Healthcare Fraud Settlements ($250,000.+) | Reported: January 1 - June 30. 2013

Healthcare and Life Sciences Companies - Monetary Settlements Recovered under the Federal and State False Claims Act (FCA)

Note : Unless noted, individual providers and healthcare professionals were not targeted for this list.

No.	Date	Violation	Party (Defendant)	Description	Settlement Amount
1	1/3/2013	False and Fraudulent Claims	American Sleep Medicine LLC	A sleep disorder diagnosis company has agreed to pay $15,301,341 million to settle a former employee's FCA suit alleging it charged the federal government for testing services that were not performed by certified professionals. The U.S. government had accused the Florida-based American Sleep Medicine LLC of improperly billing Medicare and other federal health care programs for sleep diagnostic services that were not eligible for government reimbursement.	$15.3 Million
2	1/3/2013	False and Fraudulent Claims	Golden Living; GGNSC Holdings LLC	Nursing facility operator Golden Living agreed to pay over $613,000 to settle a former employee's whistleblower suit claiming the company defrauded government health care programs by providing inadequate and worthless wound care services to residents at two of its Atlanta-area nursing homes. The federal government, which intervened in the qui tam suit originally filed by Dr. Joseph Micca in 2010, accused Texas-based GGNSC Holdings LLC, which operates over 300 facilities in 21 U.S. states under the Golden Living name, of submitting false claims to Medicare, Medicaid and the U.S. Department of Veterans Affairs.	$0.6 Million
3	1/4/2013	Medicaid Fraud	Pfizer, Inc.; Endo Pharmaceuticals	Texas authorities said that Pfizer Inc. and Endo Pharmaceuticals Inc. each paid $25 million to settle allegations their subsidiaries reported inflated drug prices to Texas' Medicaid program, the latest drug companies to resolve long-standing allegations originally made by a whistleblower. The state claims that Pfizer and Endo subsidiaries misreported the price of various generic drugs to Medicaid, causing the program to be overcharged for those drugs. Under the agreements, Texas will receive $18 million each from Pfizer and Endo, with the rest of the money going to the federal government and relator Ven-A-Care of the Florida Keys Inc. The underlying qui tam cases, which were filed in Texas state court, remain sealed.	$50 Million
4	1/7/2013	False and Fraudulent Claims	EMH Regional Medical Center; North Ohio Heart Center Inc.	Two Ohio-based medical companies agreed to pay a total of $4.4 million to settle a whistleblower's FCA allegations that they had billed government health care programs for unnecessary cardiac surgeries. According to the DOJ, Elyria, Ohio-based community hospital EMH Regional Medical Center will pay the federal government $3.86 million, while Lorain, Ohio-based cardiology physician group North Ohio Heart Center Inc. will pay $541,000, ending claims filed in Ohio federal court that they performed angioplasty surgeries — a procedure to widen blocked or narrowed arteries — on Medicare and Medicaid patients whose conditions did not require the procedures.	$4.4 Million
5	1/11/2013	False and Fraudulent Claims	OpenMRI	Diagnostic Systems, Inc. d/b/a Open MRI of Savannah; Southeast Georgia Open MRI d/b/a Open MRI at Fountain Lake, and Open MRI of Douglas, have agreed to pay the U.S. $1,273,126 to settle allegations that those facilities submitted false claims to Medicare, Medicaid and other Federal programs for certain MRI procedures that were not supervised as required by a physician. With certain MRI procedures, a contrast agent (e.g., dye) may first be injected into a patient to produce a clearer diagnostic picture. The use of contrast, however, could pose significant health risks to a patient. For this reason, under Medicare regulations, MRI procedures with contrast require a physician to be present or immediately available to handle any emergencies that may arise. MRI facilities generally receive a higher rate of reimbursement for procedures that use a contrast agent (as opposed to MRIs without contrast).	$1.3 Million
6	1/16/2013	False and Fraudulent Claims	Bartlett Regional Hospital	After it self-disclosed conduct to the OIG, Bartlett Regional Hospital, Arkansas, agreed to pay $1,434,664.50 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that Bartlett submitted claims using incorrect physician names and NPI numbers and submitted claims for non-physician provider services that were billed under a physician's name and NPI number.	$1.4 Million

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7	1/17/2013	False Claims Act	Wayne Medical Center	Wayne Medical Center, located in Waynesboro, Tenn., has agreed to pay the U.S. $883,451.40 to settle FCA allegations by submitting a voluntary self-disclosure to the U.S. HHS OIG. The self-disclosure, prepared by the hospital's compliance program, prompted an investigation into the hospital's billing for ambulance transport as part of its emergency medical services.	$0.88 Million
