UNITED STATES DEPARTMENT of JUSTICE

THE UNITED STATES ATTORNEY'S OFFICE
MIDDLE DISTRICT of FLORIDA

Department of Justice

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United States Settles False Claims Act Allegations Against Multiple Jacksonville Hospitals And An Ambulance Company For $7.5 Million

Jacksonville, FL – United States Attorney A. Lee Bentley, III announces that the United States has settled allegations that nine hospitals in Jacksonville had a practice of routinely ordering basic life support ambulances when this type of transport was not medically necessary. The United States has also settled allegations with an ambulance company for its role in submitting millions of dollars of false claims to federal healthcare programs. The allegations resolved included liability under the False Claims Act (FCA).

After a multiple-year investigation, the United States announces settlements with the following defendants: Baptist Health, who owns and operates four hospitals in Jacksonville (settlement of $2.89 million); Memorial Hospital, Specialty Hospital, Lake City Medical Center, and Orange Park Medical Center (collective settlement of $2.37 million); UF Health Jacksonville (settlement of $1 million); and Century Ambulance Service (settlement of $1.25 million). In reaching this settlement, the parties resolved allegations that, from January 1, 2009, until April 2014, the hospitals provided Certificates of Medical Necessity that attested to the need for basic life support, non-emergency ambulance transports even when these transports were not medically necessary. With respect to Century Ambulance, the parties resolved allegations, for the same time period, that Century Ambulance knowingly up-coded claims from Basic to Advanced life support, unnecessarily transported patients, and unnecessarily transported patients to their homes in an "emergent" fashion.

"The United States Attorney's Office is committed to taking the steps necessary to protect Medicare, TRICARE, and other federal health care programs from fraud," said U.S. Attorney Bentley. "Whether the fraud is intentional or the product of deliberate ignorance, we will pursue these cases and recover taxpayer money."

"Hospital staff that certify the medical need for services when they are in fact not medically necessary fail in their role as gatekeepers of valuable taxpayer-funded health care programs," said Chief Counsel to the Inspector General Gregory E. Demske of the U.S. Department of Health and Human Services Office of Inspector General.

Today's settlement involved false claims submitted to Medicare, TRICARE, Medicaid, and the Federal Employees Health Benefits Program managed by the Office of Personnel Management. This case was initiated by the filing of a qui tam lawsuit filed by Shawn Pelletier, a former employee of Century Ambulance. Mr. Pelletier will collect more than $1.2 million in proceeds from the settlements.

"Ambulance companies must ensure that services billed to federal healthcare programs are medically necessary and reasonable," said Chief Counsel Demske. "Billing Medicare and Medicaid for transports that amount to taxpayer-funded taxi services will not be tolerated."

The United States was unable to reach settlement with one defendant – Liberty Ambulance. The United States intends to pursue claims against that defendant and plans to file a civil complaint in the near future. The United States alleges that Liberty knowingly submitted medically unnecessary claims for reimbursement in violation of the federal healthcare program requirements.

"Our office is committed to working with other law enforcement organizations to ensure that both federal employees and taxpayers are protected from unscrupulous organizations that seek to reap profits by defrauding government

programs such as the Federal Employees Health Benefits Program," stated Patrick E. McFarland, Inspector General for the U.S. Office of Personnel Management. "We will continue to work to hold such entities accountable for their wrongdoing."

"The FBI is extremely grateful to have been part of this investigative team," said FBI Special Agent in Charge Michelle S. Klimt. "This is a perfect example of when all agencies work together how our collaborative efforts lead to success."

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 the Departments of Justice and Health and Human Services. 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 billion through False Claims Act cases, with more than $13.4 billion of that amount recovered in cases involving fraud against federal health care programs.

"This settlement highlights the commitment of the Defense Criminal Investigative Service (DCIS) and its law enforcement partners to protect the integrity of the Department of Defense (DoD) health care program," said Special Agent in Charge John F. Khin, Southeast Field Office. "DCIS aggressively investigates health care providers that defraud the DoD, to preserve American taxpayer dollars intended to care for our Warfighters, their family members, and military retirees."

This case was investigated by Federal Bureau of Investigation, the Office of Personnel Management, the Defense Criminal Investigative Service, the U.S. Department of Health and Human Services Office of Counsel to the Inspector General, the U.S. Department of Health and Human Services Office of Inspector General, Office of Audit Services, the Florida Medicaid Fraud Control Unit, the Defense Health Agency Program Integrity Office, and Assistant United States Attorney Jason Mehta.

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