Healthcare Audit and Enforcement Risk Analysis

Corporate Integrity Agreement (CIA) Summary - Provider Reports

January 2022 - January 2024 Updates

SUNHAWK

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To our Healthcare Management and Compliance Colleagues and Partners:

SunHawk Consulting produces this complimentary 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 two years.

The United States Government may impose a Corporate Integrity Agreement (CIA) upon an entity when settling cases related to false claims submitted for services paid for by federally funded health care programs, The CIA establishes terms companies must meet including, in most cases, the engagement of an Independent Review Organization (IRO).

The Summary Reports included here provide focused insights into recently settled healthcare-related CIAs. The Summary Reports extract key data from published CIAs and US Department of Justice press releases to guide providers, payers, and life sciences companies in designing and refining their compliance programs. For your convenience and ease of use, the electronic version of this report includes hyperlinks to the original sources. The Report is updated regularly and new settlement matters are highlighted in orange to facilitate your review.

We appreciate feedback you believe would make this report more helpful to you or others. Should you wish to proactively audit or review your organizational activities as a result of these learnings, SunHawk's team of experts are happy to offer our assistance. Visit us at SunHawkConsulting.com and connect with us on LinkedIn for updates to this and other Healthcare Audit and Enforcement Risk Analyses.

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Hospital

Three Health Care Providers Agree to Pay $22.5 Million for Alleged False Claims to California's Medicaid Program

Company Name: Sierra Vista Regional Medical Center and Twin Cities Community Hospital
Settlement: $22,500,000

Issue(s): False Claims Act, Adult Expansion

The US DOJ announced that Dignity Health (Dignity), a not-for-profit health system that owns and operates three hospitals and one clinic in Santa Barbara County and San Luis Obispo County, California, and Twin Cities Community Hospital (Twin Cities) and Sierra Vista Regional Medical Center (Sierra Vista), two acute healthcare facility subsidiaries of Tenet Healthcare Corporation operating in San Luis Obispo County, California, have agreed to pay a total of $22.5 million pursuant to two separate settlements and enter into a five-year corporate integrity agreement to resolve allegations that they violated the federal False Claims Act and the California False Claims Act by causing the submission of false claims to Medi-Cal related to Medicaid Adult Expansion under the Patient Protection and Affordable Care Act (ACA).

Pursuant to the ACA, beginning in January 2014, Medi-Cal was expanded to cover the previously uninsured "Adult Expansion" population – adults between the ages of 19 and 64 without dependent children with annual incomes up to 133% of the federal poverty level. The federal government fully funded the expansion coverage for the first three years of the program. Under contracts with California's Department of Health Care Services (DHCS), if a California county organized health system (COHS) did not spend at least 85% of the funds it received for the Adult Expansion population on "allowed medical expenses," the COHS was required to pay back to the state the difference between 85% and what it actually spent. California, in turn, was required to return that amount to the federal government.

The two settlements resolve allegations that Dignity, Twin Cities and Sierra Vista knowingly caused the submission of false claims to Medi-Cal for "Enhanced Services" that Dignity purportedly provided to the Adult Expansion patients of a COHS between Feb. 1, 2015, and June 30, 2016, and that Twin Cities and Sierra Vista purportedly provided to such patients between Jan. 1, 2014, and April 30, 2015. The United States and California alleged that the payments were not "allowed medical expenses" permissible under the contract between DHCS and the COHS; were pre-determined amounts that did not reflect the fair market value of any Enhanced Services provided; and/or the Enhanced Services were duplicative of services already required to be rendered. The United States and California further alleged that the payments were unlawful gifts of public funds in violation of the California Constitution.

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

Date: 12/05/2022 **Entity Location:** California **Government Program(s):** Medicaid

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Steward Health Care System Agrees to Pay $4.7 Million to Resolve Allegations of False Claims Act Violations

Company Name: Steward Health Care System LLC
Settlement: $4,735,000

Issue(s): False Claims Act

The US Attorney for the District of Massachusetts announced that Steward Health Care System LLC (Steward) and several related corporate entities have agreed to pay approximately $4.735 million and enter into a five-year corporate integrity agreement to resolve allegations that its relationships with several physicians and physician practice groups violated federal law, including the False Claims Act.

According to the settlement agreement, in 2011, GSMC entered into an agreement with Brockton Urology Clinic (Brockton Urology) which obligated Brockton Urology to administer a Prostate Cancer Center of Excellence at GSMC. Steward admits that, since at least January 2012, GSMC had no Prostate Cancer Center of Excellence and Brockton Urology did not provide the services specified in the agreement with GSMC. However, from April 2011 through December 2017, GSMC purportedly paid Brockton Urology pursuant to the agreement and Brockton Urology referred patients to GSMC.

The United States reached a separate settlement agreement with Brockton Urology in February 2022 regarding this conduct.

The United States alleged that GSMC entered into a similar agreement with a separate physician practice. Steward paid that physician practice from April 2011 through December 2015, purportedly for cancer center services. During a portion of that time, GSMC had an agreement that obligated the practice to provide a physician to serve as the director of GSMC's Prostate Cancer Program. Steward admits, however, that the physician practice never provided a physician to serve as the director of GSMC's Prostate Cancer Program and, in fact, did not perform any of the services specified in the agreement. That practice also referred patients to GSMC.

Over the course of the government's investigation, Steward disclosed facts concerning two other sets of physician relationships that the United States contends violated federal law. First, in October 2010, Steward entered into a compensation arrangement with a physician pursuant to which the physician agreed to serve as GSMC's Medical Director of Post-Acute Care Services. Steward admits that it has been unable to confirm that the physician performed the services but that it still paid the physician from November 2010 through June 2016 and that the physician referred patients to GSMC during that period. Second, Steward admits that it failed to charge the proper rent on some of its leases with physicians, physician organizations and non-physician organizations, resulting in some of those entities paying rent below fair market value. Steward admits that between January 2010 and October 2015, it leased real property to these physicians and physician organizations and that those entities were referral sources for Steward's Massachusetts hospitals.

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

Date: 04/08/2022 **Entity Location:** Massachusetts **Government Program(s):** Medicaid & Medicare

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Providence Health & Services Agrees to Pay $22.7 Million to Resolve Liability From Medically Unnecessary Neurosurgery Procedures at Providence St. Mary's Medical Center

Company Name: Providence Health & Services Washington
Settlement: $22,690,458

Issue(s): False Claims Act, Medical Necessity

The US Attorney for the Eastern District of Washington announced that Providence Health & Services Washington (Providence) has agreed to pay $22,690,458 and enter a five-year corporate integrity agreement to resolve allegations that it fraudulently billed Medicare, Medicaid, and other federal health care programs for medically unnecessary neurosurgery procedures.

Providence is a large health care and hospital system that operates 51 hospitals in seven western U.S. states, including Providence St. Mary's Medical Center (Providence St. Mary's) in Walla Walla, Washington. Between 2013 and 2018, Providence St. Mary's employed neurosurgeons identified in the Settlement Agreement as Dr. A and Dr. B. Providence St. Mary's paid neurosurgeons based on a productivity metric that provided them a financial incentive to perform more surgical procedures of greater complexity. Between 2014 and 2018, Dr. A was one of the highest producing neurosurgeons in the entire Providence system. Between 2014 and 2017, based on the productivity metric, Providence paid Dr. A between $2.5 million and $2.9 million per year. Today's settlement resolves allegations that Providence falsely billed Medicare, Washington State Medicaid, and other federal health care programs for deficient and medically unnecessary neurosurgery procedures performed by Dr. A and Dr. B.