8	1/17/2013	False and Fraudulent Claims	Jackson Purchase Medical Center	PineLake Regional Hospital, LLC doing business as Jackson Purchase Medical Center (JPMC), has voluntarily entered into a settlement with the U.S to pay $850,343.84 to settle allegations that the acute care facility submitted or caused to be submitted false claims for payment to the Medicare program in violation of the FCA, the Anti-Kickback Statue, and the Physician Self-Referral Law. According to the settlement agreement, the United States contends Dr. Raymond Charette, an orthopedic surgeon in private practice, received improper financial benefits from JPMC and, in return, referred patients to and treated patients at JPMC, a 107 licensed bed facility located in Mayfield, Kentucky.	$.85 Million
9	1/24/2013	Federal False Claims Act; New Jersey False Claims Act	Cooper Health System	The Cooper Health System has agreed with the U.S. Attorney's Office for the District of New Jersey and the State of New Jersey to pay $12.5 million to settle allegations that it violated the federal FCA and New Jersey FCA by making improper payments to physicians for patient referrals in violation of FCA anti-kickback provisions under so-called "consulting" and "compensation" agreements as it sought to build its cardiology program. Under the terms of the settlement, Cooper will pay the U.S. just under $10.3 million and New Jersey just over $2.3 million.	$12.5 Million
10	1/31/2013	False and Fraudulent Claims	Primary Care Associates PC	Primary Care Associates and James Ralabate entered into a civil settlement with the government in which they will pay $700,000 to resolve allegations involving violations of FCA including fraudulent billing to Medicare occurring over a five-year period for medical services allegedly provided at various nursing homes in Connecticut. The allegations include billing Medicare for high-level physician services when the services of a physician were not medically necessary. The medical records did not provide documentation necessary to meet the detailed history, examination or medical decision-making requirements necessary to justify the high level of physician care.	$0.7 million
11	2/1/2013	False and Fraudulent Claims	Shire PLC	Irish drug maker Shire PLC said Friday that it has agreed to pay $57.5 million to resolve a U.S. investigation led by the U.S. Attorney's Office for the Eastern District of Pennsylvania into the sales and marketing of three drugs used to treat attention deficit hyperactivity disorder, including Adderall. Shire said it had reached an agreement in principle to resolve the civil investigation first disclosed by the company in 2009. Shire said it had recorded a $57.5 million charge in the fourth quarter of 2012, comprised of the agreement in principle amount, interest and costs. The drug maker said the agreement also addresses sales and marketing practices relating to ulcerative colitis treatments Lialda and Pentasa pursuant to a subsequent voluntary disclosure made by Shire.	$57.5 Million
12	2/7/2013	False Claims Act	St. Joseph's Medical Center (Maryland)	St. Joseph's Medical Center, a hospital located in Towson, Md., has reached a settlement with the United States to pay $4.9 million in connection with its submission of false claims to Medicare, Medicaid and other federal healthcare programs. This settlement resolves the hospital's civil liability to the U.S. under the FCA for the hospital's disclosure that from 2007-2009 it engaged in a practice of admitting patients to the hospital unnecessarily.	$4.9 Million
13	2/7/2013	False Claims Act	St. Luke's-Roosevelt Hospital Center (St. Luke's)	New York City-based Continuum Health Partners and its St. Luke's-Roosevelt Hospital have agreed to a $2.3 million settlement with the state attorney general, resolving claims that they improperly billed Medicaid and Medicare. Continuum and St. Luke's allegedly double-billed the state Medicaid and Medicare for outpatient services provided at its mental health clinics from 1998 through 2010. The system and hospital agreed to repay the health programs in full, along with interest. New York's share in the total settlement is more than $1.06 million.	$2.3 Million

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14	2/11/2013	False Claims Act (Accepting kickbacks; unnecessary services)	Steven J. Wasserman, M.D.; Tampa Pathology Laboratory (TPL); and Dr. José SuarezHoyos (owner of TPL)	Steven J. Wasserman, M.D., a dermatologist practicing in Venice, Fla., has agreed to pay $26.1 million to resolve allegations that he violated the FCA by accepting illegal kickbacks from a pathology laboratory and by billing the Medicare program for medically unnecessary services. Dr. Wasserman entered into an illegal kickback arrangement with Tampa Pathology Laboratory (TPL) and Dr. José SuarezHoyos, a pathologist and the owner of TPL, in an effort to increase the lab's referral business. The settlement is the largest ever with an individual under the False Claims Act in the Middle District of Florida and one of the largest with an individual under the FCA in U.S. history.	$26.1 Million
