1. Health Care Fraud and Its Facilitating Crimes

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Leap, Terry L.
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The False Invoice Scheme

Two business partners, one living in Texas and the other in Tennessee, had a good thing going. Despite being separated by hundreds of miles, these middle-aged women worked together, making money hand over fist through a simple invoicing scheme that lined their pockets with hundreds of thousands of dollars.

The woman in Texas was employed by a medical center as the director of physician recruiting. The woman in Tennessee ran her own physician-recruiting service. After meeting online in 2002, the pair agreed to a physician-recruitment scam. The Texas partner told her Tennessee counterpart what items to bill the medical center along with the billing amounts. Then the crooked Tennessee partner created and sent the invoices for the bogus services to her friend in Texas. Both women knew that the work represented on the invoices had not been performed at all or had not been performed as represented. Once the Tennessee physician—recruiter received a check for “services rendered” on the invoices, she kicked back between 25 and 50 percent to her accomplice in Texas.

From 2002 to 2007, the Texas medical center paid the Tennessee businesswoman $851,416.83 based on the fraudulent invoices. Of that amount, her friend in Texas received $283,126 in kickbacks. The scheme was eventually detected, and the two women pleaded guilty to theft in January 2009. U.S. District Judge Sam R. Cummings sentenced them each to thirty months in federal prison and ordered them to pay a total of $905,166.05 in restitution.\(^1\)

This health care fraud case is extremely simple. Since the medical center was deceived into making payments for services that it never received, the women committed fraud. Yet, in addition to the primary crimes of fraud and theft,
white-collar offenders such as these two women usually face charges for a variety of facilitating crimes. By acting together, they engaged in a conspiracy to commit an illegal act. Because their scheme involved using the mail system as well as the telephone and the Internet, the pair opened themselves up to mail and wire fraud charges. Furthermore, if they had tried to hide their money or disguise its source, the women could have been charged with money laundering and tax evasion. Finally, many criminals who attempt to deceive investigators may face charges of lying to federal authorities, obstruction of justice, and perjury.

The point to remember is that even a simple health care fraud case such as the one involving these two far-flung business partners can have severe consequences. By pleading guilty instead of putting themselves at the mercy of a federal jury trial, the two women avoided twenty-two additional charges that could have lengthened their sentences considerably.²

Fraud Defined

The backbone of all white-collar crimes is fraud, and the primary ingredients of fraud are misrepresentation and acts of deception. When we use the term “fraud” in common language, it always has a pejorative meaning. “That’s fraudulent behavior,” we exclaim when we hear about someone behaving less than honestly. Certain conditions must be met, however, before an individual can be judged guilty of fraud in a legal proceeding.³

Fraud differs from abuses such as price gouging or mistakes such as billing errors. Price gouging usually occurs when someone takes advantage of a vulnerable person and charges them an exorbitant sum for goods or services. In the wake of a natural disaster such as a hurricane, unscrupulous price gougers charge devastated residents inflated prices for basic necessities. The second example—a billing error—is a mistake that will not result in criminal charges or a civil suit, unless such “mistakes” are blatant or follow a repeated pattern. Fraud also differs from a bad result (e.g., a frail patient dies after a successful surgery), an incorrect prediction or forecast (e.g., a doctor’s prognosis for a patient was wrong), and even malpractice (e.g., a doctor failed to provide adequate postoperative care and his patient developed a life-threatening infection).

Three conditions are required to prove fraud. Prosecutors must demonstrate that the perpetrator lied to or mislead the victim to conceal the fraud. Then they must show that the victim believed and acted on the perpetrator’s fraudulent statements. Finally, to constitute fraud, it must be documented that the victim suffered economic or other damages at the hands of the perpetrator.

The person committing a fraudulent act must knowingly or recklessly make a misrepresentation of a material fact. The misrepresentations they make include
lies of commission and lies of omission. A lie of commission occurs by saying something that is not true about “a fact that is significant or essential to the issue or matter at hand” (in legalese, this is known as a material fact). When a physician intentionally overcharges a health insurer, he or she has committed a lie of commission. Some health care providers contend that overbilling compensates them for accepting low payments, wasting time on claims disputes, or dealing with insurance company red tape. But no matter how justifiable their complaints, they do not have the right to decide on what payment they believe befits them. Such misrepresentations constitute fraud.

A lie of omission occurs when a health care provider hides an important fact such as a medical mistake endangering a patient’s life. According to a study by HealthGrades, over three hundred thousand deaths of Medicare patients between 2002 and 2004 resulted from medical care errors. Most of these deaths were due to mistakes, not fraud. But fraud may be used to mislead investigators, to cover up serious medical errors, to avoid malpractice suits, or to protect one’s professional reputation.

