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Georgia Hospital System and Physician to Pay More than $25 Million to Settle Alleged False Claims Act and Stark Law VIolations

Columbus Regional Healthcare System (Columbus Regional) and Dr. Andrew Pippas have agreed to pay more than $25 million to resolve allegations that they violated the False Claims Act by submitting claims in violation of the Stark Law. Today's settlement also resolves allegations that Columbus Regional and Pippas submitted claims for payment to federal health care programs that misrepresented the level of services they provided. Under the settlement agreement, Columbus Regional has agreed to pay $25 million, plus additional contingent payments not to exceed $10 million, for a maximum settlement amount of $35 million, and Pippas has agreed to pay $425,000.

"Today's settlement demonstrates our continuing vigilance to ensure that health care referrals are based solely on the medical needs of the patient and that health care providers bill the government only for the care they provide," said Principal Deputy Assistant Attorney General Benjamin C. Mizer, head of the Justice Department's Civil Division. "Healthcare providers who seek to profit at the expense of taxpayers will face serious consequences."

"The maximum amount of this settlement, some $35 million, is appropriate given the number of alleged violations involving the False Claims Act and the Stark Act," said U.S. Attorney Michael Moore of the Middle District of Georgia. "Access to health care is on everyone's mind, especially with respect to rural communities. The type of conduct alleged in this case puts that access at risk. This settlement reflects on the one hand, the Department of Justice's commitment to make sure that hospitals and physicians who commit violations of federal law are held to account, and on the other hand, especially with the requirement of the monitoring agreement, makes sure that we continue to have appropriately functioning health care providers accessible to the wide array of communities they serve."

The Stark Law prohibits physician referrals of certain health services for Medicare and Medicaid patients if the physician has a financial relationship with the entity to which he or she refers the patient. The United States alleged that between 2003 and 2013, Columbus Regional provided excessive salary and directorship payments to Pippas that violated the Stark Law.

The United States also alleged that from May 2006 through May 2013, Columbus Regional submitted claims to federal health care programs for services at higher levels than supported by the documentation, and between 2010 and 2012, they submitted claims to federal health care programs for radiation therapy at higher levels than the therapy that was provided.

Of the $25.425 million that Columbus Regional and Pippas have agreed to pay to resolve their respective civil claims, they will pay $24,666,040 to the federal government for federal healthcare program losses and $758,960 to the state of Georgia for the state share of its Medicaid losses.

Also as part of the settlement, Columbus Regional will enter into a Corporate Integrity Agreement (CIA) with the Department of Health and Human Services-Office of the Inspector General (HHS-OIG) that requires Columbus Regional to implement measures designed to avoid or promptly detect future conduct similar to that which gave rise to this settlement.

“Increasing referrals by self-dealing and violating the Stark statute – as the government contended in this case – undermines impartial medical judgment at the expense of patients and taxpayers,” said Special Agent in Charge Derrick L. Jackson of HHS-OIG. “Charging federal health care programs for pricier services than those actually provided will not be tolerated.”

The settlements resolve allegations filed in two lawsuits by Richard Barker, a former Columbus Regional executive, in federal court in Columbus, Georgia. The lawsuits were filed under the *qui tam,* or whistleblower*,* provisions of the federal False Claims Act and the Georgia False Medicaid Claims Act, which permit private individuals to sue on behalf of the federal and state governments, respectively, for false claims and to share in any recovery. Mr. Barker’s share of the settlement has not yet been determined.

This 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 Attorney General and the Secretary of 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 $24.9 billion through False Claims Act cases, with more than $15.9 billion of that amount recovered in cases involving fraud against federal health care programs.

The civil settlement was handled by the U.S. Attorney’s Office of the Middle District of Georgia and the Civil Division’s Commercial Litigation Branch. These matters were investigated by HHS-OIG’s Office of Investigations, with assistance from the HHS Office of Counsel to the Inspector General and Office of General Counsel and Center for Medicare and Medicaid Services, and the state of Georgia’s Medicaid Fraud Control Unit.

The civil lawsuits are captioned *United States ex rel. Barker v. Columbus Regional Healthcare System, et al.*, Case No. 4:12-cv-108 (M.D. Ga.) and *United States ex rel. Barker v. Columbus Regional Healthcare System, et al.*, Case No. 4:14-cv-304 (M.D. Ga.). The claims resolved by the settlement are allegations only, and there has been no determination of liability.

15-1089 Civil Division

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