As part of the Settlement Agreement, Providence admitted that, during the time period in which Dr. A and Dr. B were employed at Providence St. Mary's as neurosurgeons, Providence medical personnel articulated concerns that Dr. A and Dr. B: (1) were endangering the safety of patients; (2) created through their surgeries an excessive level of complications and negative outcomes; (3) performed surgery on candidates who were not appropriate for surgery; and (4) failed to properly document their procedures and outcomes. Providence further admitted that Providence medical personnel articulated additional concerns that Dr. A: (1) completed medical documentation with falsified and exaggerated diagnoses in order to obtain reimbursement from insurance providers; (2) performed surgical procedures that did not meet the medical necessity requirements set by Medicare and other insurance programs; (3) "over-operated", i.e., performed surgeries of greater complexity and scope than were medically appropriate; and (4) jeopardized patient safety by attempting to perform an excessive number of overly complex surgeries. Finally, Providence admitted that, while it eventually placed both Dr. B and Dr. A on administrative leave in February 2017 and May 2018, respectively, it allowed both doctors to resign while on leave, and did not take any action to report Dr. A or Dr. B to the National Practitioner Data Bank or the Washington State Department of Health.

According to court documents, the case began in January 2020, when a whistleblower, the former Medical Director of neurosurgery at Providence-St Mary's, filed a qui tam complaint under seal in the U.S. District Court for the Eastern District of Washington. When a whistleblower, or "relator," files a qui tam complaint, the False Claims Act requires the United States to investigate the allegations and elect whether to intervene and take over the action or to decline to intervene and allow the relator to go forward with the litigation on behalf of the United States.

The relator is generally able to then share in any recovery. In this case, according to court documents, the United States intervened in the action in January 2022, and subsequently reached this settlement. Pursuant to the settlement agreement, the relator will receive $4,197,734 of the total settlement amount.

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

Date: 03/17/2022 **Entity Location:** Washington **Government Program(s):** Medicare, Medicaid & Other Federal Programs

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[NEW] California Skilled Nursing Facilities, Owner and Management Company Agree to $45.6 Million Consent Judgement to Settle Allegations of Kickbacks to Referring Physicians

Company Name: Park Central Care & Rehabilitation Center, Bay Point Healthcare Center, Gateway Care & Rehabilitation Center, Hayward Convalescent Hospital, Hilltop Care and Rehabilitation Center, Yuba Skilled Nursing Center
Settlement: $45,600,000

Issue(s): Anti-Kickback, Skilled Nursing

The U.S. Department of Justice announced that Prema Thekkek, her management company, Paksn Inc., and six skilled nursing facilities (SNFs) owned by Thekkek and/or operated by Paksn have agreed to enter into a $45.6 million consent judgment and enter into a five-year corporate integrity agreement to resolve allegations that they submitted or caused the submission of false claims to Medicare by paying kickbacks to physicians to induce patient referrals. The six settling SNFs are Kayal Inc. (doing business as Bay Point Healthcare Center), Nadhi Inc. (doing business as Gateway Care & Rehabilitation Center), Oakrheem Inc. (doing business as Hayward Convalescent Hospital), Bayview Care Inc. (doing business as Hilltop Care and Rehabilitation Center), Aakash Inc. (doing business as Park Central Care & Rehabilitation Center) and Nasaky Inc. (doing business as Yuba Skilled Nursing Center) (collectively the SNF Defendants).

The U.S. DOJ alleged that, from 2009 to 2021, the SNF Defendants, under the direction and control of Thekkek and Paksn, systematically entered into medical directorship agreements with physicians that purported to provide compensation for administrative services, but in reality were vehicles for the payment of kickbacks to induce the physicians to refer patients to the six SNFs. Specifically, the defendants hired physicians who promised in advance to refer a large number of patients to the SNFs, paid physicians in proportion to the number of their expected referrals and terminated physicians who did not refer enough patients.

Under the settlement, in addition to entering into a $45,645,327.25 consent judgment, the defendants will make scheduled payments to the United States of at least $385,000 over the next five years. That payment schedule was negotiated based on the defendants' lack of ability to pay. The settlement stems from a whistleblower complaint filed in 2015 by Paksn's former Vice President of Operations and Chief Operating Officer, Trilochan Singh, pursuant to the *qui tam* provisions of the False Claims Act.

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

Date: 11/9/2023 **Entity Location:** California **Government Program(s):** Medicare

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[NEW] Queens Physician Settles Health Care Fraud Claims for $1.3 Million and Enters into Integrity Agreement to Ensure Future Compliance

Company Name: Arora, M.D., Arun
Settlement: $1,300,000

Issue(s): False Claims Act

The U.S. Attorney's Office for the Eastern District of New York announced that Queens-based physician Arun Arora has entered into a settlement agreement, as well as entered into a three-year corporate integrity agreement that addresses allegations that Dr. Arora violated the federal False Claims Act by billing Medicare for critical care services to residents of nursing homes when, in fact, he provided only routine care.

Dr. Arora provided care to residents of nursing homes. That care was, for the most part, routine care, such as regular medical checkups. The Government contends that, rather than billing for his services as routine care, Dr. Arora billed Medicare for critical care services. Critical care services involve imminent life-threatening deterioration of the patient's condition. Medicare reimburses health care providers at a higher rate for critical care services than for routine care. By billing for critical care services when he provided only routine care, as the Government contends, Dr. Arora received extra payment for care that he did not provide.

Under the terms of the agreement with the United States, Dr. Arora will pay $1.3 million for conduct that took place in the years 2019 to 2023. In addition to the payment to resolve the government's fraud claims, Dr. Arora has entered into a separate Integrity Agreement with the U.S. Department of Health and Human Services, Office of Inspector General. The Integrity Agreement imposes a number of obligations on Dr. Arora, all of which are meant to ensure that he complies with Medicare rules and regulations going forward.

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

Date: 9/20/2023 **Entity Location:** New York **Government Program(s):** Medicare

[NEW] California Skilled Nursing Facility and Management Company Agree to Pay $3.825 Million to Settle Allegations of Kickbacks to Referring Physicians

Company Name: Alta Vista Healthcare and Wellness Center, LLC
Settlement: $3,825,000

Issue(s): False Claims Act, Anti-Kickback. Skilled Nursing

The U.S. DOJ announced that Alta Vista Healthcare & Wellness Centre, LLC (Alta Vista), a skilled nursing facility in Riverside, California, and its management company, Rockport Healthcare Services (Rockport), have agreed to pay the United States and California a total of $3.825 million and enter into a five-year corporate integrity agreement to resolve allegations that they submitted and caused the submission of false claims to Medicare and Medicaid by paying kickbacks to physicians to induce patient referrals. The settlement amount was negotiated based on Alta Vista's and Rockport's lack of ability to pay.

