. and his practice, Michigan Physicians Group, P.C. (MPG) have paid the United States \$2 million and entered into a five-year corporate integrity agreement to resolve allegations that they violated the False Claims Act by knowingly billing federal healthcare programs for diagnostic testing that was either unnecessary or not performed.

This settlement resolved allegations that from 2006 to 2017, Shah and MPG knowingly billed government programs, including Medicare, Medicaid, and TRICARE, for unnecessary diagnostic testing. The investigation focused on the

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers

Provider

Hospital

Long Term Care

Medical Equipment and
Supplies

Behavioral Health

Prescriber and Drug
Testing Services

Physical and Other
Therapies

Other Providers and
Suppliers

provision of a group of diagnostic tests, which included Ankle Brachial Index and Toe Brachial Index tests, known as ABI/TBIs, which were routinely performed on patients without first being ordered by a physician and without regard to medical necessity. The ABI compares blood pressure in the ankle to blood pressure in the arm to determine how well blood is flowing from the heart to the feet. The TBI is an additional measure to assess blood pressure readings at the toes.

The investigation also focused on the provision of unnecessary Nuclear Stress Tests. The United States alleged that Shah was routinely ordering, and MPG was providing, unnecessary Nuclear Stress Tests to some patients. During a Nuclear Stress Test, a small amount of radioactive tracer is injected into a vein, after which it is detected by a special camera that produces images used to evaluate blood flow to the heart.

The settlement resolved allegations originally brought in lawsuits filed under the qui tam, or whistleblower, provisions of the False Claims Act by two separate whistleblowers, Arlene Klinke and Khrystyna Mala, both former employees of MPG.

The claims resolved by this agreement are allegations only, and there has been no determination of liability.

Date: 2/11/2021

Entity Location: Michigan

Government Program(s): Medicare, Medicaid, and TRICARE

California Genetic Testing Company Agrees To Pay \$8.25 Million To Resolve False Claims Allegations; Paducah, Ky, Area Hospital Also Settles

Company Name: Agendia, Inc.

Settlement: \$8,250,000

Issue(s): Genetic Testing

The US Attorney's Office for the Western District of Kentucky announced an \$8.25 million settlement with Agendia, Inc., a molecular diagnostics testing company based in Irvine, California, for an alleged nationwide scheme to bill Medicare for Agendia's flagship genetic test, MammaPrint. The MammaPrint test analyzes the activity of certain genes within a breast cancer tumor to predict the risk of breast cancer recurrence in patients.

The allegations resolved by this settlement were first brought in a lawsuit filed by former employee of Lourdes Hospital, located in Paducah, Kentucky, under the qui tam, or whistleblower, provisions of the False Claims Act.

The DOJ reported allegations that Agendia conspired with hospitals to artificially delay ordering the MammaPrint genetic assay in order to circumvent Medicare's 14-Day Rule (which establishes who may bill Medicare for certain lab service). During the time period covered by the settlement, Medicare's 14-Day Rule prohibited laboratories from separately billing Medicare for tests performed on specimens if a physician ordered the test within 14 days of the patient's discharge from a hospital, regardless as to whether the patient was in an outpatient or inpatient setting. However, if the test was performed 14 days after discharge, then Medicare's 14-Day Rule permitted laboratories to bill Medicare directly for the test.

The United States alleges Agendia engaged in a nationwide scheme to circumvent Medicare's 14-Day Rule so that it could inappropriately bill Medicare directly for its MammaPrint tests that were ordered within 14 days. The United States contends that Agendia perpetrated this scheme in one of two ways:

- One way involved Agendia frequently refusing to perform MammaPrint tests if a Medicare patient had been discharged less than 14 days earlier. Agendia would cancel the order and then ask a physician to resubmit the order after the 14-day period had lapsed.

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers

- A second way used what Agendia employees coined a “Medicare hold” system, whereby Agendia automatically held orders for Medicare patients at the time they were received, refusing to test the specimens until 14 days after the patient’s discharge. For orders placed in this “Medicare hold,” Agendia personnel set calendar reminders for the fourteenth day after the patient had been discharged. Agendia personnel then contacted the doctor who had ordered testing, and asked the doctor to “confirm” the order. Agendia then used the “confirmed” date for purposes of billing Medicare instead of the date the test was originally ordered.