15	2/13/2013	False and Fraudulent Claims	Fairfax Nursing Center	Fairfax, Va.-based skilled nursing facility Fairfax Nursing Center (FNC) and its owners have agreed to pay $700,000 to resolve allegations that they violated the FCA by knowingly submitting or causing the submission to Medicare of false claims for non-reimbursable rehabilitation therapy services. The settlement resolves claims that FNC provided excessive, medically unnecessary, or otherwise non-reimbursable physical, occupational, and speech therapy services to 37 Medicare beneficiaries serviced by FNC between January 2007 and December 2010. The United States alleged that the rehabilitation therapy services provided by FNC to these beneficiaries were not reasonable and necessary for the treatment of their condition. Specifically, the United States alleged that the therapy services were often excessive, duplicative, performed without clear goals or direction, and, in some instances, performed primarily to capture higher reimbursement rates.	$0.7 Million
16	2/25/2013	False and Fraudulent Claims	Williston Rescue Squad, Inc.	Williston Rescue Squad Inc. has agreed to pay the U.S. $800,000 to resolve allegations that it violated the FCA by making false claims for payment to Medicare for ambulance transports. Williston, based in Williston, S.C., provides ambulance transport services in the southwestern part of South Carolina. Medicare reimburses providers only for non-emergency ambulance transports if the patient transported is bed-confined or has a medical condition that requires ambulance transportation. The settlement resolves allegations that Williston billed Medicare for routine, non-emergency ambulance transports that were not medically necessary and that Williston created false documents to make the transports appear to meet the Medicare requirements.	$0.8 Million
17	2/25/2013	False and Fraudulent Claims	White Oaks Medical Transport	Provided of medical transportation services entered into a settlement under FCA and a Corporate Integrity Agreement.	$0.27 Million
18	3/5/2013	False Claims Act (Off-Label Marketing)	Par Pharmaceutical Companies Inc.	New Jersey-based Par Pharmaceutical Companies Inc. pleaded guilty in federal court and agreed to pay $45 million to resolve its criminal and civil allegations that it unlawfully marketed and promoted its prescription drug Megace ES for uses not approved as safe and effective by the FDA and not covered by federal health care programs. The total settlement was $45 million, of which $22.5 represented civil damages. The company also agreed to enter into a Corporate Integrity Agreement.	$45 Million
19	3/5/2013	False and Fraudulent Claims	Radiology Associates; Children's Physician Services of South Texas	Two Texas medical groups agreed to pay more than $2 million to settle whistleblower claims that they violated the FCA and Texas Medicaid Fraud Prevention Act with improper billing practices over a five-year period, the U.S. DOJ announced. The Corpus Christi-based Radiology Associates and genetic clinic Children's Physician Services of South Texas, a part of the Driscoll Health System, were accused of billing and receiving double payments for the professional reading and interpretation of genetic ultrasounds in a whistleblower suit prosecuted by the DOJ and the Texas Attorney General's Office. CPSST agreed to pay $1.5 million while Radiology Associates, an independent physician's group serving the Driscoll system, agreed to pay $800,000.	$2.3 Million

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20	3/8/2013	False and Fraudulent Claims	Corning, Inc.	Corning will pay the federal government $5.65 million to resolve an employee whistleblower suit alleging it knowingly presented false claims to the U.S. General Services Administration for laboratory research products the company sold to federal agencies through its life sciences division. The settlement resolves FCA allegations relating to Corning's 2005 contract to sell laboratory research products to federal government entities through the GSA's Multiple Award Schedule program. According to the DOJ, in negotiations and over the course of the contract's administration, Corning knowingly failed to meet its obligations to provide GSA current, accurate and complete information about its commercial sales practices, including discounts offered to other customers. The DOJ also said Corning knowingly made false statements to GSA about its sales practices and discounts.	$5.65 Million
