FOR IMMEDIATE RELEASE

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New York City Ambulance Companies Pay U.S. $2.85 Million to Resolve Claims for Fraudulent Medicare Appeals

Metropolitan Ambulance & First Aid Corp. (now known as SEZ Metro Corp.), Metro North Ambulance Corp. (now known as SEZ North Corp.) and Big Apple Ambulance Service Inc. (formerly known as United Ambulance) have paid the United States $2.85 million to resolve false claims made to Medicare, the Justice Department announced today. The United States stipulated to the dismissal of the False Claims Act \textit{qui tam} suit against the companies, including their president, Steve Zakheim.

The United States alleged that the companies and Zakheim used, or caused the use of, falsified records to appeal a Medicare program refund demand. Medicare had demanded the companies return millions of dollars they had been paid for medically unnecessary ambulance trips. Under Medicare rules, the companies could bill for these expensive non-emergency transports only if the patient could not be transported by any other means, such as by car or by wheelchair van. Medicare audited the companies’ past billings and concluded that the companies had charged Medicare tens of millions of dollars for ambulance trips that did not meet this standard. Medicare demanded a refund and afforded the companies an extensive informal and formal appeals process to prove that their billings were proper.

The government contended that, rather than contesting the refund demand fairly, the companies resorted to fraud when they could not otherwise prove an ambulance was medically needed. According to the suit, in their ensuing appeals, the companies used, and Zakheim caused the use of, hundreds of letters attesting to the need for an ambulance that were forged or otherwise purported to come from some neutral, disinterested health care provider when they in fact did not.

"Those who benefit from Medicare must play by the rules," said Tony West, Assistant Attorney General for the Civil Division of the Department of Justice. "We will diligently protect taxpayer dollars from those who use fraud and deceit to take advantage of federal health care programs."

"Healthcare providers who seek to defraud the Medicare program by submitting false documents will be vigorously pursued and held accountable for their fraud," said U.S. Attorney Loretta E. Lynch.

This action was originally filed by Larry Kaplan, a former Chief Financial Officer for one of the companies, under the False Claims Act. The \textit{qui tam}, or whistleblower, provisions of the Act permit private citizens to file suit on behalf of the United States and share in any recovery. Mr. Kaplan’s share of the settlement announced today will be $618,450.

The investigation, litigation, and resolution of these allegations resulted from a coordinated effort by the Justice Department’s Civil Division, the U.S. Attorney’s Office for the Eastern District of New York, the Department of Health and Human Services’ Office of Inspector General, and the Federal Bureau of Investigation.

The suit is \textit{United States ex rel. Kaplan v. Metropolitan Ambulance & First-Aid Corp. et al.}, Civil Action No. 00-3010 (E.D.N.Y.).

This settlement is part of the government’s emphasis on combating health care fraud. One of the most powerful tools in that effort is the False Claims Act, which the Justice Department has used to recover approximately $3 billion since January 2009 in cases involving fraud against federal health care programs.