The claims resolved by this agreement are allegations only, and there has been no determination of liability.

Date: 1/13/2021 **Entity Location:** California **Government Program(s):** Medicare

Laredo eye doctor pays over \$3M to resolve fraud claims

Company Name: Mora Eye Clinic
Settlement: \$3,234,901

Issue(s): Punctual Plug Insertion, Sensorimotor Testing, Vision Therapy/Orthoptics and Amniotic Membrane Placement

The US Attorney for the Southern District of Texas announced that Dr. David Mora, an optometrist that owns Mora Eye Clinic in South Texas, has agreed to pay \$3,234,901 and enter into a [three-year corporate integrity agreement](#) to resolve allegations he fraudulently submitted claims to the Medicare program for medically unnecessary tests and procedures.

The DOJ reported allegations that Mora billed Medicare for medically unnecessary punctual plug insertion, sensorimotor testing, vision therapy/orthoptics and amniotic membrane placement. The patient’s condition did not warrant the service or test, or many treatments were repeated on the same patient more often than what would be medically reasonable or necessary.

The claims resolved by this agreement are allegations only, and there has been no determination of liability.

Date: 9/29/2020 **Entity Location:** Texas **Government Program(s):** Medicare

William M. Kelly, M.D., Inc And Omega Imaging, Inc. Agree to Pay \$5 Million to Resolve Alleged False Claims for Unsupervised and Unaccredited Radiology Services

Company Name: Omega Imaging, Inc.
Settlement: \$5,000,000

Issue(s): Radiology Services

The US DOJ Office of Public Affairs announced that William M. Kelly Inc. and Omega Imaging Inc. have agreed to pay the United States \$5 million and enter into a [three-year corporate integrity agreement](#) to resolve allegations that they violated the False Claims Act by knowingly submitting claims to Medicare and the military healthcare program, TRICARE, for unsupervised radiology services and services provided at unaccredited facilities.

The DOJ reported allegations that the defendants submitted claims for CT scans and MRIs involving contrast injections that were not properly supervised by a physician. The defendants allegedly performed and billed for these procedures when no supervising physician was present in the office suite. The settlement also resolves allegations that a certain number of the defendants’ facilities lacked accreditation.



The settlement resolves allegations originally brought in a lawsuit filed under the qui tam, or whistleblower, provisions of the FCA by Syd Ackerman, who was formerly employed by the defendants. Mr. Ackerman will receive approximately \$925,000 of the settlement proceeds.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 8/9/2020

Entity Location: California

Government Program(s): Medicare, Military Healthcare program, TRICARE

Acting Manhattan U.S. Attorney Announces \$49 Million Settlement with Biotech Testing Company for Fraudulent Billing and Kickback Practices

Company Name: Progenity Inc.

Settlement: \$49,000,000

Issue(s): Anti-Kickback, Prenatal Testing Services

The US Attorney for the Southern District of New York announced that Progenity Inc, a San Diego-based biotechnology company that provides molecular and diagnostic tests, has agreed to pay \$49 million dollars and enter into a [five-year corporate integrity agreement](#) to resolve claim that Progenity fraudulently billed federal healthcare programs for prenatal tests and provided kickbacks to physicians to induce them to order Progenity tests for their patients.

The DOJ reported allegations that Progenity overbilled Medicaid and the VA by fraudulently using a billing code that misrepresented the tests provided. The lawsuit further alleges that Progenity provided illegal kickbacks in the form of excessive “draw fees” to physicians, meals and happy hours for physicians and their staff, and the improper reduction or waiver of patient coinsurance and deductible payments.

The claims resolved by this settlement are allegations only, and there has been no determination of liability.

Date: 7/23/2020

Entity Location: California

Government Program(s): Medicaid

Sarasota-Based Ophthalmic Consultants Agrees to Pay \$4.8 Million To Resolve Claims of Multi-Dosing Patients

Company Name: Ophthalmic Consultants, P.A.

Settlement: \$4,800,000

Issue(s): Wet Age-related Macular Generation Treatments

The US Attorney for the Middle District of Florida announced that Ophthalmic Consultants, P.A. (Sarasota, FL) and Dr. Robert K. Snyder– collectively, Ophthalmic Consultants – have agreed to pay \$4.8 million and enter into a [three-year Integrity Agreement](#) to resolve allegations of healthcare fraud.