The case of Esmin Green became a Pandora’s box for New York’s Health and Hospitals Corporation. Green’s case received widespread media coverage after she fell and died while waiting for psychiatric care at HHC’s Kings County Hospital Center in Brooklyn. A subsequent investigation of HHC by the New York Daily News revealed missing records at HHC facilities as well as discrepancies and false entries in hospital records. Some entries were faked to cover serious mistakes by HHC personnel.

Demonstrating the first condition of fraud can be vexing to prosecutors because they must show that the defendant meant to defraud and then took actions to cover his or her tracks. For this reason, prosecutors may prefer pursuing civil rather than criminal charges against an offender. The “preponderance of evidence” burden of proof standard in civil cases is less demanding than the “beyond a reasonable doubt” standard in criminal cases. Providers accused of fraud often claim they had no intention of deceiving their victim (i.e., they had no mens rea or “guilty mind”). For example, a physician may describe the liberal use of diagnostic tests on a patient not as abusive overutilization but as crucial to the thorough evaluation of that patient.

As mentioned earlier, definitions of fraud may be too broad and thus entangle clinicians who have only the best intentions toward their patients and society. Remember the obstetrician who tried to get her patient’s annual checkup covered by claiming falsely that the patient had a headache? She knew quite well that her patient suffered nothing of the sort, but she also believed that the patient’s health insurance should cover annual physical exams. Is this otherwise honest physician a perpetrator of fraud because she wanted to serve the best interests of her patient? One could argue that the physician was innocent of wrongdoing.
because she was protecting her patient. On the other hand, a cynic might argue
that if the physician was so concerned about her patient’s welfare—perhaps then
being accused of favoring one patient over another—she could have provided
the annual checkup free of charge. Another counterargument is that by giving
the patient a thorough physical exam and charging it fraudulently to the patient’s
insurer, the physician was acting in the best interests of both the patient and the
health care system. Had she spotted a serious medical problem early, she could
have nipped it in the bud before it later developed into something more debili-
tating. As can be seen, the line may be blurred between a physician’s making a
medical decision that is in the best interests of the patient versus a decision that
might be regarded as health care fraud.

A promise or opinion made in good faith and founded on reliable knowledge
does not constitute fraud. Suppose a physician prescribes an expensive antibiotic
and tells his patient he will feel better within a week. Even though the antibiotic
did not later perform as promised, no fraud occurred as long as the physician
had made an informed judgment based on current medical knowledge.

The second condition required for establishing fraudulent intent is for the victim
not only to believe but also to take action based on a misrepresentation. A Boston-
area psychiatrist fabricated medical diagnoses and made insurance claims for pa-
tients, some of whom he had never met. His false diagnoses included “depressive
psychosis,” “suicidal ideation,” “sexual identity problems,” and “behavioral problems
in school.” Many of his diagnoses were documented using fictitious counseling ses-
sion notes. In this case, the health care insurers accepted these bogus evaluations
as legitimate, and the insurers paid the psychiatrist over $1 million in reimburse-
ments. He was later caught and convicted of fraud and money laundering.8

Health care fraud cases often hinge on the trust patients place in health care
providers. “Fraud in the inducement” is a misrepresentation that entices a person
to enter into a transaction with a false impression of the risks.9 Bernard Madoff
did exactly this sort of thing in the field of financial management when he lied to
his clients and pocketed their investment monies. A patient who is paralyzed by a
controversial and dangerous experimental treatment after his physician tells him
the procedure is “routine” and “normal” is a victim of fraud in the inducement.

A San Francisco executive was sentenced to forty-one months in prison and
ordered to pay $1.3 million in restitution after he defrauded thousands of people
across the United States by selling them worthless health insurance. The phony
insurance company collected over $2.8 million in premiums, but most of these
funds were not placed into insurance trust accounts. Instead, the perpetrator
spent the premiums on expensive cars, football tickets, and commissions to pro-
moters who helped market the fraudulent plan.10

Finally, the act of fraud must cause harm. Nearly all health care frauds result
in economic damage. Economic damages include the loss of money, products, or
services as well as inflated health care costs, higher health insurance premiums, extraordinary legal expenses, additional regulatory and compliance costs, beefed up fraud detection measures that slow the processing of insurance claims, and time wasted in dealing with the fraud (an opportunity cost). Health care frauds, however, add a pernicious element to white-collar crime and fraud in general. They often cause physical harm to sick and vulnerable individuals. For example, fraud, in the form of fake or substandard laboratory tests, may allow a patient's serious health problem to go undiagnosed and untreated.

