PRESS RELEASE

Justice Department Files False Claims Act Complaint Against Priority Hospital Group and Three Long Term Care Hospitals

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For Immediate Release

Office of Public Affairs

On Jan. 16, the United States filed a complaint under the False Claims Act against Priority Hospital Group LLC (PHG), a Louisiana-based hospital management company, three PHG-managed long term care hospitals, and a doctor, alleging False Claims Act violations based on medically unnecessary care and patient referrals in violation of the Anti-Kickback Statute and Stark Law.

Long term care hospitals (LTCHs) provide inpatient hospital services for patients whose medically complex conditions require long hospital stays and programs of care. Medicare reimburses LTCHs based, in part, on a patient's length of stay. According to the United States' complaint, PHG and the LTCH defendants allegedly held patients in the hospital longer than medically necessary in order to increase their Medicare reimbursement. The United States alleges that PHG and the LTCH defendants delayed discharging certain patients, even when their course of treatment had been completed or when they could have been transferred to a lower level of care, because doing so would have resulted in lower payments from Medicare.

The United States' complaint also alleges that one LTCH, Riverside Hospital of Louisiana, entered into medical directorship agreements with a doctor, and provided him other

remuneration, to induce him to refer patients to Riverside in violation of the Anti-Kickback Statute and Stark Law.

The Anti-Kickback Statute prohibits offering, paying, soliciting or receiving remuneration of items or services covered by Medicare and other federally funded programs. The Stark Law forbids a hospital from billing Medicare for certain services referred by physicians that have a financial relationship with the hospital. The Anti-Kickback Statute and the Stark Law seek to ensure that medical providers' judgments are not compromised by improper financial incentives and are instead based on the best interests of their patients.

"Medicare patients deserve to receive care based on their clinical needs, not the financial interests of a hospital or doctor," said Assistant Attorney General Brett A. Shumate of the Justice Department's Civil Division. "The Department is committed to pursuing cases where financial interests have improperly influenced the medical decision-making of providers participating in federal health care programs."

"Billing federal healthcare programs for medically unnecessary treatment undermines the viability of those programs and exploits our most vulnerable citizens," said U.S. Attorney Zachary A. Keller for the Western District of Louisiana. "Our Office will continue to combat fraudulent billing by unravelling these schemes and holding the perpetrators accountable."

"Schemes that involve false claims and unlawful referrals erode the integrity of federal health care programs and betray the trust placed in providers," said Acting Deputy Inspector General for Investigations Scott J. Lampert at the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG). "The False Claims Act is a critical tool for protecting Medicare and ensuring that patient care decisions are driven by medical necessity — not financial gain. HHS-OIG will continue to work with or partners to hold accountable those who put profits over patients."

The LTCHs named in the United States' complaint are: Riverside Hospital LLC and Riverside Hospital of Louisiana, Inc. (collectively doing business as Riverside Hospital); Post Acute Enterprises, LLC (doing business as Mid Jefferson Extended Care Hospital); and New Lifecare Hospital of North Louisiana, LLC (doing business as Ruston Regional Specialty Hospital).

The lawsuit was originally filed under the *qui tam* or whistleblower provisions of the False Claims Act by Michaela DeVos, a former employee of Riverside Hospital. Under the False Claims Act, private parties file an action on behalf of the United States and receive a portion of the recovery. The False Claims Act permits the United States to intervene in and take over the action, as it has done here. If a defendant is found liable for violating the False Claims Act, the United States may recover three times the amount of its losses plus applicable penalties.

The investigation and prosecution of this matter illustrates the government's emphasis on combating healthcare fraud. One of the most powerful tools in this effort is the False Claims

Act. Tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement, can be reported to the Department of Health and Human Services at 800-HHS-TIPS (800-447-8477).

The Justice Department's Civil Division, Commercial Litigation Branch, Fraud Section and the U.S. Attorney's Office for the Western District of Louisiana (W.D. La.) are handling the matter with assistance from HHS-OIG. The case is captioned *United States ex rel. DeVos v. Priority Hospital Group LLC, et al.*, No. 20-cv-01041 (W.D. La.).

This case is being handled by Trial Attorney Emily Bussigel of the Justice Department's Civil Division and Assistant U.S. Attorney Melissa Theriot for the Western District of Louisiana.

The claims asserted in the complaint are allegations only, and there has been no determination of liability.

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