The DOJ reported allegations that Ophthalmic Consultants had submitted false claims to Medicare, TRICARE, and the Federal Employees Health Benefits Program (FEHBP) for treatments using the drugs ranibizumab (Lucentis) and aflibercept (Eylea) to treat patients who had wet age-related macular generation or other diseases of the eye. Although each vial contains a moderate overfill, Lucentis and Eylea are single-use medications that are not designed for multiple uses. Notwithstanding the single-use nature of Lucentis and Eylea, Ophthalmic Consultants engaged in the practice of multi-dosing (using a single drug vial to provide doses to multiple patients) to obtain excessive reimbursements.

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers



The Integrity Agreement includes also includes routine inventory requirements as well as requirements focusing on proper billing and submission of reimbursement claims.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 6/20/2020

Entity Location: Florida

Government Program(s): Medicare, TRICARE, and FEHBP

Alaska Neurology Center LLC and Its Owner to Pay \$2 Million to Settle False Claims Act Allegations Regarding Fraudulent Medical Billing

Company Name: Alaska Neurology Center LLC

Settlement: \$2,000,000

Issue(s): Physical Therapy Services

The US Attorney for the District of Alaska announced that Anchorage-based Alaska Neurology Center LLC and its owner, Franklin Ellenson, M.D., have agreed to pay \$2 million and enter into a [three-year corporate integrity agreement](#) to resolve False Claims Act allegations that the medical practice knowingly submitted false billing claims to federal healthcare programs.

The DOJ reported allegations that, from March 2013 through June 2018, Alaska Neurology Center LLC engaged in multiple fraudulent billing schemes, including: (1) submitting claims with false dates of service in order to obtain reimbursement beyond program caps, (2) submitting claims for infusion services provided by an unqualified medical assistant, (3) submitting claims for physical therapy when the service provided was non-reimbursable massage therapy, (4) submitting claims using multiple, unbundled billing codes, rather than a single required billing code, to obtain overpayment for the service, (5) submitting claims with false names of performing and/or referring medical providers, and (6) re-submitting claims with false service or diagnosis information, and without consulting a medical provider, after an original claim was rejected.

The allegations stem from a lawsuit filed under the whistleblower, or qui tam, provision of the False Claims Act. The whistleblower will receive approximately \$380,000 of the settlement.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 6/5/2020

Entity Location: Alaska

Government Program(s): Federal Healthcare Programs

Lexington Foot and Ankle Centre Agrees to Pay \$750,000 to Resolve Allegations of Violations of the False Claims Act

Company Name: Lexington Foot and Ankle Center

Settlement: \$750,000

Issue(s): Nail Debridement Services

The US Attorney for the Eastern District of Kentucky announced that Lexington-based podiatry practice Lexington Foot and Ankle Center, PSC (“Lexington Foot & Ankle”) and Dr. Michael Allen have agreed to resolve civil allegations that they violated the False Claims Act, agreeing to pay the United States \$750,000 and enter into a [five-year corporate integrity agreement](#).

The DOJ reported allegations that Lexington Foot & Ankle, at Dr. Allen’s direction, submitted false claims to Medicare and the Federal Employee Health Benefits Program (FEHBP), seeking payment for nail debridement services, for which

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers



podiatrists or other practitioners either did not assess or observe medical necessity or only performed less involved procedures. The lawsuit alleged that the defendants nevertheless submitted reimbursement claims for nail debridements, which are reimbursed at a higher rate. The United States further alleged that Lexington Foot & Ankle and Dr. Allen created cloned (or nearly identical) patient records, to secure reimbursement for the false debridement claims.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 5/4/2020 **Entity Location:** Kentucky **Government Program(s):** Medicare & FEHBP

Villages Dermatologist Agrees to Pay More Than \$1.7 Million To Settle False Claims Act Liability for Inflated Medicare Claims

Company Name: Village Dermatology and Cosmetic Surgery, LLC
Settlement: \$1,744,000

Issue(s): Mohs Surgery, Wound Repairs

The US Attorney for the Middle District of Florida announced that Dr. Thi Thien Nguyen Tran and Village Dermatology and Cosmetic Surgery, L.L.C. have agreed to pay the United States \$1.744 million and enter into a [three-year corporate integrity agreement](#) to resolve allegations that they violated the False Claims Act by submitting inflated claims to Medicare for wound repairs related to Mohs surgery.

