**AN OVERVIEW OF PERVASIVE ALLEGATIONS IN HOSPICE AND HOME HEALTH FRAUD CASES**

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Health care providers are regulated by a complicated administrative framework that requires strict compliance with numerous federal laws and regulations. This is particularly true with home health agencies and hospice care providers. The Medicare home health and hospice benefits have long been recognized as program areas vulnerable to fraud, waste and abuse. Both benefit programs require providers to comply with strict requirements and preconditions that can subject these providers to harsh criminal and civil penalties for noncompliance. Below, is an outline highlighting pervasive allegations that form the basis for liability of hospice care and home health care providers under the False Claims Act, Anti-Kickback Statue and Civil Money Penalties and Affirmative Exclusions statutes and regulations.

1. **The False Claims Act.**

The False Claims Act, 31 U.S.C. §§ 3729 *et seq*. (“FCA”) prohibits anyone from knowingly presenting or causing to be presented, a false or fraudulent claim for payment or approval, or knowingly making, using or causing to be made or used, a false record or statement material to a false or fraudulent claim. The Act makes persons who violate these prohibitions liable for a civil penalty of not less than $5,500 and not more than $11,000 for each such violation and for three times (or treble) the amount of damages the government sustains as a result of the violation or violations.[[1]](#footnote-1)

Courts evaluating FCA suits have recognized two types of actionable false claims: factually and legally false. A factually false claim is a claim that was submitted under an incorrect description of services provided or a request for reimbursement for goods and services were never provided. A legally false claims arises were a provider has made false certifications, such as if a patient is “terminally ill” or “homebound.” Both types of actionable false claims are highly prevalent in FCA cases involving home health agencies and hospice care providers.

1. **Hospice Care.**

Through the Medicare Hospice Benefit, Medicare pays for hospice care for certain terminally ill patients who elect to receive such care. 42. U.S.C. § 1395d. Hospice care refers to a comprehensive set of services identified and coordinated by an interdisciplinary group to provide for the physical, psychological, spiritual and emotional needs of a terminally ill patient and his or her family members. 42 U.S.C. § 1395x(dd)(1).

Hospice care is covered under Medicare subject to certain conditions that include:

* The patient’s attending physician and the medical director of the hospice program must both certify in writing that the individual is terminally ill. 42 U.S.C. § 1395f(a)(7)(A)(i);
* “Terminally ill” means that a patient has a medical prognosis that his or her life expectancy is six (6) months or less if the illness runs its normal course. 42 U.S.C. § 1395xx(dd)(3)(A);
* A patient must elect hospice care and agree to forego Medicare coverage for curative treatment;
* An individualized written plan (“Plan of Care” or “POC”) must be established and periodically reviewed by the attending physician and medical director and all hospice care must be provided in accordance with that plan. 42 U.S.C. § 1395f(a)(7)(B) & (C); and
* All hospice services “must be reasonable and necessary for the palliation and management of the terminal illness as well as related conditions. 42 C.F.R. § 418.200.

In light of these requirements, Hospice care providers are frequently targeted by the Department of Justice (“DOJ”) for False Claims Act violations. Fraud in this area is increasingly common and the DOJ has specifically expressed its desire to engage in more stringent enforcement of the FCA in relation to hospices. The following list represents the most pervasive allegations brought against Hospice care providers for violation of the FCA:

* Falsely certifying that a patient is terminally ill.
* Admitting and retaining patients in hospice care knowing that they

did not qualify for hospice care.

* Deceiving patients into enrolling in hospice care.
* Up-coding to inflate Medicare reimbursement and rewarding staff members who participated in the up-coding with promotions and/or increased salaries.
* Falsifying documents and patient records indicating patients were eligible for or had elected hospice benefits.
* Knowingly bill Medicare for services not in compliance with patients’ Plan of Care.
* Instructing staff to enroll patients for hospice care without proper physician authorization or clinical information.
* Failing to provide services consistent with the Plan of Care.

* Providing inadequate or incomplete services.