Counterfeit diagnoses, on the other hand, may lead to unnecessary, painful, or dangerous treatments. A hospital in Maryland has been at the center of a federal investigation over the accusation that doctors there inserted coronary implants (stents) in as many as 369 patients who did not need them. Medicare and private insurers will pay for these implants only if the patient has at least a 70 percent blockage. One sixty-nine-year-old patient was told that he had a 95 percent arterial blockage when, in fact, the blockage was closer to 10 percent. Another patient, who was told she had a 90 percent blockage, later learned that she had no problem. But for the rest of her life she will be saddled with an irremovable stent. At over ten thousand dollars a pop, cardiac catheterizations are a tempting and lucrative business for an unscrupulous physician.11

A network of doctors and clinics based in California devised a rent-a-patient scheme to defraud health insurance companies. As many as 4,500 patients from forty—four states and Puerto Rico were recruited and paid small sums of money to undergo unnecessary colonoscopies and other surgeries. The doctors then billed private insurance carriers at inflated rates, resulting in a $30 million civil suit against them by twelve Blue Cross plans.12 This fraud resulted in lost income and legal expenses for Blue Cross.

Phony diagnoses may also stigmatize a patient, later limiting employment opportunities or making it difficult to obtain health or life insurance. Charges for unnecessary tests or treatments have also caused patients to exceed their lifetime health care insurance benefit limits—something the Obama administration is eliminating in its health care reform proposals. But persons without major medical coverage are walking a tightrope with no financial safety net, which is especially dangerous if they are faced with a catastrophic illness or injury.

The psychological damage to victims of health care fraud can be devastating. Fertility scams are among the most despicable of health care frauds. One notorious case involved a Virginia physician, Dr. Cecil Jacobson. Jacobson misled some patients into believing they had conceived, and, in other cases, he secretly impregnated female patients with his own sperm. Although Jacobson duped couples into paying him tens of thousands of dollars, the psychological damage he caused undoubtedly exceeded the economic damages.13 Why did these patients sign on with the likes of a Cecil Jacobson? The answer might lie in their
desperation to conceive a healthy child. That same desperation might explain why some terminally ill patients agree to almost any form of treatment, no matter how radical, far-fetched, or expensive.

Many fraud artists view public and private insurance programs as veritable treasure chests. On March 4, 2008, an Ohio man was sentenced to thirty-seven months in prison to be followed by three years of supervised release. A few days earlier, his brother had been sentenced to thirty-three months in prison and three years of postrelease supervision. Both defendants were charged with conspiracy to commit health care fraud and money laundering. They were each ordered to pay over $1.7 million in restitution, a $75,000 fine, a $200 special assessment fee, and $550,000 for prosecution costs.

What did the two brothers do to deserve this punishment? As it turns out, they put their brains to work trying to fleece millions of dollars from Medicare, Medicaid, TRICARE, and several private health insurance programs. And, before they were finally caught, they succeeded in submitting over $4.8 million in false claims on behalf of their company, a group of chiropractic and medical clinics doing business in seven northern Ohio cities.

The brothers hired medical doctors to work in the clinics where chiropractors performed noncovered chiropractic services disguised as covered medical services. Using the hired medical doctors as a ruse, the company’s noncovered services were billed to the insurers using false billing codes. If one of the insurers questioned or denied an improper claim, the impudent brothers lied, saying the billings were for medical services, not chiropractic services. This scheme enabled their medical clinics to circumvent the insurance coverage limits on chiropractic treatments, and unsuspecting insurers were duped into reimbursing the company for more than $1.7 million. In cracking the case, agents from the Federal Bureau of Investigation, the Internal Revenue Service, the U.S. Postal Inspection Service, the Defense Criminal Investigative Service, the Ohio State Medical Board, the Ohio State Chiropractic Board, and the Ohio Bureau of Workers’ Compensation interviewed eighty people associated with the clinics, including doctors, chiropractors, staff, and patients. Agents also seized some 973 boxes of records along with twenty computers. In addition to the false claims, the defendants conspired to commit money laundering by using funds from the billing scheme to make almost $1.6 million in salary payments to the medical doctors.14

Facilitative Crimes

Health care frauds such as filing phony insurance claims, making false diagnoses, organizing a rent-a-patient scheme, or promoting the illegal off-label use of a drug are all “object crimes.” These crimes have a purpose and that purpose is...
usually to steal or misappropriate money. In August 2010, a Chicago-area cardiologist was sentenced to five years in federal prison for receiving more than $13 million in improper reimbursements from Medicare and other insurers. The cardiologist allegedly obtained confidential health care information on unsuspecting patients from three local hospitals between January 2002 and July 2007. He faxed phony handwritten treatment notes to hired “billers” to complete claims to Medicare and other insurance companies for high-end cardiac treatments that he never performed.