The DOJ reported allegations that Dr. Tran and Village Dermatology performed wound repairs that were allegedly billed to Medicare as more complex adjacent tissue transfers, which carry a higher level of reimbursement. From January 1, 2011, through July 31, 2016, Dr. Tran and Village Dermatology billed for 14,000-level tissue transfers, which should have been billed as lower-level wound repairs. These submissions resulted in inflated claims that were paid by Medicare.

The settlement concludes a lawsuit originally filed in the United States District Court for the Middle District of Florida by Dr. Robert Green and Emily Kennedy under the qui tam, or whistleblower, provisions of the False Claims Act. Dr. Green and Ms. Kennedy will receive over \$305,000 of the proceeds from the settlement with Dr. Tran and Village Dermatology.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 3/13/2020 **State:** Florida **Government Program(s):** Medicare

U.S. Settles False Claims Act Allegations Against South-Eastern Retina Associates

Company Name: Southeastern Retina Associates, P.C.
Settlement: \$1,500,000

Issue(s): Various Exams

The US Attorney for the Eastern District of Tennessee announced that Southeastern Retina Associates ("SERA") has paid \$1.5 million and entered into a [five-year corporate integrity agreement](#) to resolve False Claims Act allegations.

The DOJ reported allegations that Southeastern Retina Associates improperly used the Modifier 25 billing code to charge Medicare and Medicaid for exams that were not separately billable from other procedures performed on the same day. The settlement also resolves allegations that certain Medicare and Medicaid billings during the same period included charges for exams at higher levels than appropriate.

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers



This investigation was prompted by a lawsuit filed in 2015 under the qui tam or "whistleblower" provisions of the False Claims Act. The relator's share of the recovery in this case will be \$270,000.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 2/4/2020

State: Tennessee

Government Program(s): Medicare & Medicaid

Mid-Wilshire Cancer Doctor and His Medical Office Agree to Pay Over \$3 Million to Settle Claims They Defrauded Medicare and Medi-Cal

Company Name: Nassir Medical Corp.

Settlement: \$3,356,565

Issue(s): Oncology and Infusion Services

The US Attorney's Office for the Central District of California announced that Nassir Medical Corp. and its owner, Dr. Youram Nassir, have agreed to pay the United States and California \$3,356,565 and enter into a [three-year corporate integrity agreement](#) to settle False Claims Act allegations that they defrauded public health care programs by billing for oncology drugs and services that were not actually provided to patients.

The DOJ reported allegations that, between January 2010 and December 2013, Nassir Medical Corp. and Nassir allegedly violated the False Claims Act by submitting bogus claims to Medicare and Medi-Cal. The defendants allegedly billed public health programs for drugs that were not actually purchased, dispensed, or administered, and for infusion services that were not actually provided. This settlement resolves allegations originally brought in a lawsuit filed in 2016 by Kenneth Bryan, a retired health care consultant and administrator, under the qui tam, or whistleblower, provisions of the False Claims Act. Mr. Bryan will receive more than \$475,000 from the federal government as his share of the settlement amount.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 12/19/19

Entity Location: California

Government Program(s): Medicare & Medi-Cal

Northwest Iowa Otolaryngologist Agrees to Pay \$1,000,000 To Resolve Medicaid False Claims Allegations

Company Name: Wellendorf ENT, P.C.

Settlement: \$1,000,000

Issue(s): Endoscopic Sinus Surgeries

The US Attorney for the Northern District of Iowa has reported that Dr. Tracey Wellendorf, an otolaryngologist with a clinic in Carroll, Iowa, agreed to pay \$1,000,000 and enter into a [three-year corporate integrity agreement](#) to resolve False Claims Act allegations relating to as many as 115 procedures performed on Iowa Medicaid beneficiaries between October 13, 2014, and November 27, 2015.

