



# Department of Justice

**United States Attorney Anne M. Tompkins  
Western District of North Carolina**

FOR IMMEDIATE RELEASE  
MONDAY, AUGUST 4, 2014  
<http://www.usdoj.gov/usao/ncw>

CONTACT: Lia Bantavani  
704-338-3140  
[Lia.Bantavani@usdoj.gov](mailto:Lia.Bantavani@usdoj.gov)

**COMMUNITY HEALTH SYSTEMS INC. TO PAY \$98.15 MILLION TO RESOLVE  
FALSE CLAIMS ACT ALLEGATIONS**

WASHINGTON – The Justice Department announced today that Community Health Systems Inc. (CHS), the nation’s largest operator of acute care hospitals, has agreed to pay \$98.15 million to resolve multiple lawsuits alleging that the company knowingly billed government health care programs for inpatient services that should have been billed as outpatient or observation services. The settlement also resolves allegations that one of the company’s affiliated hospitals, Laredo Medical Center (LMC), improperly billed the Medicare program for certain inpatient procedures and for services rendered to patients referred in violation of the Physician Self-Referral Law, commonly known as the Stark Law. CHS is based in Franklin, Tennessee, and has 206 affiliated hospitals in 29 states.

“Charging the government for higher cost inpatient services that patients do not need wastes the country’s health care resources,” said Assistant Attorney General Stuart Delery for the Justice Department’s Civil Division. “In addition, providing physicians with financial incentives to refer patients compromises medical judgment and risks depriving patients of the most appropriate health care available. This department will continue its work to stop this type of abuse of the nation’s health care resources and to ensure patients receive the most appropriate care.”

The United States alleged that from 2005 through 2010, CHS engaged in a deliberate corporate-driven scheme to increase inpatient admissions of Medicare, Medicaid and the Department of Defense’s (DOD) TRICARE program beneficiaries over the age of 65 who originally presented to the emergency departments at 119 CHS hospitals. The government further alleged that the inpatient admission of these beneficiaries was not medically necessary, and that the care needed by, and provided to, these beneficiaries should have been provided in a less costly outpatient or observation setting. CHS agreed to pay \$89.15 million to resolve these allegations. The settlement does not include hospitals that CHS acquired from Health Management Associates (HMA) in January 2014.

In addition, the government alleged that from 2005 through 2010, one of CHS’s affiliated hospitals, LMC in Laredo, Texas, presented false claims to the Medicare program for certain cardiac and hemodialysis procedures performed on a higher cost inpatient basis that should have

been performed on a lower cost outpatient basis. The government also alleged that from 2007 through 2012, LMC improperly billed Medicare for services referred to LMC by a physician who was offered a medical directorship at LMC, in violation of the Stark Law. The Stark Law prohibits a hospital from submitting claims for patient referrals made by a physician with whom the hospital has an improper financial relationship, and is intended to ensure that a physician's medical judgment is not compromised by improper financial incentives, and is instead based on the best interests of the patient. CHS agreed to pay \$9 million to resolve the allegations involving LMC.

"Health care providers should make treatment decisions based on patients' medical needs, not profit margins," said U.S. Attorney Anne M. Tompkins for the Western District of North Carolina. "We will not allow this type of misconduct to compromise the integrity of our health care system."

"This significant settlement reaffirms this office's promise to investigate and pursue health care fraud of all kinds," said U.S. Attorney David Rivera for the Middle District of Tennessee. "CHS is headquartered in this district. It engaged in a scheme to admit more inpatients to increase its profits, not because those beneficiaries needed a higher level of care. Our office is committed to ensuring that all companies billing government healthcare programs are responsible corporate citizens and appropriately bill for care that is medically necessary."

"This settlement demonstrates our commitment to working with our law enforcement partners and with the Department of Justice to protect the integrity of our nation's health care system," said U.S. Attorney Kenneth Magidson of the Southern District of Texas. "Put simply, these types of fraudulent practices will not be tolerated and the investigation and resolution of such claims will continue to be a high priority of this office."

As part of today's agreement, CHS entered into a Corporate Integrity Agreement with the U.S. Department of Health and Human Services - Office of Inspector General (HHS-OIG), requiring the company to engage in significant compliance efforts over the next five years. Under the agreement, CHS is required to retain independent review organizations to review the accuracy of the company's claims for inpatient services furnished to federal health care program beneficiaries.