21	3/8/2013	False and Fraudulent Claims	Grace Healthcare	Chattanooga, Tenn., based nursing home manager Grace Healthcare LLC and its affiliate Grace Ancillary Services LLC agreed to pay $2.7 million to resolve allegations that they violated the FCA by knowingly submitting or causing the submission to the Medicare and TennCare/Medicaid programs of false claims for medically unreasonable and unnecessary rehabilitation therapy. Grace Ancillary Services LLC provided the therapy in some of the skilled nursing facilities Grace Healthcare LLC owns and/or manages in Tennessee and elsewhere. The settlement resolves claims that in ten nursing home facilities in which Grace provided physical, occupational, and speech therapy for periods ranging from 2007 through June of 2011, Grace pressured therapists to increase the amount of therapy provided to patients in order to meet targets for Medicare revenue that were set without regard to patients' individual therapy needs and could only be achieved by billing for a large amount of therapy per patient.	$2.7 Million
22	3/13/2013	False and Fraudulent Claims	Bangor Women's Healthcare	Robert A. Grover, D.O., a board certified gynecologist who owns and operates Bangor Women's HealthCare, the Maine Center for Continence and Pelvic Floor Disorders, and the Laser Vaginal Rejuvenation Institute of Bangor ("BWH") agreed to pay $296,492 to settle claims involving improper billing to Medicare and Medicaid. In the summer of 2009, Dr. Grover and BWH informed the U.S. HHS and OIG through the OIG's Self-Disclosure Protocol program, that there were problems in their billings to the Medicare and Medicaid programs, including overbilling for various gynecological services and billing for services that were never performed. In a separate criminal action brought in 2011, a former employee of BWH pled guilty to fraud charges and was sentenced to more than three years in prison related to the false billings.	$0.3 Million
23	3/20/2013	False Claims Act (Ineligible hospice services)	Hospice of Arizona L.C.; American Hospice Management LLC; American Hospice Management Holdings LLC	Hospice of Arizona L.C., along with a related entity, American Hospice Management LLC, and their parent corporation, American Hospice Management Holdings LLC, have agreed to pay $12 million to resolve allegations that they violated the FCA by submitting or causing the submission of false claims to the Medicare program for ineligible hospice services. The company also agreed to enter into a Corporate Integrity Agreement.	$12 Million
24	3/27/2013	False and Fraudulent Claims	University of California Board of Regents	The University of California Board of Regents will hand $1.2 million to the federal government to settle allegations that it let residents and nurse anesthetists administer anesthesia without proper supervision and made improper Medicare and Medicaid claims for anesthesia services. David O'Connor, a former University of California, Irvine, professor and anesthesiologist, was the whistleblower who filed the qui tam suit in 2008, claiming UCI routinely prefiled anesthesia records to circumvent federal supervision regulations.	$1.2 Million
25	4/3/2013	False Claims Act; and Stark Law	Intermountain Health Care Inc.	Intermountain Health Care Inc. has agreed to pay the U.S. $25.5 million to settle claims that it violated the Stark Statute and the FCA by engaging in improper financial relationships with referring physicians. Intermountain operates the largest health system in the state of Utah.	$25.5 Million

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26	4/3/2013	False Claims Act	St. Luke's University Health Network	St. Luke's University Health Network agreed to pay the U.S. $1,029,791 to resolve allegations that it erroneously submitted improper claims to the Medicare program. St. Luke's University Health Network owns and operates St. Luke's Hospital of Bethlehem, St. Luke's Quakertown Hospital, and St. Luke's Miners Memorial Hospital.	$1 Million
27	4/3/2013	False Claims Act	Easton Hospital (Subsidiary of Community Health Systems)	Easton Hospital has agreed to pay the United States $454,866 to resolve allegations that it submitted improper claims to the Medicare program.	$0.45 Million
28	4/16/2013	False Claims Act	Amgen Inc.	Amgen Inc., a California-based biotechnology company, has agreed to pay the United States $24.9 million to settle allegations that it violated the FCA. The settlement resolves allegations that Amgen paid kickbacks to long-term care pharmacy providers Omnicare Inc., PharMerica Corporation and Kindred Healthcare Inc. in return for implementing "therapeutic interchange" programs that were designed to switch Medicare and Medicaid beneficiaries from a competitor drug to Aranesp.	$24.9 Million
29	4/17/2013	False and Fraudulent Claims	Roberts Physical Therapy	Connecticut physical therapist Todd Roberts has been sentenced to three years of probation for obstructing a federal audit into possible Medicare fraud. He has also settled civil allegations that he and Roberts Physical and Aquatics Therapy, his physical therapy practice, violated the FCA.	$0.33 Million