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The U.S. DOJ alleged that, from 2009 through 2019, Alta Vista, under the direction and control of Rockport, gave certain physicians extravagant gifts, including expensive dinners for the physicians and their spouses, golf trips, limousine rides, massages, e-reader tablets, and gift cards worth up to $1,000. Separately, Alta Vista paid these physicians monthly stipends of $2,500 to $4,000, purportedly for their services as medical directors. At least one purpose of these gifts and payments was to induce these physicians to refer patients to Alta Vista.

The defendants' conduct allegedly resulted in false claims to Medicare and California's Medicaid programs, the latter of which is jointly funded by the federal government and California. Under the settlement, they will pay $3,228,300 to the United States and $596,700 to California.

The settlement stems from a whistleblower complaint filed in 2015 by a former Alta Vista accounting employee, Neyirys Orozco, pursuant to the *qui tam* provisions of the False Claims Act, which permit private persons to bring a lawsuit on behalf of the government and to share in the proceeds of the suit. Orozco will receive $581,094 as her share of the federal government's recovery in this case.

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

Date: 6/14/2023 **Entity Location:** California **Government Program(s):** Medicare, Medicaid

U.S. Attorney Announces $7.85 Million Settlement With Citadel Skilled Nursing Facility In Bronx For Fraudulently Switching Residents' Healthcare Coverage To Boost Medicare Payments

Company Name: Citadel Consulting Group LLC D/B/A Citadel Care Centers LLC and TCPRNC, LLC D/B/A The Plaza Rehab and Nursing Center
Settlement: $7,850,000

Issue(s): False Claims Act

The US Attorney's Office for the Southern District of New York announced that Plaza Rehab and Nursing Center and Citadel Consulting Group LLC agreed to pay a total of $7.85 million and enter into a five-year corporate integrity agreement to resolve allegations that Plaza Rehab Center, acting at the direction of Citadel, fraudulently switched the type of Medicare coverage in which elderly residents were enrolled in order to maximize the Medical payments that Plaza Rehab Center would receive. Citadel made extensive factual admissions regarding their conduct. Specifically, Plaza Rehab Center and Citadel admitted that their staff often did not obtain the consent of the resident or their authorized representatives prior to disenrolling the resident from their Medicare Advantage Plan. In addition, as part of the settlement, Citadel agreed to take steps to ensure that all skilled nursing facilities that are Citadel Care Centers comply with applicable guidance on Medicare health plan disenrollment's and enrollments.

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

Date: 6/17/2022 **Entity Location:** New York **Government Program(s):** Medicare

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Carter Healthcare Affiliates and Two Senior Managers to Pay $7.175 Million to Resolve False Claims Act Allegations for False Florida Home Health Billings

Company Name: Carter Healthcare
Settlement: $7,175,000

Issue(s): False Claims Act, Medical Necessity

The US DOJ announced that Carter Healthcare LLC, an Oklahoma-based for-profit home health provider, its affiliates CHC Holdings and Carter-Florida (collectively Carter Healthcare), and their President Stanley Carter and Chief Operations Officer Bradley Carter have agreed to pay $7.175 million and enter into a five-year corporate integrity agreement to resolve allegations that they violated the False Claims Act by billing the Medicare program for medically unnecessary therapy provided to patients in Florida. Bradley Carter will pay $175,000, Stanley Carter will pay $75,000, and Carter Healthcare will pay the remaining $6.925 million of the settlement.

The US DOJ alleged that between 2014 and 2016, Carter Healthcare allegedly billed the Medicare Program knowingly and improperly for home healthcare to patients in Florida based on therapy provided without regard to medical necessity and overbilled for therapy by upcoding patients' diagnoses.

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

Date: 09/26/2022 **Entity Location:** Oklahoma **Government Program(s):** Medicare

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Medical Equipment and Supplies

[NEW] Lincare Holdings Agrees to Pay $29 Million to Resolve Claims of Overbilling Medicare for Oxygen Equipment in Largest-Ever Health Care Fraud Settlement in Eastern Washington

Company Name: Lincare Inc.
Settlement: $29,000,000

Issue(s): False Claims Act, Respiratory-Related Medical Equipment

The U.S. Attorney's Office for the Eastern District of Washington announced that, Lincare Holdings, Inc., a Florida-based, wholly-owned subsidiary of German multinational chemical corporation Linde plc, has agreed to pay $29 million and perform extensive corrective actions as well as enter into a five-year corporate integrity agreement to resolve allegations that it fraudulently overbilled Medicare and Medicare Advantage Plans for oxygen equipment. The settlement announced today is the largest-ever health care fraud settlement in the Eastern District of Washington.

In the settlement, Lincare admitted that it improperly billed Medicare, MA Plans, and beneficiaries for oxygen equipment rental payments and co-payments after it had already received 3 years of payments. Lincare admitted that it lacked adequate controls to ensure that MA Plans and beneficiaries were not improperly billed after 3 years of rental payments had already been received. Lincare additionally admitted that for traditional Medicare recipients, it had controls in place to prevent improper billing, but that those controls were not always effective. Finally, Lincare admitted that when Lincare employees raised concerns about Lincare's billing practices, Lincare officials in its Regional Billing and Collections Office located in Spokane Valley, Washington, and at Lincare's corporate headquarters in Clearwater, Florida, instructed them that Lincare would continue its billing practices. The settlement resolved claims that Lincare's conduct violated the False Claims Act.

According to court documents, the case began in May 2021, when two whistleblowers, former employees in Lincare's center in Libby, Montana, filed a *qui tam* complaint under seal in the U.S. District Court for the Eastern District of Washington. In this case, according to court documents, the United States intervened in the action in July 2023, and subsequently reached this settlement. Pursuant to the settlement agreement, the relator will receive $5,655,000 of the total settlement amount.

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

Date: 08/10/2023 **Entity Location:** Florida **Government Program(s):** Medicare

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Vision Quest Industries to Pay $2,250,000 to Resolve False Claims Act Allegations

Company Name: Vision Quest Industries, Incorporated, and General Orthocare, Inc.
Settlement: $2,250,000

Issue(s): False Claims Act, Anti-Kickback, Knee Braces

The U.S. Attorney's Office for the District of Minnesota announced that Vision Quest Industries, Incorporated ("VQ") has agreed to pay the United States $2,250,000 and enter into a five-year corporate integrity agreement to resolve False Claims Act allegations that VQ caused Osteo Relief Institutes ("ORIs") to bill Medicare for knee braces that were tainted by illegal kickbacks.

VQ is a manufacturer of durable medical equipment, including knee braces and other products intended to treat conditions such as osteoarthritis. VQ utilizes independent sales representatives to sell these products, which are routinely billed to Medicare.

The settlement resolves allegations that between 2011 and 2018, VQ paid Mathias Berry, an independent sales representative of VQ, and Berry's company, Results Laboratories, LLC, kickbacks in the form of commission payments that ranged from 20–35 percent of VQ's net revenue on each knee brace ordered by the ORI Clinics. Operating under the direction of Berry and his companies, the ORI Clinics submitted claims for millions of dollars in Medicare reimbursements. VQ profited substantially from the arrangement. By paying Berry and his company kickbacks in the form of sales commissions, VQ was able to establish itself as the exclusive brace supplier for 10-12 ORIs annually between 2011 and 2018. VQ understood that Berry was in a position to tell the ORIs which braces to order. This arrangement locked in millions of dollars in annual brace sales for VQ.