Cases and Settlements Exemplifying These Allegations

*United States ex rel. Fowler and Towl v. Evercare Hospice, Inc.* (D. Colo.)

* In July 2016, Evercare, now known as Optum Palliative and Hospice Care agreed to pay $18 million to resolve allegations that it submitted false claims to Medicare for patients who were not terminally ill.
* The complaint alleged that the defendant knowingly submitted claims for hospice care for patients who were not eligible because the medical records did not support that they were terminally ill.
* Additionally, the defendant engaged in business practices that included discouraging doctors from recommending that ineligible patients be discharged from hospice and failing to ensure that nurses accurately and completely documented patients’ conditions in the medical records.

*United States v. VITAS Hospice Services, LLC* (W.D. Mo.)

* Vitas is the largest hospice chain in the United States, providing hospice services to patients in 18 states.
* In May 2013, DOJ filed a complaint alleging that Vitas submitted false claims for hospice services which were excessive, unnecessary or not provided.
* Specifically the complaint alleged:
	+ Engaged in marketing campaigns that misrepresented the purpose of hospice care;
	+ Improperly encouraged employees to render continuous home care services to ineligible hospice patients;
	+ Submitted or caused to be submitted hospice claims to Medicare for patients who were not terminally ill;
	+ Submitted claims for services that were unnecessary and not actually performed; and
	+ Paid bonuses to staff based on the number of patients enrolled in the program and which rewarded them for patients with longer lengths of stay.
* This FCA litigation is ongoing.

*United States ex rel. Willis v. Angels of Hope Hospice, Inc.*, (M.D. Ga.)

* *Qui tam* complaint filed by former employees in 2011.
* The complaint alleged that the defendant:
	+ Admitted patients who never previously elected hospice care;
	+ Employed marketers to solicit patients by driving around neighborhoods looking for elderly disabled people;
	+ Knowingly admitted patients who did not qualify for the hospice benefit; and
	+ Falsified records to indicate that patients were terminally ill.
* This FCA litigation is ongoing.

*United States v. Hospice Care of Kansas, LLC,* (D. Kan.)

* *Qui tam* complaint filed by hospice nurse in 2006. Government intervened in June 2010 alleging defendants’ business practices caused the submission of false claims from 2004-2008.
* The allegations included:
	+ Compensating clinical employees based on patient census and admissions;
	+ Delaying discharges of patients determined not to have six months or less to live;
	+ Corporate leaders would challenge physician decisions to discharge;
	+ Corporate instructions to nursing staff to omit observations of patient improvement;
	+ “Knowingly” implementing an inadequate compliance program.
* Hospice Care of Kansas agreed to settle for $6.1 million and denied liability.

*United States ex rel. Paradies et al. v. AseraCare Inc. et al*., (N.D. Ala.)

* *Qui tam* complaint filed by former employees in 2009. The Complaint alleged that AseraCare:
	+ Knowingly submitted false claims to Medicare for hospice care for patients who were not terminally ill;
	+ Pressured staff to admit and retain ineligible patients; and
	+ Directed Medical Directors to rely on admissions nurses to make certification decisions.
* The court bifurcated the trial agreeing that the defendant would be prejudiced if the government were allowed to present evidence that false claims were submitted knowingly at the same time that it presented evidence that the claims were false.
* The government sought to prove the falsity element via statistical sampling. Specifically, the government’s proof of the number of false claims in a total of 2,181 false claims was a sample of 233 claims. Of those claims, DOJ’s expert found 123 were unsubstantiated.
* After trial a 10-week jury trial, AseraCare was found liable and faced damages in excess of $200 million.
* The court subsequently granted the AseraCare’s motion for new trial after finding that, in the court’s view, it committed major reversible error when it instructed the jury about objective falsity and failed to include an instruction proposed by the defendant regarding differences of opinion with respect to the falsity of claims.
* Prior to the new trial, the court considered summary judgment sua sponte and addressed the issue of whether the government could point to any admissible evidence to prove falsity other than its expert’s opinion that the medical records for the 123 patients at issue did not support the Certifications of Terminal Illness.
	+ In granting summary judgment in favor of AseraCare, the court held that the opinion of one medical expert, alone, was insufficient to support a FCA claim alleging false certification of patient eligibility for Medicare hospice.
* This matter is currently pending on appeal before the United States Court of Appeals for the Eleventh Circuit.