30	4/18/2013	False and Fraudulent Claims	Neurological Institute	Charlotte neurologist has agreed to pay $2 million to the U.S. to settle civil fraud allegations. Hemanth P. Rao, MD, is the owner of and principal neurologist at The Neurological Institute in Charlotte, formerly known as Neurological Consultants of the Carolinas. The settlement was reached following a multi-year investigation by HHS-OIG into Dr. Rao's practices associated with the administration of intravenous immunoglobulin (IVIG) therapy. Government investigators found that from October 13, 2003 to May 26, 2006, Dr. Rao failed to meet the Medicare supervision regulations associated with IVIG therapy. Investigators found that Dr. Rao sought and obtained reimbursement for his IVIG therapy services from Medicare even though he was not present in the building with his patients when they were receiving IVIG treatment, as required by Medicare.	$2 Million
31	4/23/2013	False and Fraudulent Claims	Ensign Group Inc.	The Ensign Group Inc. has "put aside" $48 million to settle a DPJ investigation into allegations that it overbilled federal health care programs in California. Ensign, which owns a collection of nursing, rehabilitative care services, home health, hospice care, assisted living and urgent care companies, said it "expects to enter" into a corporate integrity agreement with the inspector general for the Department of Health and Human Services and make a single lump-sum payment to resolve allegations that date back to 2006. The company said that the settlement agreement was "tentative," but it expects to make the $48 million payment in the second or third quarter of 2013.	$48 Million
32	4/26/2013	False and Fraudulent Claims; Food and Drug Cosmetic Act	CareFusion	CareFusion Corp. announced that it will pay $41 million under an agreement in principle with the U.S government to avoid prosecution and resolve investigations related to the sales and marketing practices of its antiseptic medical wipes. CareFusion, a former Cardinal Health Inc. unit, said the allegations concerned its marketing of ChloraPrep preoperative skin products as well as its relationship with health care professionals. As part of the agreement, CareFusion has entered into a nonprosecution agreement and agreed to cooperate with the government.	$41 Million
33	4/30/2013	False and Fraudulent Claims	California Rural Indian Health Board Inc.	The California Rural Indian Health Board Inc., a nontribal entity and grantee of the U.S. Department of HHS Substance Abuse and Mental Health Services Administration, agreed to pay the U.S. $532,000, and to be terminated from an existing SAMHSA grant, thereby relinquishing funds valued at over $4.6 million.	$0.5 Million

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34	5/1/2013	Stark Law; False Claims Ac	St. Vincent Healthcare; Holy Rosary Healthcare (Sisters of Charity of Leavenworth Health System)	Two Montana hospitals agreed to pay more than $3.95 million to the U.S. government to resolve allegations that they wrongfully provided bonuses to physicians for making referrals to the hospitals. St. Vincent Healthcare and Holy Rosary Healthcare, hospitals under the Sisters of Charity of Leavenworth Health System, reached a settlement agreement over allegations that it violated the Stark Law and the FCA by improperly paying physicians to make referrals to the hospitals. Sisters of Charity discovered the alleged scheme in 2009 during an internal compliance review and then contacted authorities.	$3.95 Million
35	5/6/2013	Anti-Kickback Act; Stark Statute; False Claims Act	Adventist Health System/West; White Memorial	Nonprofit hospital owner Adventist Health System/West and an affiliate agreed to pay $14.1 million to settle whistleblower allegations that they violated the FCA by paying kickbacks to doctors for patient referrals. The U.S. DOJ claims that Adventist Health System steered illegal payments towards physicians who referred patients to Los Angeles teaching hospital White Memorial Medical Center in the form of assets, including medical and nonmedical supplies and inventory, at less than fair market value. White Memorial also allegedly rewarded doctors who sent patients its way by providing discount teaching services at its family practice residency program.	$14.1 Million
36	5/7/2013	Medicaid Fraud and Tax	Bennington School, Inc.	The Office of the United States Attorney for the District of Vermont and the Office of the Vermont Attorney General entered into global resolution of criminal and civil investigative matters concerning alleged tax and health care fraud by former officers of Bennington School Inc.. Individual defendants, which served as the president and trustee of BSI; plant manager; and CFO of BSI, have agreed to plead guilty to one charge each of federal tax fraud. To resolve potential civil health care fraud liability, the three Merritt family members have agreed to pay a total of $3,000,000 to the U.S. Defendant, who was the executive director of BSI, has also agreed to plead guilty to a federal tax fraud charge and will pay $1,300,000 to resolve his potential civil health care fraud liability.	$4.3 Million