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

Date: 08/26/2022 **Entity Location:** California **Government Program(s):** Medicare

Medical Device Manufacturer Biotronik Inc. Agrees To Pay $12.95 Million To Settle Allegations of Improper Payments to Physicians

Company Name: Biotronik, Inc.
Settlement: $12,950,000

Issue(s): False Claims Act, Anti-Kickback, Cardiac Devices

The US DOJ announced that Biotronik Inc. (Biotronik), a medical device manufacturer based in Oregon, has agreed to pay $12.95 million and enter into a five-year corporate integrity agreement to resolve allegations that it violated the False Claims Act by causing the submission of false claims to Medicare and Medicaid by paying kickbacks to physicians to induce their use of Biotronik's implantable cardiac devices, such as pacemakers and defibrillators.

The settlement resolves allegations that Biotronik engaged in a kickback scheme to pay certain favored physicians to induce and reward their use of Biotronik's pacemakers, defibrillators and other cardiac devices. In particular, Biotronik allegedly abused a new employee training program by paying physicians for an excessive number of trainings and, in

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some cases, for training events that either never occurred or were of little or no value to trainees. Biotronik allegedly made these payments despite concerns raised by its own compliance department, which warned that salespeople had too much influence in selecting physicians to conduct new employee training and that the training payments were being over-utilized. The settlement also resolves allegations that Biotronik violated the Anti-Kickback Statute when it paid for physicians' holiday parties, winery tours, lavish meals with no legitimate business purpose and international business class airfare and honoraria in exchange for making brief appearances at international conferences.

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

Date: 08/26/2022 **Entity Location:** Oregon **Government Program(s):** Medicaid & Medicare

Philips Subsidiary to Pay Over $24 Million for Alleged False Claims Caused by Respironics for Respiratory-Related Medical Equipment

Company Name: Phillips RS North America LLC, F/K/A Respironics, Inc.
Settlement: $24,000,000

Issue(s): False Claims Act, Anti-Kickback, Respiratory-Related Medical Equipment

The US DOJ announced that Philips RS North America LLC, formerly known as Respironics Inc., a manufacturer of durable medical equipment (DME) based in Pittsburgh, Pennsylvania, has agreed to pay over $24 million and enter into a five-year corporate integrity agreement to resolve False Claims Act allegations that it misled federal health care programs by paying kickbacks to DME suppliers. The affected programs were Medicare, Medicaid and TRICARE, which is the health care program for active military and their families.

The settlement resolves allegations that Respironics caused DME suppliers to submit claims for ventilators, oxygen concentrators, CPAP and BiPAP machines, and other respiratory-related medical equipment that were false because Respironics provided illegal inducements to the DME suppliers. Respironics allegedly gave the DME suppliers physician prescribing data free of charge that could assist their marketing efforts to physicians.

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

Date: 08/25/2022 **Entity Location:** Pennsylvania **Government Program(s):** Medicare, Medicaid and TRICARE

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Solera Specialty Pharmacy Agrees to Enter into Deferred Prosecution Agreement; Company and CEO to Pay $1.31 Million for Submitting False Claims for Anti-Overdose Drug

Company Name: Solera Specialty Pharmacy, LLC
Settlement: $1,310,000

Issue(s): False Claims Act

The US DOJ announced that Solera Specialty Pharmacy has entered into a deferred prosecution agreement and agreed to pay a $1.31 million civil settlement and enter into a three-year corporate integrity agreement to resolve allegations that it submitted fraudulent claims to Medicare for Evzio, a high-priced drug used in rapid reversal of opioid overdoses.

According to Solera's admissions in the criminal and civil agreements, the pharmacy dispensed Evzio from January 2017 to May 2018. During that time, Evzio was the highest-priced version of naloxone on the market and insurers frequently required the submission of prior authorization requests before they would approve coverage for Evzio. Solera completed Evzio prior authorizations forms in place of the prescribing physicians, including instances in which Solera staff signed the forms without the physician's authorization and listed Solera's contact information as if it were the physician's information. In addition, Solera submitted Evzio prior authorization requests that contained false clinical information to secure approval for the expensive drug. Finally, Solera waived Medicare beneficiary co-payment obligations for Evzio on numerous occasions without analyzing whether the patient had a genuine financial hardship.

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

Date: 07/08/2022 **Entity Location:** Florida **Government Program(s):** Medicare

Essilor Agrees to Pay $16.4 Million to Resolve Alleged False Claims Act Liability for Paying Kickbacks

Company Name: Essilor of America Inc.
Settlement: $16,400,000

Issue(s): False Claims Act, Anti-Kickback

The DOJ Office of Public Affairs announced that Essilor International, Essilor of America Inc., Essilor Laboratories of America Inc. and Essilor Instruments USA (collectively, "Essilor"), headquartered in Dallas, have agreed to pay $16.4 million and enter into a five-year corporate integrity agreement to resolve allegations that the company violated the False Claims Act by causing claims to be submitted to Medicare and Medicaid that resulted from violations of the Anti-Kickback Statute.

Essilor manufactures, markets and distributes optical lenses and equipment used to produce optical lenses. The United States alleged that between Jan. 1, 2011, and Dec. 31, 2016, Essilor knowingly and willfully offered or paid remuneration to eye care providers, such as optometrists and ophthalmologists, to induce those providers to order and purchase Essilor products for their patients, including Medicare and Medicaid beneficiaries, in violation of the Anti-Kickback Statute. The Anti-Kickback Statute prohibits offering or paying anything of value to induce the referral of items or services covered by

Medicare, Medicaid and other federally-funded programs. The statute is intended to ensure that medical providers' judgments are not compromised by improper financial incentives.

The civil settlement includes the resolution of claims brought under the *qui tam* or whistleblower provisions of the False Claims Act by relators Laura Thompson, Lisa Brez, and Christie Rudolph, former Essilor district sales managers.

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

Date: 04/04/2022 **Entity Location:** Texas **Government Program(s):** Medicaid & Medicare

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Western Maryland Physician and Pain Management Practice Group Agree to Pay $980,000 to Settle Federal False Claims Act Allegations of Billing for Medically Unnecessary Urine Drug Tests

Company Name: Gonzaga Interventional Pain Management, and Garrett Anesthesia and Pain Management, P.A.
Settlement: $980,000

Issue(s): False Claims Act, Urine Drug Testing, Medical Necessity

The US Attorney for the District of Maryland announced that Melvin Gonzaga, M.D., his son Rommel Gonzaga, and their practice group Gonzaga Interventional Pain Management ("GIPM") have agreed to pay the United States $980,000 and enter into a three-year corporate integrity agreement to resolve allegations that they violated the federal False Claims Act by submitting false claims to the United States for urine drug tests ("UDT") that were medically unnecessary.

