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April 24, 2014

## **Amedisys Settlement Signals DOJ Focus on Health Care Billing Practices in The Affordable Care Act Era**

On Wednesday, the U.S. Department of Justice announced that it had entered into a \$150 million settlement with Amedisys Inc. to resolve claims concerning the company's Medicare billing practices, the first such settlement against a national health care provider in recent years. This settlement highlights the DOJ's renewed focus on fraudulent billing practices and controlling costs in the Affordable Care Act era.

The settlement between the DOJ and Amedisys, one of the largest home-nursing providers in the U.S., resolves claims that the company had submitted "false home health care billings" to Medicare and that it had "improper financial relationships" with referring doctors. The settlement also resolved seven False Claims Act suits, a statute that provides for treble damages, against the company. Additionally, Amedisys agreed to implement certain compliance measures and enter into a corporate integrity agreement with the Office of Inspector General of the Department of Health and Human Services.

The government's allegations focused on Amedisys's billing practices and physician referral relationships. The DOJ accused the company of billing Medicare for medically unnecessary nursing and therapy services and for services to patients who were not homebound. According to the government, the company's management pressured nurses and therapists to provide care based on "financial benefits to Amedisys, rather than the needs of patients." The DOJ also alleged that Amedisys had improper financial relationships with doctors who referred patients to the company. In particular, the government alleged that Amedisys employees coordinated patient care services at below-market prices for a Georgia oncology practice in violation of the Anti-Kickback Statute and the Stark Statute. Amedisys has denied all wrongdoing in connection with the settlement.

This settlement is significant because it signals a potential new trend in DOJ enforcement actions against fraudulent billing practices and other large-scale financial fraud in the health care sector at a time of intense scrutiny of health care costs. While over the past ten years the DOJ has primarily focused on off-label marketing and other pharmaceutical cases, the number of new such cases has slowed as the DOJ focuses on reducing health care costs in the Affordable Care Act era. As then Acting Assistant Attorney General Mythili Raman stated on May 14, 2013, the DOJ has "made it part of our core mission at the Department of Justice to hold accountable those who steal from the Medicare program to line their own pockets." This emphasis on fraudulent billing practices, coupled with the new fraud fighting measures provided by the Affordable Care Act, will likely lead to increased enforcement actions in this area over the coming years.

To the extent they have not done so already, companies that operate in this arena would be well advised to make sure that they take another look at their compliance function to ensure that it is likely to withstand future government scrutiny as DOJ and other agencies continue to press this enforcement priority.

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This memorandum is not intended to provide legal advice, and no legal or business decision should be based on its content. Questions concerning issues addressed in this memorandum should be directed to:

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