37	5/9/2013	Stark Law; Anti-Kickback; False Claims	Tuomey Healthcare System Inc.	In May 2013, a jury in the Eastern District of North Carolina returned a $39 million verdict against a South Carolina hospital for allegedly defrauding Medicare in violation of the FCA. The government had argued that the hospital entered into contracts that overpaid physicians for their services, and submitted claims to Medicare for payment based on improper patient referrals.	$39 Million
38	5/9/2013	Anti-Kickback Act	DaVita HealthCare Partners Inc.	Dialysis giant DaVita HealthCare Partners Inc. has set aside $300 million to settle criminal and civil anti-kickback investigations, a sign the company could soon pay a price after years of fighting allegations about its relationships with doctors. The criminal case relates to a Denver federal grand jury investigation into the relationship between DaVita and one of the city's largest kidney doctors' offices. The probe has focused on whether the dialysis company paid a kickback to those doctors to guarantee a steady stream of patients. The money set aside is part of a "comprehensive offer to settle all the related civil, administrative and criminal matters."	$300 Million
39	5/13/2013	False and Fraudulent Claims; Food and Drug Cosmetic Act	Ranbaxy USA Inc.	In the largest drug safety settlement to date with a generic drug manufacturer, Ranbaxy USA Inc., a subsidiary of Indian generic pharmaceutical manufacturer Ranbaxy Laboratories Limited, pleaded guilty today to felony charges relating to the manufacture and distribution of certain adulterated drugs made at two of Ranbaxy’s manufacturing facilities in India, the Justice Department announced today. Ranbaxy also agreed to pay a criminal fine and forfeiture totaling $150 million and to settle civil claims under the False Claims Act and related State laws for $350 million.	$500 Million

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40	5/13/2013	Anti-Kickback Statute; False Claims Act	C.R. Bard Inc.	C.R. Bard Inc. agreed to settle for approximately $48.3 million the federal government the whistleblower allegations that it filed false Medicare claims and paid hospitals various kickbacks to use its brachytherapy seeds for prostate cancer treatments. According to the DOJ, Bard gave hospitals grants, guaranteed minimum rebates, marketing assistance, free medical equipment and conference fees to entice them to use the radiation therapy seeds from 1998 to 2006. As the hospitals also submitted bills to Medicare for the treatment, Bard violated the Anti-Kickback Statute and FCA.	$48.3 Million
41	5/16/2013	False and Fraudulent Claims	RS Medical	The government has reached a settlement with RS Medical for $1,214,665.00 to resolve claims that employees of RS Medical in South Carolina and Illinois submitted claims to Medicare for Transcutaneous Electrical Nerve Stimulation (TENS) Units, conductive garments for TENS Units, back braces, cervical traction systems, muscle stimulators, and custom-fit knee braces that lacked physician orders; lacked the required supporting documentation; and/or lacked medical necessity. The investigation in District of South Carolina began in February of 2011 when whistleblower filed a qui tam lawsuit in federal court under the FCA.	$1.2 Million
42	5/17/2013	False and Fraudulent Claims	C.F. Health Management dba Gainesville Pain Management	Dr. Matthew James Britton and C.F. Health Management, Inc. d/b/a Gainesville Pain Management, Georgia, agreed to pay $1,577,597 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that Gainesville submitted false or fraudulent claims: by inappropriately using modifiers with HCPCS codes G0431 and G0434 and with code G0431.	$1.56 Million
43	5/21/2013	False and Fraudulent Claims	U.S. Renal Care	Dialysis company U.S. Renal Care agreed to pay $7.3 million to settle whistleblower allegations that a Maryland subsidiary violated the FCA by excessively charging Medicare for the anemia drug Epogen. The DOJ alleged that Dialysis Corp. of America, a Maryland-based acquisition of U.S. Renal Care, charged Medicare for 10 to 11 percent more of the anemia drug than it used during dialysis treatments from 2004-11. According to the DOJ, DCA's syringes couldn't contain the additional Epogen, but DCA continued to file the false claims with Medicare.	$7.3 Million