It is alleged that from January 1, 2016 through March 31, 2019, GIPM billed the Medicare Program, the Medicaid Program, and the Railroad Retirement Board ("RRB") for a large number of UDTs. GIPM tested its patients using two types of UDTs: presumptive and definitive. A presumptive UDT is an initial test to detect the presence or absence of a substance or class of substances in the body. A definitive UDT is a more advanced test that can identify individual drugs, distinguish between structural isomers, and report the results of drugs present in concentrations of nanograms per milliliter.

This settlement resolves allegations that the UDTs that GIPM billed to the government were not ordered based on an individualized determination of medical necessity for each patient. Instead, GIPM used blanket orders that tested all patients for the same 22+ drug classes. GIPM patients were required to provide a UDT sample upon entry into the clinic and before being seen by a provider and discussing the results from any prior UDT the patient received. Often, UDTs showing unexpected positive or negative results were ignored, or not checked at all, while GIPM providers continued to prescribe the patients opioids and other controlled substances despite obvious warning signs that the patients were abusing drugs.

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

Date: 07/22/2022 **Entity Location:** Maryland **Government Program(s):** Medicaid, Medicare, TRICARE & Other Federal Programs

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Provider

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Home Health Services

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Other Providers and Suppliers

United States Settles $1.66 Million Healthcare Fraud Claim Against Iowa Dermatologist

Company Name: Eastern Iowa Dermatology, PLC
Settlement: $16,600,000

Issue(s): False Claims Act, Dermatology

The U.S. Attorney's Office for the Southern District of Iowa announced that Eastern Iowa Dermatology, PLC, located in Bettendorf, and Dr. Manish Kumar have agreed to pay $1.66 million and enter into a three-year corporate integrity agreement to resolve allegations for violations of the False Claims Act by submitting false claims to Medicare for dermatology office visits and the destruction or removal of skin tags and lesions.

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

Date: 07/21/2022 **Entity Location:** Iowa **Government Program(s):** Medicare

Radeas LLC Agrees to Pay $11.6 Million to Resolve Allegations of Fraudulent Billing

Company Name: Radeas LLC
Settlement: $11,600,000

Issue(s): False Claims Act, Anti-Kickback, Urine Drug Testing, Medical Necessity

The U.S. Attorney's Office for the District of Massachusetts announced that Radeas LLC has agreed to pay $11.6 million and enter into a five-year corporate integrity agreement to resolve allegations that it submitted false claims for payment to Medicare for medically unnecessary urine drug testing (UDT).

According to the settlement agreement, Radeas admits that between January 2016 and September 2021, it regularly billed Medicare for medically unnecessary UDT. Specifically, Radeas performed and then billed Medicare for two types of UDT: presumptive testing, a relatively inexpensive test that quickly provides qualitative results, and confirmatory testing, an expensive test that is designed to confirm quantitatively the results of presumptive UDT. Radeas performed both types of tests at approximately the same time and then simultaneously submitted the results to health care providers. Absent any physician review of a presumptive UDT result there was often nothing to support the medical necessity of a separate, simultaneous confirmatory test. The settlement makes clear that Radeas' confirmatory UDT was therefore frequently baseless. Yet, Radeas billed Medicare for these medically unnecessary lab tests.

According to the settlement agreement, Radeas also admits that, between May 2013 and April 2021, it paid third-party sales organizations based on the volume of UDT referrals those sales representatives made to Radeas. The government alleges this conduct violated the Anti-Kickback Statute and the False Claims Act.

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

Date: 03/30/2022 **Entity Location:** North Carolina **Government Program(s):** Medicare

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Physician Partners of America to Pay $24.5 Million to Settle Allegations of Unnecessary Testing, Improper Remuneration to Physicians and a False Statement in Connection with COVID-19 Relief Funds

Company Name: Physician Partners of America LLC (PPOA)
Settlement: $24,500,000

Issue(s): False Claims Act, Corona Virus, Urine Drug Testing, Stark Law, Medical Necessity

The DOJ Office of Public Affairs announced that Physician Partners of America LLC (PPOA), headquartered in Tampa, Florida, its founder, Rodolfo Gari, and its former chief medical officer, Dr. Abraham Rivera, have agreed to pay $24.5 million and enter into a five-year corporate integrity agreement to resolve allegations that they violated the False Claims Act by billing federal healthcare programs for unnecessary medical testing and services, paying unlawful remuneration to its physician employees and making a false statement in connection with a loan obtained through the Small Business Administration's (SBA) Paycheck Protection Program (PPP). Certain PPOA affiliated entities are jointly and severally liable for the settlement amount, including the Florida Pain Relief Group, the Texas Pain Relief Group, Physician Partners of America CRNA Holdings LLC, Medical Tox Labs LLC and Medical DNA Labs LLC.

The United States alleged that PPOA caused the submission of claims for medically unnecessary urine drug testing (UDT), by requiring its physician employees to order multiple tests at the same time without determining whether any testing was reasonable and necessary, or even reviewing the results of initial testing (presumptive UDT) to determine whether additional testing (definitive UDT) was warranted. PPOA's affiliated toxicology lab then billed federal healthcare programs for the highest-level UDT. In addition, PPOA incentivized its physician employees to order presumptive UDT by paying them 40% of the profits from such testing in violation of the Stark Law, which prohibits physicians from referring patients to receive "designated health services" payable to Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies.

The United States further alleged that PPOA required patients to submit to genetic and psychological testing before the patients were seen by physicians, without making any determination as to whether the testing was reasonable and necessary, and then billed federal healthcare programs for the tests.

The United States further alleged that when Florida suspended all non-emergency medical procedures to reduce transmission of COVID-19 in March 2020, PPOA sought to compensate for lost revenue by requiring its physician employees to schedule unnecessary evaluation and management (E/M) appointments with patients every 14 days, instead of every month as had been PPOA's prior practice. PPOA then instructed its physicians to bill these E/M visits using inappropriate high-level procedure codes. Moreover, the United States alleged that at the same time PPOA was engaged in this unlawful overbilling, PPOA falsely represented to the SBA that it was not engaged in unlawful activity in order to obtain a $5.9 million loan through the PPP. The settlement announced today resolves liability under the False Claims Act and the Financial Institutions Reform, Recovery and Enforcement Act (FIRREA) arising from the false claims submitted to federal healthcare programs for the E/M visits as well for PPOA's false statement in connection with its PPP loan.

The civil settlement includes the resolution of claims brought under the *qui tam* or whistleblower provisions of the False Claims Act by Donald Haight, Dawn Baker, Dr. Harold Cho, Dr. Venus Dookwah-Roberts and Dr. Michael Lupi, who are current or former employees of PPOA or its affiliated entities.

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

Date: 03/24/2022 **Entity Location:** Florida **Government Program(s):** Medicaid & Other Federal Programs

Provider

- Hospital
- Long Term Care
- Home Health Services
- Medical Equipment and Supplies
- **Prescriber and Drug Testing Services**
- Behavioral Health
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Provider

- Hospital
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- **Behavioral Health**
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Behavioral Health

[*NEW*] Behavioral Services Healthcare Provider and its Owner Settle False Claims Act Allegations

Company Name: Connex Family Services LLC
Settlement: $918,000

Issue(s): False Claims Act

Connex Family Services, LLC (Connex), located in Warrenton, and Bianca Riddle, 33, a resident of Gloucester, have agreed to pay $918,000 and enter into a three-year corporate integrity agreement to settle a civil fraud case that claimed Connex and Riddle submitted or caused false claims to be submitted to Medicaid and TRICARE.