In another Chicago-area case, a forty-seven-year-old general practitioner bilked Blue Cross Blue Shield of Illinois out of $900,000 for bogus treatments. A number of bloggers familiar with these two cases weighed in. One wrote: “As a guy who knows a lot about doctors, I would say 80% of them do this type of thing and is quite common. There is a reason why some primary care physicians are able to afford $400,000 cars for telling some people to take aspirin.” Another had this to say: “I saw [the doctor] Dec 05, I was very diligent about reviewing my bills. I received bills from him for dates I did not see him, 4 or 5 separate occasions. My husband also saw him once and received numerous bills. They even tried sending me to collections. I called the office and kept getting the runaround. I finally called BCBS and filed a complaint with the fraud department. I’m glad they finally put a stop to this.”

The crimes that support or enable the object crimes are known as facilitative or auxiliary crimes. Facilitative crimes include conspiracy, money laundering, tax evasion, mail and wire fraud, and obstruction of justice. No one commits a facilitative crime (with the possible exception of tax evasion) without an object crime in mind. You might say that the facilitating crimes provide the traction for the object crimes. For example, the facilitative crimes of mail or wire fraud are necessary for the commission of the object crime of filing false insurance claims. It is difficult to imagine how those Chicago-area physicians whose frauds I have described could have committed this primary crime without using the mail system or some form of wire communications such as a telephone, fax machine, e-mail, or other component of the Internet.

Federal prosecutors have found a silver lining in facilitating crimes. It is often easier for them to convict a white-collar defendant of conspiracy, mail fraud, tax evasion, or money laundering than it is to convict someone of an object crime such as embezzlement or fraud. Evidence to support a Medicare fraud charge against a physician may be weak, but evidence to convict the doctor of tax evasion, money laundering, or obstruction of justice may be strong. Furthermore, tax evasion and money laundering convictions alone carry prison sentences that may be lengthy enough to satisfy federal prosecutors.

Charges of facilitative crimes also enable prosecutors to present a comprehensive view of the case before a judge and jury including timelines and background
information on the defendants, their motives, their victims and the harm they suffered, and the statutes violated. Information pertaining to the facilitative crimes may then be useful in demonstrating the defendant's guilt for the object crime.

Individuals charged with a white-collar crime are almost always charged with at least one (and usually more than one) facilitative crime. The two brothers from Ohio, for example, were charged with the object crime of health care fraud as well as the facilitative crimes of conspiracy and money laundering. And the Miami physician discussed in the introductory chapter, was charged not only with making false claims and receiving kickbacks (both object crimes), but she was also charged with conspiracy and tax evasion (both facilitative crimes).

In February 2008, a woman was sentenced to twenty-four months in prison followed by two years of supervised release and ordered to pay $596,429 in restitution for funds she had stolen from her employer, Blue Cross Blue Shield of Massachusetts. Over a period of five years, this $90,000-a-year systems manager created a false self-insured health plan and defrauded Blue Cross Blue Shield into issuing refund checks to the plan. She then cashed the checks, using the money for personal expenses and failing to report the income on her federal tax returns. Thus, we have the object crime, defrauding Blue Cross Blue Shield of Massachusetts, and at least one facilitating crime, income tax evasion. This woman could have been charged with two additional facilitating crimes, mail and wire fraud, if she had used the mails or online banking services to deposit the stolen funds into her Boston-area bank account.

**Conspiracy**

Charges of conspiracy arise when two or more individuals participate in the planning or execution of a crime. The Blue Cross Blue Shield employee described above appears to have acted alone, so she cannot be charged with conspiracy. But many white-collar crimes—including health care fraud—involve more than one participant. Conspiracy is also an amorphous crime. Because participants in a health care fraud case are involved to different degrees, it is sometimes hard to know when knowledge of a crime or participation in a crime crosses the line into an illegal conspiracy. For this reason, prosecutors favor conspiracy charges because it enables them to cast a wide net, ensnaring anyone who might be even slightly involved in a crime.

Conspiracy is an agreement or meeting of the minds to achieve an illegal end. One such illegal end, health care fraud, often entails complex arrangements and a concerted effort by several individuals who have specific expertise or specialized access. They may use their expertise or access to navigate unobtrusively through information systems, insurance-claims procedures, and money-laundering channels.
That is why criminal statutes treat conspiracy as a charge that is separate from the object crime.

When health care frauds are conspiratorial, they work either as a chain or as a wheel conspiracy. The chain conspiracy is one in which, in “a single conspiracy,” “each person is responsible for a distinct act within the overall plan.”20 A fraud in which one person steals patient information, a second person files fraudulent Medicare claims, and a third person launders money derived from the scam is an example of a chain conspiracy.

