UNITED STATES DEPARTMENT of JUSTICE

Amedisys Home Health Companies Agree to Pay U.S. $150 Million to Resolve False Claims Act Allegations

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PHILADELPHIA - Amedisys Inc. and its affiliates (Amedisys) have agreed to pay $150 million to the federal government to resolve allegations that they violated the False Claims Act by submitting false home healthcare billings to the Medicare program. Amedisys, a Louisiana-based for-profit company, is one of the nation's largest providers of home health services and operates in 37 states, the District of Columbia, and Puerto Rico.

The settlement was announced today by United States Attorney Zane David Memeger and the Department of Justice. It resolves allegations that, between 2008 and 2010, certain Amedisys offices improperly billed Medicare for ineligible patients and services. Amedisys allegedly billed Medicare for nursing and therapy services that were medically unnecessary or provided to patients who were not homebound, and otherwise misrepresented patients' conditions to increase its Medicare payments. These billing violations were the alleged result of management pressure on nurses and therapists to provide care based on the financial benefits to Amedisys, rather than the needs of patients.

"Combating Medicare fraud and overbilling is a priority for my office, other components of the Department of Justice, and United States Attorneys' Offices across the country," said Memeger. "We have recovered billions of dollars in Federal health care funds from schemes such as the one alleged in this case. Those are health care dollars that should be spent on legitimate medical needs. This settlement should send a message to all healthcare providers in the Eastern District of Pennsylvania, including home health providers, that we will continue to dedicate our full attention and resources to pursuing similar violations of the False Claims Act."

Additionally, this settlement resolves certain allegations that Amedisys maintained improper financial relationships with referring physicians. The Anti-Kickback Statute and the Stark Statute restrict the financial relationships that home healthcare providers may have with doctors who refer patients to them. The United States alleged that Amedisys' financial relationship with a private oncology practice in Georgia – whereby Amedisys employees provided patient care coordination services to the oncology practice at below-market prices – violated statutory requirements.

"It is critical that scarce Medicare home health dollars flow only to those who provide qualified services," said Stuart F. Delery, Assistant Attorney General for the Civil Division. "This settlement demonstrates the Department's commitment to ensuring that home health providers, like other providers, comply with the rules and don't misuse taxpayer dollars."

Amedisys also agreed to be bound by the terms of a Corporate Integrity Agreement with the Department of Health and Human Services – Office of Inspector General that requires the companies to implement compliance measures designed to avoid or promptly detect conduct similar to that which gave rise to this settlement.

"Improper financial relationships and false billing, as alleged in this case, can shortchange taxpayers and patients," said Daniel R. Levinson, Inspector General for the U.S. Department of Health and Human Services. "Our compliance agreement with Amedisys contains strong monitoring and reporting provisions to help ensure that people in Federal health programs will be protected."

This settlement resolves seven lawsuits pending against Amedisys in federal court – six in the Eastern District of Pennsylvania and one in the Northern District of Georgia – that were filed under the qui tam, or whistleblower, provisions of the False Claims Act, which allow private citizens to bring civil actions on behalf of the United States and share in any recovery. As part of today's settlement, the whistleblowers – primarily former Amedisys employees – will collectively split over $26 million.

For the United States Attorney's Office for the Eastern District of Pennsylvania, this investigation and settlement were handled by Assistant United States Attorneys Gregory B. David and Eric D. Gill. The United States' investigation was conducted by the Justice Department's Commercial Litigation Branch of the Civil Division; the United States Attorneys' Offices for the Northern District of Alabama, Northern District of Georgia, Eastern District of Kentucky, District of South Carolina, and Western District of New York; the Department of Health and Human Services' Office of Inspector General; the FBI; the Office of Personnel Management's Office of Inspector General; the Defense Criminal Investigative Service of the Department of Defense; and the Railroad Retirement Board's Office of Inspector General.

The claims settled by the agreement are allegations only, and there has been no determination of liability. The lawsuits are captioned United States ex rel. CAF Partners et al. v. Amedisys, Inc. et al. 10-cv-2323 (E.D. Pa.); United States ex rel. Brown v. Amedisys, Inc. et al., 13-cv-2803 (E.D. Pa.); United States ex rel. Umberhandt v. Amedisys, Inc., 13-cv-2789 (E.D. Pa.); United States ex rel. Doe et al. v. Amedisys, Inc., 13-cv-3187 (E.D. Pa.); United States ex rel. Ognen et al. v. Amedisys, Inc. et al. 13-cv-4232 (E.D. Pa.); United States ex rel. Lewis v. Amedisys, Inc., 13-cv-3359 (E.D. Pa.); and United States ex rel. Natalie Raven et al. v. Amedisys, Inc. et al., 11-cv-0994 (N.D. Ga.).

This settlement illustrates the government's emphasis on combating health care fraud and marks another achievement for the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, which was announced in May 2009 by Attorney General Eric Holder and Secretary of Health and Human Services Kathleen Sebelius. The partnership between the two departments has focused efforts to reduce and prevent Medicare and Medicaid financial fraud through enhanced cooperation. One of the most powerful tools in this effort is the False Claims Act. Since January 2009, the Justice Department has recovered a total of more than $19.2 billion through False Claims Act cases, with more than $13.6 billion of that amount recovered in cases involving fraud against federal health care programs.

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