The government alleged that Connex and Riddle submitted claims to TRICARE and Medicaid for applied behavioral analysis services that were not provided during the period from March 1, 2019, through November 13, 2021. Connex's behavioral analysis services are provided to children who have been diagnosed with Autism Spectrum Disorder and other related disorders.

Connex and Riddle will pay additional amounts, up to $2,053,387, if the company is sold within five years.

The settlement arises in connection with two lawsuits filed by former employees under the whistleblower provision of the False Claims Act. *United States ex rel. Schwartz v. Connex Family Services, LLC, et al*., and *United States ex rel. Liguori v. Connex Family Services, LLC, et al.* The matters were consolidated in the Newport News Division.

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

Date: 9/15/2023 **Entity Location:** Virginia **Government Program(s):** Medicaid, TRICARE

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Other Providers and Suppliers

Provider

- Hospital
- Long Term Care
- Home Health Services
- Medical Equipment and Supplies
- Prescriber and Drug Testing Services
- Behavioral Health
- **Other Providers and Suppliers**

[NEW] Indiana Health Network Agrees to Pay $345 Million to Settle Alleged False Claims Act Violations

Company Name: Community Health Network, Inc.
Settlement: $345,000,000

Issue(s): False Claims Act, Stark Law

The U.S. DOJ announced that Community Health Network Inc. (Community), a health care network headquartered in Indianapolis, has agreed to pay the United States $345 million and to enter into a five-year corporate integrity agreement to resolve allegations that it violated the False Claims Act by knowingly submitting claims to Medicare for services that were referred in violation of the Stark Law.

In this lawsuit, the United States alleged that the compensation Community paid to its cardiologists, cardiothoracic surgeons, vascular surgeons, neurosurgeons and breast surgeons was well above fair market value, that Community awarded bonuses to physicians that were tied to the number of their referrals, and that Community submitted claims to Medicare for services that resulted from these unlawful referrals.

The United States' complaint alleged that beginning in 2008 and 2009, senior management at Community embarked on an illegal scheme to recruit physicians for employment for the purpose of capturing their lucrative "downstream referrals." Community successfully recruited hundreds of local physicians, including cardiovascular specialists, neurosurgeons and breast surgeons, by paying them salaries that were significantly higher — sometimes as much as double — what they were receiving in their own private practices. Community was well aware of the Stark Law requirements that the compensation of employed physicians had to be fair market value and could not take into account the volume of referrals. Community hired a valuation firm to analyze the compensation it proposed paying to its recruited specialists. The complaint alleged that Community knowingly provided the firm with false compensation figures so that the firm would render a favorable opinion. The complaint further alleged that Community ignored repeated warnings from the valuation firm regarding the legal perils of overcompensating its physicians. In addition to paying specialists excessive compensation, the complaint alleged that Community awarded incentive compensation to physicians, in the form of certain financial performance bonuses that were based on the physicians reaching a target of referrals to Community's network, again in violation of the Stark Law.

The settlement stems from a whistleblower complaint filed in 2014 by CHN's former Chief Financial and Chief Operating Officer Thomas Fischer pursuant to the False Claims Act's *qui tam* provisions, which permit private persons to bring a lawsuit on behalf of the government and to share in any recovery. The Act also permits the government to intervene and take over the lawsuit, as it did in this case as to certain of Fischer's allegations. Fischer's share has not yet been determined in this matter.

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

Date: 12/18/2023 **Entity Location:** Indiana **Government Program(s):** Medicare

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[NEW] Cardiac imaging company and founder to pay historic $85M settlement

Company Name: Cardiac Imaging, Inc.
Settlement: $85,480,000

Issue(s): False Claims Act, Stark Law, Anti-Kickback, Cardiology, Cardiac Imaging

The U.S. Attorney's Office for the Southern District of Texas announced that Cardiac Imaging Inc. (CII), headquartered in Illinois, and its founder, owner and CEO Sam Kancherlapalli, a resident of Florida, have agreed to pay a total of $85,480,000, and to enter into a five-year corporate integrity agreement to resolve False Claims Act allegations that they paid referring cardiologists excessive fees to supervise PET scans in violation of the Anti-Kickback Statute (AKS) and the Physician Self-Referral Law (Stark Law).

CII agreed to pay $75 million plus additional amounts based on future revenues, while Kancherlapalli agreed to pay $10,480,000.

The United States alleged that between March 1, 2014, and May 31, 2023, CII and Kancherlapalli knowingly caused false or fraudulent claims to federal health care programs arising from violations of the AKS and the Stark Law. Specifically, with Kancherlapalli's oversight and approval, CII allegedly paid kickbacks to referring cardiologists in the form of above-fair market value fees of $500 or more per hour, ostensibly for the cardiologists to supervise the PET scans for the patients they referred to CII. The United States alleged these fees substantially exceeded fair market value for the cardiologists' services because CII paid the referring cardiologists for each hour CII spent scanning the cardiologists' patients, including time the cardiologists were away from CII's mobile scanning units providing care for other patients or were not even on site. CII's fees also purportedly compensated the cardiologists for additional services beyond supervision that were not actually provided. CII purported to rely on a consultant's fair market value analysis that the U.S. government contends CII knew was premised on fundamental inaccuracies about the services referring physicians provided and that the consultant ultimately withdrew.

The civil settlement resolves claims brought under the qui tam or whistleblower provisions of the False Claims Act by Lynda Pinto, a former billing manager at CII. Under those provisions, a private party can file an action on behalf of the United States and receive a portion of any recovery. The qui tam action also raises claims against CII's former president and part-owner Richard Nassenstein, which are not resolved in this settlement.

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

Date: 9/29/2023 **Entity Location:** Illinois **Government Program(s):** Other Federal programs

[NEW] Fayetteville Cardiologist Agrees to Pay Over $5 Million to Resolve Allegedly False Medicare and Medicaid Claims

Company Name: Carolina Heart and Leg Center, P.A.
Settlement: $5,015,554

Issue(s): False Claims Act, Cardiology, Atherectomy Procedures

The U.S. Attorney's Office for the Eastern District of North Carolina announced that Fayetteville, North Carolina cardiologist Dr. Hari Saini and his current practice, Carolina Heart and Leg Center, P.A., agreed to pay $5,015,554 to the United States and North Carolina and enter into a three-year corporate integrity agreement to resolve allegedly false Medicare and Medicaid claims.

This settlement arose from whistleblower allegations that Dr. Saini and his cardiology practice performed unnecessary atherectomy procedures to remove minor plaque blockage in leg arteries in patients. The United States filed a complaint

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against Dr. Saini, Carolina Heart and Leg Center, and Carolina Cape Fear Medical Group, alleging that Defendants "systematically overstated the stenosis percentage" to justify medically unnecessary atherectomies for the maximum number of procedures for their patients. More specifically, the Government alleged that Dr. Saini—who was one of the highest billing cardiologists in North Carolina for this type of claim—conducted "risky and invasive atherectomy procedures to unnecessarily remove plaque blockage that was, at best, only minimally present, all in blatant disregard for patient safety and Program billing requirements." Based upon billing and medical records, Defendants were paid millions from Medicare and Medicaid, which the Government alleged was not supported by the retained medical records for the services provided and billed.