*United States ex rel. Michaels v. Agape Senior Community Inc. et al.* (D. S.C.)

* *Qui tam* action alleging that the Defendants systematically defrauded federal healthcare programs by certifying patients for hospice care when no such care was needed.
	+ Following discovery, it became known that over 63,000 separate invoices would be presented at trial for purposes of establishing liability and damages.
	+ Accordingly, the relators sought to prove their case through the use of statistical sampling evidence in which the parties would try to a jury claims involving a sample of 95 patients.
* The parties reached a settlement before trial. However the government, after declining to intervene in the case, objected to the settlement on the basis that the size of the settlement was too small based on its use of statistical extrapolation to identify the universe of potential claims.
* Recognizing that the claims asserted in the case were highly fact-intensive involving medical testimony based on a thorough review of the detailed medical chart of each individual patient, the court certified to questions for review, including whether the use of statistical sampling to prove liability and damages was appropriate under the facts of this case.
* The Fourth Circuit accepted the question and the case is currently pending before that court.

*United States v. Odyssey HealthCare, Inc*. (E.D. Wisc*.* 2009*)*

* Odyssey provides hospice services to approximately 27 states throughout the country.
* In 2009, a *qui tam* action was brought against Odyssey alleging violations of the False Claims Act.
* The complaint alleged that Odyssey improperly billed for unnecessary continuous care services and for services that were not performed.
* In 2012, Odyssey agreed to pay $25 million to resolve the allegations and entered into a five-year Corporate Integrity Agreement.
1. **Home Health Agencies.**

To qualify for home health care reimbursement under Medicare a patient must: (1) be homebound; (2) need part-time skilled nursing services or speech therapy, physical therapy, or continuing occupational therapy as determined by a physician; and (3) be under a plan of care established and periodically reviewed by a physician and administered by a qualified home health agency. 42 U.S.C. §§ 1395f; 1395x(o). In order to receive covered care, a physician must certify that skilled care is medically necessary and that the patient is homebound, meaning that they are unable to leave their home except for brief trips for medical care. The physician must also establish and periodically review a plan of care, document a "face-to-face" evaluation, and such services must actually be provided by a qualified home health agency.

In light of these strict requirements, complaints alleging violations of the False Claims Act have become more complex. The following list represents the common allegations brought against HHAs for violating the False Claims Act:

* Performing medically unnecessary procedures to increase Medicare or Medicaid reimbursement.
* Billing for home health services not actually rendered.
* Billing unskilled services as skilled services.
* Falsifying documents to make it appear that patients are homebound and qualify for home health services when they do not, or that those services were provided when they were not.
* Forging physician signatures when such signatures are required to receive reimbursement.
* Double billing for the same visit under multiple categories.
* Up-coding routine treatments by billing them as more complicated, elevated levels.
* Billing for services not provided by certified home health workers.
* Failing to timely return overpayments.

Cases and Settlements Exemplifying These Allegations

*United States v. Amedisys, Inc. et al.* (E.D. Pa.)

* Between 2008 and 2010, Amedisys Inc., one of the nation's largest providers of home health services, allegedly billed Medicare for medically unnecessary services and services provided to patients who were not homebound.
* The defendant also allegedly misrepresented patients' conditions to increase its Medicare payments.
* Additionally, the complaint alleged that Amedisys violated the Anti-Kickback Statute and the Stark Law via an improper financial relationship with a private oncology practice in Georgia, where services were provided at below-market prices.
* Seven lawsuits were brought in federal court under the qui tam provisions of the FCA.
* In April 2014, defendant settled the claims for $150 million to resolve seven pending qui tam lawsuits. The defendant also agreed to be bound by the terms of a Corporate Integrity Agreement, imposing continuing compliance obligations. The whistleblowers collectively split over $26 million.