A Texas couple, along with a third conspirator, admitted to defrauding Medicare and Medicaid in a two-year durable medical equipment (DME) fraud conspiracy. Federal District Court Judge Leonard Davis sentenced the couple to twenty-seven months in prison for conspiracy, money laundering, and fraud. They were ordered to pay $284,689 in restitution and to submit to three years of supervision after completing their prison terms.

Through medical supply companies in East Texas, the defendants obtained information about legitimate beneficiaries, submitted fraudulent claims to Medicare and Medicaid for the cost of motorized wheelchairs and accessories, and hid the money from law enforcement and tax authorities. The seven-count indictment listed frauds totaling $427,150. The third conspirator in this chain cooperated in the prosecution of the other two defendants and was sentenced to two years in prison for defrauding Medicare of more than $800,000. He contributed to the chain conspiracy by filing Medicare claims for motorized wheelchairs and scooters on behalf of recipients who were not eligible for these benefits.21

When we do not have links in a chain, we have spokes in a wheel. Here we are dealing with a conspiracy in which a single member or group (the hub of the wheel) colludes with two or more conspirators—the spokes. The person or group at the hub is the only party liable for all the conspiracies.22 In the case of a New York podiatrist, we see that almost any health care service or piece of equipment might be used to commit fraud. The podiatrist was indicted by a Westchester County grand jury on the charge of stealing $1.8 million by submitting fraudulent Medicaid billings for special footwear. He billed Medicaid for expensive custom-made foot appliances even though he provided patients with cheap stock goods or no goods at all. The indictment accused him of masterminding what a special prosecutor for Medicaid fraud called “the largest and most sophisticated podiatry fraud yet perpetrated on the nation’s Medicaid system.” Between 1983 and 1986 he paid kickbacks to New York area podiatrists for steering business to his five custom footwear businesses. Inventive to a fault, he even tried to mislead state investigators by creating a mock laboratory, complete with leather dust, in the basement of his office.23 In this case, the crooked podiatrist was the hub of the wheel with the other New York podiatrists, who may not have even known each other, serving as the spokes.
Even those playing a minor role in a criminal activity are subject to conspiracy charges. A custodian who is paid by other conspirators to “accidently” leave a door unlocked so that unauthorized personnel can enter a room and steal laptop computers containing confidential patient information may be charged with conspiracy even though the custodian was at home when the thefts occurred. But someone who merely suspects that others are involved in criminal activity, however, will not be charged with conspiracy. Getting cold feet and withdrawing from a conspiracy does not necessarily protect a party from criminal charges. Furthermore, prosecutors may grant leniency to those playing a less significant role in the conspiracy in exchange for information or testimony against the more culpable participants.

Whether chains or wheels, conspiracy is an “inchoate” crime. That is, perpetrators of a health care fraud may be arrested for planning a crime even before they have the opportunity to execute it. Suppose that three former information technology employees at a medical center plan to steal patient medical information and use the information to commit identity theft. If the former employees hack into the center’s computer system but their plot is foiled before they have a chance to steal any information, they will be charged with conspiracy even though the object crime never reached fruition. Discussing a crime over drinks in a bar without doing anything to set it in motion, however, does not qualify as a conspiracy.

Federal rules govern the introduction of evidence in both criminal and civil cases. In conspiracy cases involving hearsay testimony, the rules have a twist. Hearsay might include rumor, gossip, unverified statements, or evidence based on the reports of others rather than on the personal knowledge of the witness—what we call secondhand information. Because hearsay evidence is often unreliable, it is not admissible in most legal proceedings—except conspiracy cases. By relaxing the hearsay rule, prosecutors are able to use information about coconspirators that was obtained through out-of-court or secondhand sources. The hearsay rule is relaxed because conspiracy cases offer little or no direct evidence, and inferior evidence is preferable to no evidence at all.24

Using the Racketeering Influenced and Corrupt Organizations (RICO) Act

When we think of health care fraud, we do not usually think of mobsters such as John Gotti and Charles “Lucky” Luciano (or fictional ones such as Tony Soprano or Vito Corleone). As mentioned earlier, a $2.5 trillion industry is not only a magnet for run-of-the-mill crooks, but it is also becoming a magnet for people who have made crime an organized business. Not surprisingly, the Racketeer Influenced and Corrupt Organizations Act of 1970, which was enacted primarily to combat organized crime, can be used to pursue the mob’s entrance into the health care arena.25 But the law has also been used—at least to a limited
extent—against health care institutions, pharmaceutical manufacturers, and health insurers. Indeed, in 1985, the U.S. Supreme Court in Sedima v. Inrex made it easier for civil plaintiffs to use the RICO Act by expanding its coverage beyond organized crime. The Court’s decision in Sedima has transformed the act into an integral weapon against white-collar criminals.26