Ultimately, after six years of discovery and litigation, and with trial looming, Dr. Saini and his practice agreed to pay more than $5 million to resolve the False Claims Act allegations.

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

Date: 5/26/2023 **Entity Location:** North Carolina **Government Program(s):** Medicaid, Medicare

[NEW] Florida Cardiology, P.A. And 10 Physicians Agree To Pay $2 Million To Settle False Claims Act Liability

Company Name: Florida Cardiology, P.A.
Settlement: $2,000,000

Issue(s): False Claims Act, Cardiology, Intravascular Stents, Radiofrequency Ablations

The U.S. Attorney's Office for the Middle District of Florida announced that Florida Cardiology, P.A., Sandeep Bajaj, Karan Reddy, and eight other physicians have agreed to pay the United States and the State of Florida $2 million and to enter into a three-year corporate integrity agreement to resolve allegations that they violated the False Claims Act by submitting inflated claims to Medicare and Medicaid and for billing while the physicians were outside the United States.

The United States and the State of Florida previously intervened in a whistleblower lawsuit against Florida Cardiology and the physician-defendants on June 27, 2022. The lawsuit and settlement relate to the submission of claims that were improperly billed or performed, and submitted or caused to be submitted by Florida Cardiology, Sandeep Bajaj, Abbas Ali, Karan Reddy, Claudio Manubens, Milan Kothari, Saroj Tampira, Sayed Hussain, Raviprasad Subraya, Harish Patil, and Edwin Martinez.

According to the lawsuit and settlement agreement, Dr. Bajaj and Dr. Reddy caused Florida Cardiology to bill for more intravascular stents than were actually inserted into patients; Dr. Bajaj caused Florida Cardiology to bill for radiofrequency ablations that were not performed by him and in some instances, were not performed by a qualifying provider; and all ten physician-defendants caused Florida Cardiology to bill for procedures and services while they were outside the United States. According to the Complaint in Intervention, except in limited circumstances, providers cannot bill for services while outside the United States. According to the settlement agreement, Florida Cardiology submitted these false claims for payment to Medicare, Medicaid, TRICARE, and the Federal Employee Health Benefits Program.

The settlement concludes a lawsuit originally filed in the United States District Court for the Middle District of Florida by Relators Derrick Graham and Jesse Frauenhofer. The Relators will receive $420,000 of the proceeds from the settlement with the Defendants.

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

Date: 01/06/2023 **Entity Location:** Florida **Government Program(s):** Medicare, Medicaid, TRICARE, & Other Federal Programs

Arkansas Cardiologist Agrees To Pay $900,000 To Settle False Claims Act Allegations

Company Name: Hot Springs National Park Hospital Holdings, LLC d/b/a National Park Medical Center (NPMC)
Settlement: $900,000

Issue(s): False Claims Act, Medical Necessity, Cardiology

The U.S. Attorney's Office for the Middle District of Tennessee announced that an Arkansas cardiologist has agreed to settle allegations that he violated the False Claims Act by submitting claims for payment to the Medicare Program for the medically unnecessary placement of cardiac stents.

Jeffrey G. Tauth, M.D., 60, of Hot Springs, Arkansas, is a cardiologist who treated patients at Hot Springs National Park Hospital Holdings, LLC d/b/a National Park Medical Center (NPMC) and National Park Cardiology Services, LLC d/b/a Hot Springs Cardiology Associates. The United States alleges that from September 2013 through August 2019, Tauth submitted or caused the submission of claims for payment to the Medicare Program for cardiac stents that Tauth inserted into Medicare patients that were not medically necessary. As part of the settlement, Tauth has agreed to pay $900,000 and enter into a three-year corporate integrity agreement with the U.S. Department of Health & Human Services (HHS).

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

Date: 12/28/2022 **Entity Location:** Arkansas **Government Program(s):** Medicare

Connecticut Physician and Urgent Care Practice Pay Over $4.2 Million to Settle False Claims Act Allegations

Company Name: Jasdeep Sidana, M.D., DOCS Medical Group, Inc. d/b/a DOCS Medical, DOCS Medical Inc., DOCS Urgent Care LLP, Lung Docs of CT, P.C., Epic Family Physicians, LLP, and Continuum Medical Group, LLC
Settlement: $4,267,950

Issue(s): False Claims Act, E&M Services, Medical Necessity, Allergy Services

The U.S. Attorney's Office for the District of Connecticut announced that JASDEEP SIDANA, M.D. and DOCS MEDICAL GROUP, INC. (doing business as Docs Medical), DOCS MEDICAL INC., DOCS URGENT CARE LLP, LUNG DOCS OF CT, P.C., EPIC FAMILY PHYSICIANS, LLP, and CONTINUUM MEDICAL GROUP, LLC (collectively, "DOCS"), have entered into a civil settlement agreement with the federal and state governments in which they will pay a total of $4,267,950.21 and enter into a three-year corporate integrity agreement to resolve allegations that they submitted false claims for payment to Medicare and the Connecticut Medicaid program for medically unnecessary allergy services, unsupervised allergy services, and services improperly billed as though provided by Sidana. The agreement also resolves allegations that Sidana and DOCS improperly billed for certain office visits associated with COVID-19 tests.

It is alleged that in early 2014, DOCS and Sidana started providing allergy testing and treatment services to their patients. The government alleged that between October 1, 2016, and September 30, 2017, DOCS and Sidana submitted false claims to Medicare and Medicaid for immunotherapy services that were not medically necessary and were not directly supervised by a physician. The allegations also involve claims to Medicare and Medicaid for medically unnecessary annual re-testing of allergy patients between January 1, 2014, and November 11, 2018.

The government also alleged that between January 1, 2014, and January 1, 2019, DOCS and Sidana submitted claims for medical services performed by Sidana on dates of service when he was traveling internationally and did not perform or supervise the services. Instead, the services were actually performed by lower-level providers, who typically receive a lower reimbursement rate from Medicare and Medicaid for such services.

Finally, the government contends that when administering tests for COVID, DOCS and Sidana improperly billed Medicare and Connecticut Medicaid for certain evaluation and management ("E&M") services, commonly referred to as office visits. The government alleges that between April 1, 2020, and December 31, 2020, on the same dates that patients received COVID-19 tests, DOCS and Sidana submitted claims for moderately complex "level 3" E&M services, when those level 3 office visits were not in fact provided.

