THE UNITED STATES ATTORNEY'S OFFICE
SOUTHERN DISTRICT of INDIANA

FOR IMMEDIATE RELEASE

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U.S. Attorney's Office Recovers Over $5.5 Million in Civil False Claims Settlement with American Senior Communities

INDIANAPOLIS – American Senior Communities, L.L.C. (ASC), a provider of skilled nursing and long-term care services throughout Indiana, has agreed to pay $5,591,044.66 to resolve allegations that it violated the False Claims Act by submitting false claims to the Medicare program.

In 2017, a former employee of a hospice services company doing business with ASC filed a sealed civil complaint or "whistleblower" lawsuit under the False Claims Act in the United States District Court for the Southern District of Indiana. The complaint alleged that ASC had engaged in conduct to defraud the Medicare program. Specifically, the complaint alleged that ASC was charging Medicare directly for various therapy services provided to beneficiaries who had been placed on hospice, when those services should have already been covered by the beneficiaries' Medicare hospice coverage.

The False Claims Act provides that when a whistleblower files a lawsuit alleging fraud that results in a recovery of funds by the Government they are entitled to between 15 and 25% of the recovery. This whistleblower provision of the law encourages people to come forward when they believe fraud is being committed. Under the False Claims Act, the Government may collect up to three times the loss it incurred, plus a fine of between approximately $5,500 to $22,000 for each false bill submitted.

Based on the investigation, the estimated loss to the Medicare program was $2,795,522.33 and ASC has agreed to pay $5,591,044.66 to the United States.

The resolutions obtained in this matter were the result of a coordinated effort between the U.S. Attorney's Office for the Southern District of Indiana, the Department of Health and Human Services – Office of the Inspector General, and the Federal Bureau of Investigation.

"Whistleblowers are critical to protecting public funds from fraud, waste, and abuse," said U.S. Attorney Zachary A. Myers. "Health care providers who submit false claims or otherwise violate state and federal regulations when billing the United States Government will face consequences.

Today's settlement demonstrates that federal law enforcement agencies will vigorously investigate reports of false claims and seek to recover funds on behalf of the public."

"Health care providers that submit inappropriate claims to Medicare to boost their own profits compromise the integrity of this important federal health care program," said Special Agent in Charge Mario M. Pinto of the U.S. Department of Health and Human Services Office of Inspector General. "We will continue to work tirelessly, alongside our law enforcement partners, to ensure the appropriate use of taxpayer dollars and hold those who violate the law accountable."

U.S. Attorney Myers thanked Assistant U.S. Attorneys Shelese Woods and Justin Olson who handled the case for the United States.

The claims resolved by this settlement are allegations only and there has been no determination of liability. In agreeing to the settlement terms, ASC denied all liability under the False Claims Act. In investigating the case, HHS-OIG did not uncover any evidence of injury or harm to patients because of the alleged conduct.