*United States v. University of Pennsylvania Health System* (E.D. Pa.)

* *Qui Tam* complaint filed against University of Pennsylvania Health System (UPHS)'s home health unit, Penn Care at Home.
* The complaint alleged that Penn Care submitted claims to Medicare for services not rendered and for services that were not reasonable or necessary.
* In May 2016, UPHS settled with the United States for $75,787 to resolve these allegations.
* As part of the settlement, UPHS agreed to implement new compliance measures and submit annual compliance reports through 2019.

*United States v. ResCare Iowa Inc.* (N.D. Iowa)

* In February 2015, ResCare Iowa Inc., agreed to pay $5.63 million to the United States and the State of Iowa to reoslove allegationst that it submitted false home healthcare billings to Medicare.
* Between 2009 and 2014, ResCare Iowa billed the government for services provided to Medicare and Medicaid patients in Iowa without documenting compliance with Medicare’s billing requirements.
* Specifically, ResCare failed to document that an independent physician certified that the services were medically necessary and did not document that a physician performed a "face-to-face" evaluation of each patient prior to submitting claims for payment.

*United States v. Nurses’ Registry and Home Health Corp. et al*. (E.D. Ky.)

* In this qui tam lawsuit, the government alleged that between 2004 and 2011, defendants submitted false and fraudulent claims by engaging in conduct that included:
* Up-coding the severity of patients' symptoms to bill for more expensive services and providing medically unnecessary therapy visits.
* Falsifying medical records and forged physician's signatures to falsely certify that patients were homebound and needed skilled nursing or therapy services.
* Frequently re-certified patients for home health services long after they ceased to meet the eligibility requirements.
* Providing tickets to popular events, bottles of liquor, and other things of value to physicians to induce or reward patient referrals in violation of the Anti-Kickback Statute and the Stark Law.
* In October 2015, Defendants settled with the United States for $16 million. Under the terms of the agreement, Nurses' Registry was sold to an independent third party, and 70% of the net sale proceeds would be remitted to the federal government.

*United States v. J.W. Carell Enterprises, Inc., et al*., (M.D. Tenn.)

* Between 2006 and 2013, the defendants (CareAll Management LLC and affiliated entities) allegedly overstated the severity of patients’ conditions to increase billings and billed for services that were not medically necessary rendered to patients who were not homebound.
* To resolve these allegations, the defendants settled with the United States and the state of Tennessee for $25 million.
1. **The Federal Anti-Kickback Statute.**

The Federal Anti-Kickback Statute (“AKS”) prohibits any person or entity from knowingly and willfully offering, making, soliciting, or accepting remuneration, in cash or in kind, directly or indirectly, to induce or reward any person for purchasing, ordering, or recommending or arranging for the purchasing or ordering of federally-reimbursable medical goods or services. 42 U.S.C. § 1320a-7b(b). The term “remuneration” is broadly defined and includes transfers of items or services for free or for other than fair market value. 42 U.S.C. § 1320a-7a(i)(6). A person need not have actual knowledge of the statute or specific intent to commit a violation in order to violate the Anti-Kickback Statute.

Claims submitted for services rendered in violation of the AKS constitutes a false or fraudulent claim for purposes of the False Claims Act and will subject a perpetrator to False Claims Act liability. Violation of the Anti-Kickback Statute subjects the violating individual or entity to criminal and civil liability, exclusion form federal healthcare programs, as well as civil monetary penalties of $50,000 per violation and three times the amount of remuneration paid.

