PRESS RELEASE

BioTelemetry and LifeWatch to Pay More than $14.7 Million to Resolve False Claims Act Allegations Relating to Remote Cardiac Monitoring Services

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BioTelemetry Inc. and its subsidiary, LifeWatch Services Inc., headquartered in Malvern, Pennsylvania, and Rosemont, Illinois, respectively, (collectively LifeWatch), have agreed to pay more than $14.7 million to resolve allegations that they violated the False Claims Act by knowingly submitting claims to federal health care programs for a higher level of remote cardiac monitoring than physicians had intended to order or that was medically necessary, thus inflating the level of reimbursement paid to LifeWatch.

The United States alleged that, during the period July 1, 2014, through Dec. 31, 2020, LifeWatch marketed its ACT-3L device (also known as the LifeStar ACT-3L and the MCT-3L) to doctors as being capable of performing three different types of heart monitoring services: holter monitoring, event monitoring and telemetry. Of these, telemetry provided the highest rate of reimbursement. The United States contended that LifeWatch knew the design of their online enrollment portal for the ACT-3L device caused unwitting clinical staff to select options that would enroll the patient in the most expensive service, telemetry, even when the doctor intended to order a less expensive service. The United States also contended that LifeWatch's sales personnel instructed clinical staff to select the options that resulted in patients being enrolled for telemetry services, even when the sales personnel knew the clinic's physicians intended to order less costly services. LifeWatch also allegedly disregarded written notes that clinic personnel included in patient enrollments that specifically reflected the treating physicians' intent to order a service other than telemetry.

“Diagnostic companies, like other providers, are expected to bill federal healthcare programs only for medically necessary services,” said Principal Deputy Assistant Attorney General Brian M. Boynton, head of the Justice Department’s Civil Division. “We will hold accountable those who misuse taxpayer-funded programs for their own enrichment.”

“Our health care system is based on doctors choosing the level of care appropriate for their patients,” said U.S. Attorney Philip R. Sellinger for the District of New Jersey. “It undermines this system and costs taxpayers if companies design systems that make it harder for physicians to order only necessary services and also use their sales force to mislead health care practitioners, as we allege happened here. Our office is committed to holding accountable companies who try to take advantage of the system in these ways.”

“Companies that bill Medicare and other federal healthcare programs must ensure that they are billing for the services actually ordered by medical providers, rather than the most expensive service,” said U.S. Attorney Jacqueline C. Romero for the Eastern District of Pennsylvania. “This office will continue to pursue cases that will reduce costs for the government while ensuring that patients receive consistent and quality care, as prescribed by their physicians.”

“Proper billing of federal insurers is essential and underpins the reliability of our health care system,” said Deputy Inspector General for Investigations Christian J. Schrank of the Department of Health and Human Services Office of Inspector General (HHS-OIG). “HHS-OIG, along with our law enforcement partners, will continue to steadfastly pursue entities which fraudulently charge federal health care programs for financial gain and ensure they are held accountable.”

“Today's announcement demonstrates our ongoing commitment to work with the U.S. Department of Justice and our law enforcement partners to investigate allegations of fraud against TRICARE, the healthcare system for military members and their dependents,” stated Special Agent in Charge Patrick J. Hegarty for the Northeast Field Office of the Defense Criminal Investigative Service, the law enforcement arm of the Department of Defense Office of Inspector General. “When healthcare providers submit claims to TRICARE for services that are excessive and medically unnecessary, they place financial pressure on the TRICARE system and undermine its integrity.”

“The VA Office of Inspector General is committed to safeguarding the integrity of VA’s healthcare programs and preserving taxpayer funds,” said Special Agent in Charge Christopher Algieri of the Department of Veterans Affairs (VA) Office of Inspector General’s Northeast Field Office. “We thank the DOJ Civil Fraud Section, the United States Attorneys’ Offices and our law enforcement partners for their efforts leading to today’s meaningful settlement.”

“The OPM OIG takes fraud against the Federal health care programs very seriously,” said Deputy Assistant Inspector General for Investigations Conrad J. Quarles of the Office of

Personnel's Office of Inspector General (OPM OIG). "Our office stands ready to work with our law enforcement partners on holding unscrupulous health care providers accountable."

The civil settlement includes the resolution of claims brought under the *qui tam* or whistleblower provisions of the False Claims Act by Michael Pelletier, an individual employed by one of LifeWatch's customers, and SFP I LLC, whose members are Paul Davis, Charles Richardson, MD, MBA and Chris Riedel. Under those provisions, a private party can file an action on behalf of the United States and receive a portion of any recovery. The *qui tam* cases are captioned *U.S. ex rel. Pelletier et al. v. LifeWatch Services, Inc., et al.*, No. 2:18-cv-11391 (D.N.J.), and *United States ex rel. SFP I, LLC v. LifeWatch Corp., et al.*, No. 2:19-cv-2169 (E.D. Pa.). As part of today's resolution, Pelletier will receive approximately $2.3 million, and SFP I, LLC will receive approximately $270,000.

The resolution obtained in this matter was the result of a coordinated effort among the Justice Department's Civil Division, Commercial Litigation Branch, Fraud Section and the U.S. Attorneys' Offices for the District of New Jersey and the Eastern District of Pennsylvania, with assistance from HHS-OIG, the Department of Defense's Defense Criminal Investigative Service, the Department of VA Office of Inspector General and the OPM-OIG.

The investigation and resolution of this matter illustrates the government's emphasis on combating health care 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 HHS at 800-HHS-TIPS (800-447-8477).

The matter was handled by Fraud Section attorneys Amy Kossak and Jessica Sievert, Assistant U.S. Attorney Paul Kaufman for the District of New Jersey and Assistant U.S. Attorney Erin Lindgren for the Eastern District of Pennsylvania.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

Settlement Agreement

Updated December 18, 2023

Topic

FALSE CLAIMS ACT

Components

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