According to the RICO Act, it is a crime for someone to gain control of a legitimate business through intimidation, violence, or other illegal means.27 The RICO Act defines a pattern of criminal activity as the commission of two or more related instances of racketeering within a ten-year period. “Racketeering” is defined by a wide range of “predicate acts,” which are spelled out in the RICO Act. Predicate acts include murder, extortion, theft from an interstate shipment, embezzlement from pension and welfare funds, and many more. In addition to targeting organized crime, the Act’s broad definition of racketeering has been applied to corporations, partnerships, associate-in-fact enterprises (a loose-knit group of associates who engage in both legal and illegal activities), and even individuals.

Federal court decisions have dealt extensively with definitions of what constitutes an “enterprise,” or what is meant by the terms “management” and “racketeering.” The courts have also had to wrestle with whether a proximate cause, or close relationship, exists between the actions of an illegal enterprise and the damages inflicted by that enterprise.

And what constitutes a pattern of criminal activity? To constitute such a pattern, a set of crimes must have a common element. Crimes all linked to defrauding Medicare, for example, constitute a pattern, whereas a variety of unrelated crimes (e.g., drug trafficking, securities fraud, and automobile theft) might not constitute a pattern. To qualify as a “pattern” such crimes must share a degree of continuity—that is, the frauds must be committed by a core group of perpetrators over a period of time.

Under section 1962(d) of the RICO Act, it is unlawful for a person to conspire to violate subsections 1962(a), (b), or (c) of the RICO Act, which make it illegal for persons to have a financial or business interest in an organization engaged in racketeering.28 So when it comes to health care fraud, the RICO Act prohibits the associated crimes or predicate acts of bribery, money laundering, counterfeiting, extortion, dealing in narcotics or other dangerous drugs, mail and wire fraud, and obstruction of justice. It not only establishes stiff criminal penalties, but it also permits civil suits and the forfeiture of assets derived from criminal activities. Victims of health care fraud may pursue civil action under the RICO Act section 1962(c) against persons who have caused them harm. The following cases illustrate the ever-widening scope of RICO Act litigation.

A national class action was certified in March 2008 against First DataBank and the McKesson Corporation. The suit alleged that First DataBank and McKesson engaged in a racketeering enterprise by falsifying the average wholesale
price for numerous prescription pharmaceuticals in violation of the RICO Act and California state law. In late 2001, First DataBank, a drug-pricing publisher, and McKesson, a drug wholesaler, reached a secret agreement to increase the spread between the wholesale acquisition cost of certain drugs and their average wholesale price. According to a health care policy report released by the Bureau of National Affairs, the average wholesale price (AWP) for most brand-name drugs is 20 to 25 percent above the wholesale acquisition cost (WAC). The agreement between McKesson and First DataBank increased profit margins on over four hundred drugs. McKesson communicated these new markups to First DataBank, and the company then published them.

Prior to the secret agreement between McKesson and First DataBank, little uniformity existed between the WAC and the AWP for hundreds of brand-name drugs; differentials were based on information supplied independently by the drug manufacturers or by First DataBank’s surveys of wholesale costs and prices. Once the secret AWP-WAC agreement went into effect, the prices of most drugs were raised to artificially high levels and fixed. By 2004, 99 percent of all prescription-drug manufacturers were using the inflated markups. The scheme resulted in higher profits for retail pharmacies because these firms purchased drugs on the basis of the wholesale acquisition cost, but they were reimbursed on the basis of the marked-up average wholesale price.

McKesson was accused of implementing the scheme to increase profit margins for major retail pharmacy clients such as Rite Aid and Wal-Mart as well as for its own pharmacy businesses. Court documents revealed differences in customer profits between the “old spreads” and “new spreads” for drugs such as Lipitor (20 mg. 90s from $6.86 to $17.18), Prilosec (20 mg. 30s from $4.92 to $8.92); and Befaseron (from $20.00 to $58.25). Douglas Hoey, chief operating officer for the National Community Pharmacists Association, has said that First DataBank’s pricing scheme was of little help to community pharmacists who continue to be burdened by slim profit margins.

Although a federal judge had earlier dismissed the price-fixing suit against McKesson, the company agreed in November 2008 to pay $350 million to settle a suit brought by the New England Carpenters Health Benefits Fund and others. McKesson settled the suit without admitting any guilt, and CEO John H. Hammergren commented, “We believe the plaintiffs’ allegations are without merit, and that McKesson adhered to all applicable laws. We did not enter into any alleged conspiracy, did not manipulate drug prices and did not violate any laws.” Hammergren remarked further that McKesson’s settlement agreement was motivated by the company’s desire to avoid the “inherent uncertainty” of litigation, a tactic that has been used repeatedly in other fraud settlements against pharmaceutical firms.