The DOJ reported allegations that Wellendorf ENT, P.C. submitted claims for endoscopic sinus procedures were improper either because they did not meet the applicable medical necessity standard or were otherwise incorrectly coded for payment.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers

Date: 10/15/2019

Entity Location: Iowa

Government Program(s): Medicaid

Justice Department Reaches Settlement Agreement with Physicians and El Paso Physicians Group over Allegations of Violating the False Claims Act

Company Name: El Paso Integrated Physicians Group, P.A.
Settlement: \$2,929,162

Issue(s): Infusion Drugs

The U.S. Attorney of the Western District of Texas announced that Dr. Robert Moreno, Cheryl Moreno, William “Bill” Collins, Accutrack Medical Claims Service, LLC, and El Paso Integrated Physicians Group, P.A. paid \$2,929,162 and entered into a [three-year corporate integrity agreement](#) to settle allegations that they defrauded the U.S. and the State of Texas through their Medicare, Medicaid and other federal healthcare programs.

The DOJ reported allegations that Robert Moreno, Cheryl Moreno, William “Bill” Collins, Accutrack Medical Claims Service, LLC, and El Paso Integrated Physicians Group, P.A. double-billed and over-billed government payors for Remicade (Infiximab), an infusion drug sold in single-use vials. Relator alleged that the Group pooled Remicade from partially used vials and used it in other patients, resulting in double-billing for the split vial, and that it billed for Remicade not used or that was diluted. The complaint further alleged that the Group billed for drugs illegally imported from Canada and other foreign countries.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 9/5/2019

Entity Location: Texas

Government Program(s): Medicare, Medicaid, and other federal programs

Skyline Urology to Pay \$1.85 Million to Settle False Claims Act Allegations of Medicare Overbilling

Company Name: Skyline Urology
Settlement: \$1,850,000

Issue(s): E&M Services, Urological Services

The DOJ Office of Public Affairs announced that Skyline Urology has agreed to pay the United States \$1.85 million and enter into a [three-year corporate integrity agreement](#) to resolve allegations that it violated the False Claims Act by submitting improper claims to the Medicare program for evaluation and management services.

The DOJ reported allegations that, between Jan. 1, 2013, and Dec. 31, 2016, Skyline Urology allegedly submitted false claims to the Medicare program for evaluation and management (E&M) services that were not allowable under Medicare. Medicare generally prohibits healthcare providers from separately billing for E&M services provided on the same day as another medical procedure, unless the E&M services are significant, separately identifiable, and above and beyond the usual preoperative and postoperative care associated with the medical procedure. If an E&M service satisfies these criteria, the provider can use a billing code known as “Modifier 25” to bill for the significant and separately identifiable E&M services. In this case, the government alleged that Skyline Urology used Modifier 25 to improperly unbundle routine E&M services that were not separately billable from other procedures performed on the same day, and, as a result, improperly claimed compensation from Medicare for certain urological services.

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers



The settlement resolves allegations in a lawsuit filed in the District of Maryland by James M. Cesare, the founder of the consulting firm Bay Area Healthcare Advisors LLC. The lawsuit was filed under the qui tam, or whistleblower, provisions of the False Claims Act. As part of the resolution, Mr. Cesare will receive approximately \$323,750.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 2/25/2019 **Entity Location:** California **Government Program(s):** Medicare

Electronic Health Records Vendor to Pay \$57.25 Million to Settle False Claims Act Allegations

Company Name: Greenway Health, LLC
Settlement: \$57,250,000

Issue(s): EHR Software

The US DOJ Office of Public Affairs announced that Greenway Health LLC (Greenway), a Tampa, Florida-based developer of electronic health records (EHR) software, will pay \$57.25 million and enter into a [five-year corporate integrity agreement](#) to resolve allegations in a complaint filed by the United States under the False Claims Act alleging that Greenway caused its users to submit false claims to the government by misrepresenting the capabilities of its EHR product “Prime Suite” and providing unlawful remuneration to users to induce them to recommend Prime Suite.

The DOJ reported allegations that Greenway falsely obtained 2014 Edition certification for its product Prime Suite when it concealed from its certifying entity that Prime Suite did not fully comply with the requirements for certification. Among other things, Greenway’s product did not incorporate the standardized clinical terminology necessary to ensure the reciprocal flow of information concerning patients and the accuracy of electronic prescriptions. Greenway accomplished its deception by modifying its test-run software to deceive the company hired to certify Prime Suite into believing that it could use the requisite clinical vocabulary.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Date: 2/6/2019 **Entity Location:** Florida **Government Program(s):** Medicare & Medicaid

Provider

Hospital

Long Term Care

Medical Equipment and Supplies

Behavioral Health

Prescriber and Drug Testing Services

Physical and Other Therapies

Other Providers and Suppliers