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Florida-Based American Sleep Medicine to Pay $15.3 Million for Improperly Billing Medicare and Other Federal Healthcare Programs

Facilities in Alabama, California, Delaware, Florida, Illinois, Indiana, Kansas, Kentucky, Maryland, Missouri, New Jersey, Tennessee, Texas and Virginia

Florida-based American Sleep Medicine LLC has agreed to pay $15,301,341 to resolve allegations that it billed Medicare, TRICARE – the health care program for Uniformed Service members, retirees and their families worldwide– and the Railroad Retirement Medicare Program for sleep diagnostic services that were not eligible for payment, the Justice Department announced today.

American Sleep, headquartered in Jacksonville, Fla., owns and operates 19 diagnostic sleep testing centers throughout the United States, including in Alabama, California, Delaware, Florida, Illinois, Indiana, Kansas, Kentucky, Maryland, Missouri, New Jersey, Tennessee, Texas and Virginia. The company's primary business is to provide testing for patients suffering from sleep disorders such as obstructive sleep apnea. The test results are used by doctors to determine the most appropriate course of treatment for patients. The most common tool used to diagnose sleep disorders, particularly sleep apnea, is a procedure called polysomnographic diagnostic sleep testing. Under federal program requirements for the reimbursement of claims submitted for sleep disorder testing, initial sleep studies must be conducted by technicians who are licensed or certified by a state or national credentialing body as sleep test technicians.

The United States contend that Medicare and TRICARE claims submitted by American Sleep during this period were false because the diagnostic testing services were performed by technicians who lacked the required credentials or certifications, when it knew this violated the law. American Sleep submitted false claims to Medicare and TRICARE between Jan. 1, 2004, and Dec. 31, 2011, according to the United States' allegations.

"Medicare patients and military families deserve to be treated by appropriately credentialed professionals when seeking medical care," said Stuart F. Delery, Principal Deputy Assistant Attorney General for the Justice Department's Civil Division. "When companies providing those services seek to skirt the rules, there will be a steep price to pay."

"Pursuing health care fraud is a priority of my office and the Department of Justice. We will continue to work with the Department of Health and Human Services and the public to ensure that fraudulent claims are investigated and those responsible are required to pay," stated David J. Hale, U.S. Attorney for the Western District of Kentucky. "Medical providers who overbill Medicare defraud the taxpayers and drive up the cost of health care for us all. Recovering taxpayer dollars lost to fraud helps keep strong those critical public health care programs so many people depend on."

"Patients seeking care from licensed professionals deserve to receive exactly what was represented, and the taxpayer-funded Medicare program expects no less," said Derrick Jackson, Special Agent in Charge of the U.S. Department of Health and Human Services Office of Inspector General Region IV, which includes Kentucky.

"The company has agreed to Federal monitoring and reporting requirements designed to avoid such problems in the future."

The allegations covered by today's settlement were raised in a lawsuit filed against American Sleep under the *qui tam*, or whistleblower, provisions of the False Claims Act. *United States ex rel. Daniel Purnell v. American Sleep Medicine LLC*, no. 3:07-cv-12-S (W.D. Ky.). The act allows private citizens with knowledge of fraud to bring civil actions on behalf of the United States and share in any recovery. Relator Daniel Purnell will receive $2,601,228 as part of today's settlement.

In addition to the $15.3 million payment, American Sleep entered into a five-year Corporate Integrity Agreement with the Office of Inspector General of the Department of Health and Human Services. The agreement requires enhanced accountability and wide-ranging monitoring activities conducted by both internal and independent external reviewers.

Principal Deputy Assistant Attorney General Delery thanked the Office of the Inspector General for the Department of Health and Human Services, the Medicare Railroad Retirement Program, the Defense Criminal Investigative Service, the FBI, the U.S. Attorney's Office for the Western District of Kentucky and the Commercial Litigation Branch for the collaboration that resulted in today's settlement. The claims settled by this agreement are allegations only, and there has been no determination of liability.

This resolution is part of the government's emphasis on combating health care fraud and another step for the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, which was announced by Attorney General Eric Holder and Kathleen Sebelius, Secretary of the Department of Health and Human Services in May 2009. 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 that effort is the False Claims Act, which the Justice Department has used to recover $10.1 billion since January 2009 in cases involving fraud against federal health care programs. The Justice Department's total recoveries in False Claims Act cases since January 2009 are over $13.9 billion.

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