To establish a civil claim under section 1962(c) of RICO, the plaintiff must demonstrate that the defendant engaged in a pattern of racketeering activity in
association with an enterprise affecting interstate commerce. The plaintiff must then demonstrate that the pattern of racketeering activity caused harm to his or her property or business.36

A physician in New York filed civil charges under the RICO Act against two large health insurers. The doctor claimed the insurers conspired with medical evaluation companies and associated physicians to perform rigged boilerplate medical examinations meant to deny his patients future treatments.37 According to the complaint, the insurers pressured the independent medical examination (IME) companies to conclude that the doctor’s patients did not require future treatments. This pressure, of course, deprived the doctor of revenues that he would have received for the treatments. In essence, IMEs were expected to issue reports that were favorable to the insurance carriers and detrimental to the insured patients. In one complaint, the doctor said that “[the insurer] made it known to the other defendants that if they did not provide sufficient denials within the evaluation reports then [the insurer] would not use their IME services.”38

Mail and Wire Fraud

The lifeblood of health care—information—moves primarily through the mails or wires. Medical billings, insurance claims, laboratory test results, and patient medical histories are sent to patients, providers, and insurers by the U.S. Postal Service, package delivery services, telephones, fax machines, electronic mail, and Internet websites. So, not surprisingly, transmitting phony diagnoses, filing insurance claims for services not rendered, or upcoding medical treatments all carry potential charges of mail and wire fraud.

The same applies to false advertising. Health care consumers—especially senior citizens—are often the targets of mail or telephone sales pitches by con artists with no medical training who are selling elixirs for aging, weight loss, baldness, or impotency. Other quacks use the telephone or Internet to peddle remedies for heart disease, cancer, arthritis, rheumatism, and Parkinson’s disease. These miracle cures are supposedly derived from “secret ancient sources” or from “recent scientific breakthroughs,” and they are bolstered by phony money-back guarantees and staged testimonials from “satisfied customers.”39

The federal mail fraud statute is the oldest federal criminal statute, and it continues to be used extensively by prosecutors.40 The mail and wire fraud statutes make it a criminal act for anyone to use the mail service or the wires to advance a fraudulent scheme across state lines. Mail fraud applies not only to items shipped by the U.S. Postal Service, but also to items shipped by package delivery services such as UPS and FedEx.

Although the transmission of sales hyperbole does not constitute mail or wire fraud, true but misleading statements may violate federal law. An advertisement
claiming that a certain vitamin will make a person “feel like a million dollars” is sales hyperbole. Telling prospective customers that a brand of vitamins, if taken for the rest of their lives, will cure cancer is a true but misleading statement. If customers take the vitamins for the rest of their lives, their cancer will be “cured” when they die. But the proclamation is fraudulent because a reasonable person might misconstrue the actual meaning and act on it.

Prosecutors must prove that the defendant engaged in a “scheme to defraud” by using the mails or wires to make material misstatements or omissions, which then resulted in the victim’s loss of money or property. Because nearly every organization in the United States uses the mails or wires in the course of conducting business, almost any health care fraud violates the federal mail and wire fraud statutes. Furthermore, it is not necessary for the primary fraudulent statement itself (e.g., “These vitamins cure cancer”) to be transmitted by mail or wire. The fraudulent scheme needs only to be advanced in some fashion by the use of the U.S. mail or the wires. As with conspiracy, prosecutors can obtain a conviction for mail and wire fraud even if the object crime was not committed. But inaccurately predicting future events, failing to fulfill a promise, breaching a contract, or using fine-print disclaimers do not necessarily constitute fraud. Mail and wire fraud are both predicate acts under the RICO Act. According to one attorney:

The RICO Act is almost single-handedly responsible for the small print disclaimers that appear on every newspaper and T.V. advertisement and for the fast-talking and whispered disclaimers that we hear on the radio. All of those disclaimers essentially say that all the statements made in the advertisement are opinions or are based upon assumptions that may or may not apply to the circumstances of any individual consumer. So, the next time you’re squinting to read the fine-print or waiting for the radio announcer to run out of breath, you can thank the RICO Act.

Despite its broad application, the mail and wire fraud statutes stipulate that a fraudulent act must cause harm. Not all prosecutions falling under the broad umbrella of mail fraud, however, meet this test.