* 1. **Hospice Care.**

Allegations that support AKS liability are typically brought in conjunction with FCA allegations. The most pervasive types of AKS allegations against hospice providers include:

* Obtaining referrals of patients for hospice services by promises and payment of incentives and kickbacks to employees, primary care providers, nursing homes, and assisted living facilities.
* Providing incentives such as gifts or free services to referral sources (e.g., physicians, nursing homes, hospitals, patients, etc.).
* Paying kickbacks to employees in the form of bonuses, prizes, better performance evaluations, free meals and other valuable items given to staff that generated the most referrals.
* Incentivizing patients to elect to stay in hospice care by providing them gifts.
* Physicians referring patients to hospices that they have a financial interest in (e.g., physician owns a percentage of the hospice and benefits from increasing enrollment).

Cases and Settlements Exemplifying These Allegations [[2]](#footnote-2)

*United States ex rel. Smallwood v. Thi of Mich. LLC* (N.D. Ala.)

* Multistate hospice operator over a five your period admitted patients who were not qualified for hospice benefits.
* Defendant also paid illegal inducements to its staff for increasing the number of patients admitted and operated a garnishing program that paid financial incentives to employees for reducing the cost of patient in its facilities.
* Staff members also rationed supplies and substituted cheaper medications in ways that negatively affected patient care.
* The hospice operator denied the allegations but agreed to pay $3.9 million to settle the allegations in March 2014.

*Druding v. Care Alternatives, Inc.* (D.N.J.)

* *Qui tam* complaint filed by former employees of hospice care provider that alleged that the defendant:
	+ Fraudulently certified ineligible patients.
	+ Falsified patient records to change their diagnosis to qualify for hospice eligibility.
	+ Engaged in an aggressive marketing campaign to bring in more patients by providing meals, gifts, and facility perks to physicians and employees to induce referrals.
	+ Promised community liaisons elevated levels of care, extra aids, full time nurses, and gifts to induce referrals of patients.
* This litigation is still ongoing.

*United States ex rel. Cordingley and Jones v. Good Shepherd Hospice, Mid America Inc.*, (W.D. Mo.)

* *Qui tam* complaint filed by a nurse and Executive Director that alleged that Defendant:
	+ Fraudulently certified and recertified ineligible patients.
	+ Failed to create or follow mandated plans of care.
	+ Required Medical Directors to refer one patient per month and offering nursing aides to nursing homes for referrals.
	+ Paid bonuses to staff and hospice marketers based on the number of patients enrolled.
	+ Hired medical directors based on their ability to refer patients, focusing particularly on medical directors with ties to nursing homes, which were seen as an easy source of patient referrals.
* The defendants agreed to pay $4 million to resolve these allegations.

*United States v. Eugene Goldman* (E.D. Pa.)

* Dr. Goldman, the medical director of Home Care Hospice, Inc. (“HCH”), entered into a written contract to create the false appearance that all payments to Goldman from HCH were for services rendered in Goldman’s capacity as medical director for HCH, when in fact the large majority of payments from HCH to Goldman were illegal payments for the referral of Medicare and/or Medicaid patients to HCH.
* Goldman received approximately $263,000 in illegal payments for patient referrals.
* At trial, **Dr. Goldman, was found guilty for referring more than 400 Medicare patients to hospice care in exchange for kickbacks in excess of $300,000 and was sentenced to 51 months in prison.** His conviction was affirmed by the United States Court of Appeals for the Third Circuit in March 2015.
	1. **Home Health Agencies.**

The below list exemplifies common allegations against HHAs for violations of the AKS.

* Purchasing Medicare or Medicaid beneficiary information and creating fake patient files.
* Paying kickbacks/bribes (cash, drugs, free services, etc.) to recruit beneficiaries (from group homes, senior housing developments, homeless shelters, etc.) for home health services, regardless of whether the beneficiaries needed home health care.
* Paying physicians to sign medical documents falsely certifying that beneficiaries required home health care when patients are not under their care or do not qualify for home health services.
* Paying physicians or others to hold sham positions, when payments were actually inducements to refer patients to the HHA.
* Receiving payments in exchange for referring patients to HHAs.

