Tennessee-Based Health Services Company Settles FCA Case Alleging Medicaid Fraud For $9.5 Million

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The Department of Justice ("DOJ") announced another False Claims Act ("FCA") settlement centered around a health services company’s practice of providing unnecessary therapy services to patients in order to receive the maximum amount of reimbursement under Medicare. The $9.5 million settlement is with Diversicare Health Services Inc, a Tennessee-based company that provides nursing and rehabilitation services at 74 locations throughout the country. Diversicare’s alleged violations are similar to those in a medicaid fraud case settled by the DOJ for $15.4 million two weeks earlier concerning fraudulent Medicare reimbursements for unnecessary rehabilitation services.

The settlement resolves two separate qui tam FCA lawsuits filed by whistleblowers Mary Haggard and Bryant Fitzmorris, both former Diversicare employees. Ms. Haggard will receive a whistleblower award of roughly $1.4 million, and Mr. Fitzmorris will receive $145,350. The FCA allows private citizens who possess inside information of fraudulently billing against the United States Government to initiate a lawsuit on the Government’s behalf to recover those funds. The citizens, known as qui tam relators, are then entitled to receive a share of any damages that the Government ultimately recovers from the litigation.

The settlement concerned Diversicare corporate policies, in use from the beginning of 2010 through the end of 2015, that specifically instructed its employees to provide patients rehabilitation treatments to receive the highest level of Medicare reimbursement, regardless of the need for, the efficacy of, or risks associated with such treatment. Specific allegations include “instances of improper co-treatment in order to achieve minute thresholds, repetitive and unskilled exercises that did not match plan of care goals to obtain additional minutes, engaging patients in activities contraindicated by underlying medical conditions, [and] extending patient lengths of stay beyond what was medically indicated.” In addition to the allegations of improper therapy, it was alleged that Diversicare billed Medicare for therapy services that were never in fact provided.

Additional allegations highlight the fraudulent attempts to maximize Medicare revenue, claiming that Diversicare threatened to undertake, and in some instances took, adverse employment actions against employees who failed to meet set budgetary goals and quotas. Finally, the settlement also resolves allegations of FCA violations regarding Diversicare’s Medicaid billing practices, including its submission of “forged, photocopied, or pre-signed physician signatures” on certifications necessary for Medicaid reimbursement.

Federal regulations governing the disbursement of taxpayer dollars for Medicare and Medicaid exist to both protect the patients receiving treatment, as well as the taxpayers whose dollars fund the programs. When companies intentionally circumnavigate these regulations in search of higher revenue, they not only rip off the taxpayers but also put vulnerable populations of patients at risk with unnecessary and often dangerous treatments. In the fiscal year 2019, the United States Government reported that using the FCA, it recovered $2.6 billion of taxpayer dollars fraudulently paid out under health care programs, including for violations such as those alleged against Diversicare. FCA relators and the Government should continue to utilize this powerful tool to protect Medicare and Medicaid patients, as well as every United States taxpayer.

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