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$12.7 Million Settlement in Whistleblower Medicare Fraud Case Against MedStar Ambulance

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MedStar Ambulance, Inc. (MedStar) agreed to pay $12.7 million and enter into a corporate integrity agreement with the Office of Inspector General at the ***U.S. Department of Health and Human Services*** to settle a ***False Claims Act (FCA)*** lawsuit alleging that MedStar fraudulently billed Medicare for ambulance services.

MedStar is alleged to have: (1) billed for transports that were not medically reasonable and necessary; (2) billed for higher levels of services than patients' conditions necessitated; and (3) billed for higher levels of services than were actually provided. In particular, the complaint claimed that MedStar purposely changed scheduled ambulance trips, such as routine trips to a doctor's appointment or nursing home, to emergency runs in order to receive higher Medicare reimbursements. It was also found MedStar double-billed patients and Medicare, and billed Medicare when it should have billed hospitals or municipalities.

The case was brought in 2013 by MedStar's former billing manager, Dale Meehan, in Massachusetts federal court. Meehan claimed that MedStar terminated her employment after her continued inquiries regarding MedStar's billing practices. For her reward as a whistleblower in the case, Meehan will receive approximately $3.5 million. Whistleblowers typically receive 10-30 percent of the total amount collected by the government. These rewards offer incentive for current and former employees to report alleged wrongdoing.

Ambulance service providers can reduce their risk under the FCA by implementing clear compliance policies and procedures. Providers should implement confidential reporting of any suspected fraud or wrongdoing through defined channels within the organization. Providers also should consider taking the following steps to reduce their FCA risk:

- Develop and implement a whistleblower policy;
- Implement written compliance policies and procedures and employee standards of conduct;
- Designate a compliance officer and compliance committee;
- Conduct staff training and education;

- Develop effective lines of communication;
- Conduct internal auditing and monitoring;
- Develop and well-publicize disciplinary guidelines;
- Apply “claims scrubbing” software to billing system;
- Investigate reports of potential violations from staff;
- Investigate complaints regarding potential violations from patients, family members and friends;
- Develop internal monitoring process, including risk assessments; and
- Conduct internal audits.

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