Cases and Settlements Exemplifying These Allegations

*United States v. Minhas*(E.D. Mich. 2016)

* Defendant, owner and operator of a home health care agency illegally recruited beneficiaries by paying a physician and recruiters to refer beneficiaries and created fake patient files to make it appear that services rendered were necessary.
* The defendant pled guilty. Sentence is pending.

*United States v. Davis et al.* (E.D. La. 2016)

* Defendants (a physician and an owner of a home health agency) submitted $34.4 million in false claims to Medicare.
* The HHA owner paid employees to recruit new patients.
* Owner then sent prospective patients’ information to the physician, who certified that they qualified for home health services that they did not need without even seeing the patients.
* Both defendants were convicted of one count of conspiracy to commit health care fraud and one count of health care fraud. Another physician had been charged but was cleared on all counts.

*United States v. Alvarez et al*. (S.D. Fla. 2016)

* One of the defendants was a patient recruiter for two fraudulent home health care agencies in Miami.
* The defendant created a shell company for the purpose of accepting kickbacks from the two HHAs, and received approximately $250,000 as a result of his role in the elaborate scheme.
* The defendant was sentenced to five years in prison and ordered him to pay $2.3 million in restitution.

*United States ex rel. Simony v. Recovery Home Care, et al.* (M.D. Fla.)

* Owner and operator of Recovery Home Care (“RHC”) paid kickbacks to doctors who agreed to refer Medicare patients to RHC for home health care services.
* From 2009 to 2012 the owners paid dozens of physicians thousands of dollars per month to serve as sham medical directors who supposedly conducted quality review of RHC patient charts.
* Recovery Home Care settled with the United States and agreed to pay $1.1 million to resolve these allegations. In a separate settlement, the former owner, operator and sole shareholder of Recovery Home Care agreed to pay $1.75

*United States ex rel. Guthrie v. A Plus Home Health Care, Inc.,* (S.D. Fla. 2014)

* Government alleged that A Plus Home Health Care engaged in a scheme to increase Medicare referrals in south Florida.
* The company allegedly hired at least seven physicians’ spouses and one physician’s boyfriend to perform marketing duties, but required the spouses and boyfriend to perform few, if any, actual job duties.
* The spouses’ and boyfriend’s salaries allegedly served as an inducement and reward for the physicians’ referrals of Medicare patients to A Plus.
* The owner allegedly fired at least two spouses when their husbands failed to refer a certain number of patients to A Plus.
* In September 2014, A Plus agreed to pay $1.65 million to settle allegations.

*United States v. Tahir et al*. (E.D. Mich. 2016)

* The indictment alleged that the defendants offered, paid, solicited, and received kickbacks and bribes in exchange for beneficiary referrals and the use of Medicare beneficiary information used to submit false claims for home health care services, hospice services, and physician services that were often medically unnecessary.
* One of the defendants bribed patients into accepting home health services from his agency by providing them with medically unnecessary controlled substance prescriptions.
* The last of the five defendants pled guilty in March 2016 for his role in the scheme and is awaiting sentencing.

*United States v. George* (N.D. Ill. 2016)

* The defendant, a marketer, was charged with two counts of receiving kickbacks for Medicare referrals and one count of conspiring to pay or offer kickbacks.
* For her part in the large-scale fraud scheme, George received approximately $500 from Rosner Home Healthcare Inc. for each patient she referred to the company.
* Further, nurses at Rosner regularly put false information into patient charts to make home health services appear to be medically necessary, and to make patients appear to be sicker than they actually were.
* George was convicted on all three counts and is awaiting sentencing. She is the eleventh defendant to be convicted as a part of this scheme.