44	5/21/2013	False and Fraudulent Claims	Las Vegas Urology, LLP	Las Vegas Urology, LLP, has agreed to pay the U.S. DOJ $1 million to resolve civil allegations that it improperly billed Medicare, TRICARE, and other Federal health care insurance programs. In consideration of the $1 million payment and an integrity agreement entered into between the federal government and Las Vegas Urology, the federal government has agreed not to seek exclusion of Las Vegas Urology from federal health care programs.	$1 Million
45	5/22/2013	False and Fraudulent Claims	Tufts University School of Dental Medicine	Trustees of Tufts College and Tufts University School of Dental Medicine in, Massachusetts, agreed to pay $841,120.88 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that TUSDM submitted claims to Medicare for various services from four of their clinics. The OIG contends that these claims were improper because the services were provided by dentists who were not credentialed by Medicare and/or the services or the code level billed were not supported by sufficient medical record documentation.	$0.84 Million

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46	5/24/2013	Off-Label; Federal Anti-Kickback Statute	ISTA Pharmaceuticals, Inc.	Pharmaceutical company ISTA Pharmaceuticals, Inc. pled guilty to conspiracy to introduce a misbranded drug into interstate commerce and conspiracy to pay illegal remuneration in violation of the Federal Anti-Kickback Statute. The guilty pleas are part of a global settlement with the United States in which ISTA agreed to pay $33.5 million to resolve criminal and civil liability arising from its marketing, distribution and sale of its drug Xibrom. ISTA also entered into a civil settlement agreement under which it agreed to pay $15 million to the federal government and states to resolve claims arising from its marketing of Xibrom, which caused false claims to be submitted to government health care programs. The United States further alleged that ISTA's violations of the Anti-Kickback Statute resulted in false claims being submitted to federal health care programs. The federal share of the civil settlement is $14,609,746.16, and the state Medicaid share of the civil settlement is $390,253.84.	$33.5 Million
47	5/28/2013	False and Fraudulent Claims	K-V Pharmaceutical Co.	K-V Pharmaceutical Co. has agreed to hand Texas a $3 million unsecured claim in its bankruptcy to settle a whistleblower suit alleging the company made false claims to the state's Medicaid program, according to court documents filed. In a motion to approve the settlement filed in New York bankruptcy court, K-V said it still disputes the state's allegations, but that the deal was in the best interests of its creditors, considering Texas was asserting claims worth potentially tens of millions of dollars.	$3 Million
48	5/29/2013	False Claims Act	Dermatology & Skin Cancer Prevention Center	A Georgia-based dermatology center agreed to pay $600,000 to resolve allegations by a pair of whistleblowers under the FCA that the center submitted fraudulent charges to federal health care programs.	$0.6 Million
49	5/31/2013	False Claims Act; and Texas Medicaid Fraud Prevention Act	Dallas County Hospital District d/b/a Parkland Health and Hospital System (Parkland)	Dallas County Hospital District d/b/a Parkland Health and Hospital System settled allegations it violated the civil FCA and Texas Medicaid Fraud Prevention Act. The U.S. and Texas contend Parkland caused unallowable and "upcoded" physician consultations and other services to be submitted to Medicare and Texas Medicaid for certain physical medicine and rehabilitation related items and services between 2007 and 2011.	$1.4 Million
50	6/18/2013	False and Fraudulent Claims	Parkshore Home Health Care LLC	The United States and New York State have entered into settlement agreements with Parkshore Home Health Care, LLC, d/b/a Renaissance Home Health Care, Inc., a Brooklyn-based licensed home health care services agency. These settlements resolve allegations that Renaissance provided unqualified home health aides to home health agencies, who in turn sent these unqualified aides into the homes of Medicaid recipients throughout New York City and then billed the Medicaid program for their services. Under the terms of the agreements, Renaissance will pay a total of $1,000,000.	$1 Million
51	6/19/2013	False and Fraudulent Claims	Rutherford Hospital, Inc.	After it self-disclosed conduct to the OIG, Rutherford Hospital located in North Carolina agreed to pay $706,090.46 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that Rutherford submitted or caused to be submitted claims for physicians' services provided by a doctor to beneficiaries of Federal health care programs using the provider identification numbers of another doctor, who did not further the services. The OIG contends that Rutherford knowingly misused provider identification numbers, which resulted in improper billing of the claims identified and disclosed by Rutherford.	$0.7 Million
				Total	**$1,303.9 Million**

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Sources:

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