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

Date: 12/13/2022 **Entity Location:** Connecticut **Government Program(s):** Medicaid & Medicare

Physician and Medical Office to Pay Over $2.6 Million to Settle False Claims Act and Kickback Allegations

Company Name: Feel Well Health Center of Southington, P.C.
Settlement: $2,600,000

Issue(s): False Claims Act, Anti-Kickback, Medical Necessity, Neurofeedback, Ultrasounds, Autonomic Function Testing

The U.S. Attorney's Office for the District of Connecticut announced that FEEL WELL HEALTH CENTER OF SOUTHINGTON, P.C. (formerly doing business as "Feel Well Health Center") and KEVIN P. GREENE, M.D. ("Greene") have entered into a civil settlement agreement with the federal and state governments and agreed to pay more than $2.6 million and enter into a three-year corporate integrity agreement to resolve allegations that they violated the federal and state False Claims Acts by improperly billing federal and state healthcare programs, and that they received illegal kickbacks.

The federal and state governments alleged that Greene and Feel Well Health Center violated the federal and state False Claims Acts by improperly billing Medicare, Connecticut Medicaid, and the State of Connecticut Comptroller Healthcare Programs. Between April 2016 and January 2020, Greene and Feel Well Health Center submitted false claims for payment for medical visits when, in fact, the patients had received fitness-related services with no legitimate medical component at a gym they operated that was staffed by a medically unlicensed coach and yoga instructor. Greene and Feel Well Health Center created false medical records for these gym visits and attached false diagnoses in association with these claims.

In addition, the government alleged that between April 2016 and March 2020, Greene and Feel Well Health Center submitted false claims for services allegedly rendered by Greene in an office setting when he was not physically present in the office suite, including when he was out of the country, on vacation, or in a different office at the time. For instances

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where Greene and Feel Well Health Center submitted claims for alleged telemedicine, they did not meet applicable telemedicine requirements for office location or use an interactive telecommunications system.

It is also alleged that Greene and Feel Well Health Center also submitted false claims for medically unnecessary testing or procedures for neurofeedback, ultrasounds, and autonomic function testing between April 2016 and August 2021.

The governments further allege that Greene and Feel Well Health Center violated the Anti-Kickback Statute by receiving remuneration from Boston Heart Diagnostics Corp. in return for ordering from the company clinical laboratory services for Medicare patients. The payments were in the form of purported "processing and handling" fees between October 2012 and June 2014, and "speaker" fees, which were for rates greater than fair market value, between January 2017 and December 2018.

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

Date: 11/08/2022 **Entity Location:** Connecticut **Government Program(s):** Medicaid, Medicare & Other Federal Programs

Stockton Doctor and Medical Practice Agree to Pay Nearly $2 Million to Resolve Allegations of Health Care Fraud

Company Name: Aziz Kamali, M.D., Inc.
Settlement: $1,963,953

Issue(s): False Claims Act, Anti-Kickback, Neurostimulators

The US Attorney for the Eastern District of California announced that Azizulah "Aziz" Kamali and his medical corporation, Aziz Kamali, M.D. Inc., have agreed to pay $1,963,953 and enter into a three-year corporate integrity agreement to resolve allegations that they violated the False Claims Act by submitting millions of dollars of false claims to Medicare for surgically implanted neurostimulators and paying kickbacks to sales marketers.

According to the settlement, Dr. Kamali and his medical corporation admitted that they submitted claims to Medicare for surgically implanted neurostimulator devices even though they did not perform surgery or implant neurostimulators. Dr. Kamali and Kamali Inc. admitted that they instead taped a disposable electroacupuncture device called "Stivax" to their patients' ears. Stivax devices do not require surgical implantation and are not reimbursable by Medicare. The government alleges that this conduct violated the False Claims Act.

Dr. Kamali and his medical corporation also admitted that they paid a marketing company a percentage of the reimbursements they received from Medicare for billing implantable neurostimulators, in return for the marketing company arranging for and recommending that patients order Stivax from them. The United States alleges that this conduct violated the Anti-Kickback Statute and the False Claims Act.

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

Date: 08/12/2022 **Entity Location:** California **Government Program(s):** Medicare

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Suburban Chicago Home Sleep Testing Company To Pay $3.5 Million To Settle Federal Health Care Fraud Suit

Company Name: SNAP DIAGNOSTICS, LLC
Settlement: $3,500,000

Issue(s): False Claims Act, Anti-Kickback, Home Sleep Testing, Medical Necessity

The US Attorney for the District of Illinois announced that a suburban Chicago diagnostics company that provides home sleep testing will pay $3.5 million and enter into a five-year corporate integrity agreement to the United States to settle a civil lawsuit accusing the company of defrauding Medicare and four other federal health care programs through kickbacks and unnecessary home sleep testing.

The suit in U.S. District Court in Chicago alleged that SNAP Diagnostics, a nationwide provider of home sleep testing diagnostic services based in Wheeling violated the False Claims Act and the Anti-Kickback Statute by fraudulently billing Medicare and four other federal health care programs for medically unnecessary services and for services that were occasioned by kickbacks. The suit alleged that SNAP to submit claims for patients' second and third nights of home sleep testing when, in fact, the company knew that only a single night of testing was needed to effectively diagnose obstructive sleep apnea and that it routinely tested and claimed only one night for patients with private health insurance. As a result, the suit alleged that, in addition to defrauding five federal agencies, SNAP unlawfully multiplied the copays it received from senior citizens who were Medicare beneficiaries. The suit also alleged that SNAP's business model relied on several unlawful kickback schemes, which incentivized physicians and their staffs to refer all of their home sleep testing services to SNAP.

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

Date: 06/01/2022 **Entity Location:** Illinois **Government Program(s):** Medicare & Other Federal Programs

Miami-Based VirtuOx, Inc. Agrees to Pay $3.15 Million to Resolve Allegations that it Fraudulently Billed Medicare

Company Name: VirtuOx, Inc.
Settlement: $3,150,000

Issue(s): False Claims Act, Overnight Pulse Oximetry

The U.S. Attorney's Office of Southern District of Florida announced that VirtuOx, Inc. ("VirtuOx"), based in Coral Springs, Florida and operating Medicare approved Independent Diagnostic Testing Facilities ("IDTF"), has agreed to pay $3,150,000.00 and enter a five-year corporate integrity agreement to resolve allegations that it submitted or caused to be submitted false claims to Medicare for reimbursement.

The United States alleged that, from January 2016 to December 2020, VirtuOx violated the False Claims Act by falsely identifying the place of service for certain services it performed to obtain a higher rate of reimbursement from Medicare. In particular, the United States alleged that, in connection with its billing for overnight pulse oximetry claims, VirtuOx knowingly submitted false claims to Medicare identifying its IDTF located in San Francisco, California as the location of service for overnight pulse oximetry tests when, in fact, no services were performed at that location in relation to the overnight oximetry claims.

The United States further alleged that, from January 2016 to December 2020, VirtuOx administered overnight pulse oximetry tests and, at times, also billed Medicare for single determination pulse oximetry tests (commonly referred to as an oxygen "spot check") for the same patient when in fact the only test performed was the overnight test. In particular, the

United States alleged that, because an awake reading is necessarily taken as part of an overnight pulse oximetry test, the separate billing of a "spot check" is redundant and generally not necessary. Accordingly, the United States alleged that VirtuOx knowingly submitted false claims by separately billing for both an oxygen "spot check" and an overnight pulse oximetry test when only an overnight pulse oximetry test was performed.

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

Date: 05/11/2022 **Entity Location:** Florida **Government Program(s):** Medicare

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