United Sates v. Deaconess Home Health, Inc.(E.D. Wisc. 2015)

* The defendant, the owner of an HHA, allegedly engaged in a scheme to defraud the Medicaid program by intentionally recruiting patients regardless of whether home care services were medically necessary, instructing nurses to routinely inflate assessments for Medicaid patients to bill at elevated levels, failing to conduct required supervisory visits to ensure that services were actually provided and medically necessary, and hiring physicians to sign plans of care for patients they had never examined.
* Between 2011 and 2012, Deaconess Home Health Inc. increased its billing to the Medicaid Program for personal care service by over 100%.
* The defendant HHA and its owner settled with the United States for $3,724,000. Additionally, the HHA owner agreed to be voluntary excluded from participating in any federal health care program, including Medicare and Medicaid, for fifteen years.
1. **Civil Money Penalties and Affirmative Exclusions.**

The Office of Inspector General of the Department of Health and Human Services (“OIG”) also has the authority to levy administrative penalties and assessments against providers as punishment for filing false and improper claims. 42 C.F.R. § 1003.102. Sancitonable conduct includes the submission of false and fraudulent claims and illegal remuneration in violation of the Anti-Kickback Statute.

Additionally, the submission of false or fraudulent claims or a violaiton of the Anti-Kikcback Statute can lead to a provider’s exclusion from federal health care programs. 42 U.S.C. § 1320a-7. The OIG has authority to exclude HHAs and hospice care providers from Medicare who engage in this unlawful activitiy. Recently, the OIG has pursued HHAs and hospice providers who employ individuals who it knows or should know is excluded from participation in federal health care programs.

Cases and Settlements Exemplifying These Allegations*:*

*United States v. Choice Home Health Care Inc. et al.* (Tex. 2016)

* OIG alleged that CHHC employed a home health community liaison/marketing specialist who was excluded from participating in any Federal health care program. This employee provided items or services to CHHC patients that were billed to Federal health care programs.
* CHHC settled the case for $89,587.82 with the Office of the Inspector General (OIG).

*United States v. Accurate Home Care, LLC* (Minn. 2015)

* OIG alleged that Accurate employed an excluded individual to provide services to Medicaid beneficiaries.
* Accurate settled with OIG for $334,651.82 to resolve the allegations.

*United States v. Ambulatory Health Care Services, LTD* (Ill. 2015)

* Ambulatory, an Illinois home health agency allegedly employed an excluded nurse and billed Federal health care programs for services provided by the nurse to Medicare and Medicaid beneficiaries.
* Ambulatory was excluded from participation in all Federal health programs for 3 years.

*Pinnacle Hospice Care* (Colo. 2016)

* On July 14, 2016 Pinnacle Hospice Care entered into a $50,000 settlement agreement with OIG.
* The settlement resolved allegations that PHC employed an individual who was excluded from practicipating in any federal health care program.

*Hospice of the Valley*  (Ariz. 2016)

* On June 24, 2016, an Arizona hospice provider entered into a $91,932.16 settlement agreement with OIG.
* The settlement resolved allegations that HOTV submitted claims for hospice services at the general inpatient level of care when it knew or should have known that routine care was the correct level of hospice care that should have been billed.

*Arizona Hospice CEO* (Ariz 2015)

* In connection with the resolution of FCA liability, a former CEO of an Arizona hospice agreed to be excluded from participating in federal health care programs for a period of five years.
* During the tenure of the CEO, the hospice submitted false claims to Medicare for patients who were provided a higher level of hospice care than was necessary and patients who were ineligible for Medicare’s hospice benefits because they were not terminally ill.

*Permier Hospice and Palliative Care, LLC* (Ind. 2014)

* On December 18, 2014 the OIG entered into a $2.6 million settlement agreement with the current and former owners of Premier Hospice.
* The settlement agreement resolved allegations that Premier violated the Civil Monetary Penaltties Law by submitting claims to Medicare for patients whose health records indicated they were ineleible for such services.
1. Recently, the DOJ published an Interim Final Rule announcing that it intended to increase the minimum per-claim penalty under Section 3729(a)(1) of the FCA from $5,500 to $10,781 and increase the maximum per-claim penalty from $11,000 to $21,563. These adjusted amounts will apply only to civil penalties assessed after August 1, 2016, whose violations occurred after November 2, 2015. [↑](#footnote-ref-1)
2. A majority of the cases identified in Section I(B) *supra,* also contain allegations pertaining to violations of the AKS. [↑](#footnote-ref-2)