"In an effort to ensure the company's fraudulent past is not its future, CHS agreed to a rigorous multi-year Corporate Integrity Agreement requiring that the company commit to compliance with the law," said Inspector General Daniel R. Levinson, of the U.S. Department of Health and Human Services. "The dedicated work of OIG's investigators, auditors, and attorneys, in concert with our law enforcement partners, has again resulted in the recovery of taxpayer dollars and better protection against fraud in the future."

The settlement resolves lawsuits filed by several whistleblowers under the *qui tam* provisions of the False Claims Act, which permit private parties to file suit on behalf of the government and obtain a portion of the government's recovery. Those relators are Kathleen Bryant, former Director of Health Information Management at CHS's Heritage Medical Center in Shelbyville, Tennessee; Rachel Bryant, former nurse at CHS's Dyersburg Hospital in

Dyersburg, Tennessee; Bryan Carnithan, former Emergency Medical Services Coordinator at CHS' Heartland Hospital in Marion, Illinois; Amy Cook-Reska, former coder for CHS' LMC in Laredo; Sheree Cook, former nurse at CHS's Heritage Medical Center in Shelbyville; James Doghramji, former internal medicine and emergency room physician at CHS's Chestnut Hill Hospital in Philadelphia; Thomas L. Mason, former emergency room physician at Lake Norman Regional Medical Center in Mooresville, North Carolina; Scott Plantz, former emergency room physician at CHS's Longview Regional Medical Center in Longview, Texas; and Nancy Reuille, former nurse and Supervisor of Case Management at CHS's Lutheran Hospital in Fort Wayne, Indiana. The relators' share of the settlement has not yet been determined.

The allegations against CHS were filed in the Western District of North Carolina by Relator Thomas L. Mason in April 2011. Dr. Mason had previously filed a qui tam lawsuit against another hospital chain, Health Management Associates (HMA). On April 18, 2011, Dr. Mason added allegations and claims against CHS to this previously filed qui tam. Allegations against the two different hospital chains were subsequently severed and the case against HMA was transferred, along with eight other qui tam cases filed against HMA, to the United States District Court in Washington, D.C. for consolidated pre-trial practice.

"We thank relator Dr. Mason for his insight and assistance in this case," said U.S. Attorney Tompkins. "He and his lawyers have been available to assist the United States multiple times in this case." Tompkins added that "information from citizens like Dr. Mason and the work of their legal representatives is essential to detecting and stopping fraud against government health care programs and recovering public funds."

This settlement 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 Attorney General Eric Holder 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 \$20.2 billion through False Claims Act cases, with more than \$14 billion of that amount recovered in cases involving fraud against federal health care programs.

This settlement was the result of a coordinated effort by the U.S. Attorney's Offices for the Middle District of Tennessee, Southern District of Texas, Northern and Southern Districts of Illinois, Northern District of Indiana and Western District of North Carolina; the Civil Division's Commercial Litigation Branch; HHS-OIG; DOD's Defense Health Agency - Program Integrity Office and the FBI.

The lawsuits are captioned *United States ex rel. Bryant v. Community Health Systems, Inc., et al.*, Case No. 10-2695 (S.D. Tex.); *United States ex rel. Carnithan v. Community Health Systems, Inc., et al.*, Case No. 11-cv-312 (S.D. Ill.); *United States ex rel. Cook-Reska v. Community Health Systems, Inc., et al.*, Case No. 4:09-cv01565 (S.D. Tex.); *United States ex rel. James Doghramji; Sheree Cook; and Rachel Bryant v. Community Health Systems Inc., et al.*, Case No. 3-11-cv-00442 (M.D. Tenn.); *United States ex rel. Mason v. Community Health*

*Systems, Inc., et al.*, Case No. 3:12-cv-817 (W.D.N.C.); *United States ex rel. Plantz v. Community Health Systems, Inc., et al.*, Case No. 10C-0959 (N.D. Ill.); *United States ex rel. Reuille v. Community Health Systems Professional Services Corporation, et al.*, Case No. 1:09-cv-007RL (N.D. Ind.). The claims resolved by this agreement are allegations only and there has been no determination of liability.

###