Consider the case of a Kansas psychologist. He operated a private outpatient psychology practice where he supervised as many as fifteen psychologists and counselors. By extracting payments for patient referrals from a nearby Kansas City hospital, he found himself in trouble with the federal government. The hospital agreed to pay him $1,000 a month for referrals, calling them “marketing” services. No evidence surfaced, however, that the psychologist ever proffered such services. Nonetheless, between July 1989 and October 1990, the Kansas City hospital paid him $40,500. A hospital administrator testified that the psychologist threatened to refer patients to other hospitals if the payments were not increased,
and he allegedly confronted the administrator with a letter from another hospital offering him a monthly payment of $2,500 per patient referral.

The psychologist was convicted in a federal district court of violating both the mail fraud and Medicare antikickback statutes. On appeal, his Medicare kickback conviction was upheld, but his mail fraud conviction was thrown out by the U.S. Court of Appeals (8th Circuit). The opinion states:

The mail fraud statute prohibits use of the mails to execute “any scheme or artifice to defraud.” Essential to a scheme to defraud is fraudulent intent…. The scheme to defraud need not have been successful or complete. Therefore, the victims of the scheme need not have been injured. However, the government must show that some actual harm or injury was contemplated by the schemer… The essence of a scheme to defraud is an intent to harm the victim. When there has been no actual harm, “the government must produce evidence independent of the alleged scheme to show the defendant’s fraudulent intent.” Here, all the evidence suggests that [the psychologist] intended to provide and did in fact provide his patients with the highest quality psychological services. While he also extracted undisclosed, unethical referral fees from an interested third party provider, there is no independent evidence proving that he thereby intended to defraud his patients. True, [he] did not disclose the referral fees, but a fiduciary’s nondisclosure must be material to constitute a criminal scheme to defraud. There is no evidence that any patient would have considered [the psychologist’s] relationship with [the hospital] material if it did not affect the quality or cost of his services to that patient.44

Money Laundering

Health care frauds, especially those involving bribes and kickbacks, may generate large amounts of cash. This embarrassment of riches poses two problems for criminals. First, moving large sums of cash through the U.S. banking system attracts the attention of law enforcement agencies and the IRS. Second, criminals must find places to deposit their wealth that are both secret and safe. That is where money laundering comes in.

Money laundering is the process of converting proceeds derived from criminal activities (“dirty” money) to proceeds that can be spent or invested safely (“clean” money). Money launderers prefer Caribbean nations or other politically stable countries with modern banking systems that are beyond the reach of U.S. authorities. Furthermore, money launderers want to maintain easy access to their funds.

Unlike the nineteenth-century mail and wire fraud statutes, money-laundering statutes are of recent vintage. Over the past two decades, leveling
money-laundering charges against white-collar criminals has become increasingly popular with federal prosecutors. Many people regard money launderers with a special disdain, not only because their activities support lucrative criminal enterprises, but also because they evade income taxes. If I make $1 million legitimately, I am entitled to take whatever deductions are allowable under income tax law, but I must still pay my fair share of taxes. Health care crooks who launder money, on the other hand, will pay no taxes on their ill-gotten gains.

Money launderers employ a variety of methods. Cash from illegal endeavors may be transferred electronically to foreign accounts or converted to money orders, U.S. Treasury notes, cashier's checks, or traveler's checks. Some ingenious money launderers convert U.S. currency to gold, jewelry, or expensive merchandise. These items are shipped to other countries and reconverted to cash through legal or black market sales. Other money launderers use foreign currency exchanges, check-cashing services, stored-value cards, shell companies, trusts, gambling casinos, and fake invoices to obfuscate their financial transactions.

Even eBay scams have been used to launder money. An unsuspecting California medical researcher was hired by a European and, supposedly, nonprofit health care organization to forward charitable donations through her bank account to Western Union offices in Germany and Romania. She was told by those who hired her that the money was to be used for AIDS research. In reality, she had been pulled into an international money-laundering scheme. When police showed up at her door, she learned that at least some of the “donations” she received were actually payments from eBay customers. Customers notified the authorities when they paid for merchandise they never received. Although this well-intentioned and trusting intermediary avoided prosecution, she was saddled with having to repay $25,000 to the swindled eBay customers.

In 2007 twelve defendants entered pleas or were convicted in South Florida Federal District Court in connection with a $12.5 million health care fraud and money-laundering operation. The defendants and their thirty-four-year-old ringleader laundered illicit Medicare proceeds through a series of shell corporations and a phony medical clinic. The defendants’ fraudulent claims involved medical equipment and expensive HIV treatments and related medications. One distasteful aspect of these crimes was the operation of an HIV clinic that recruited and paid patients to receive injections of a saline solution from recycled medication bottles. In reality, these individuals appeared to be “rent-a-patients” who knowingly received treatments—in this case injections—that they did not need. The defendants were also charged with conspiracy as well as perjury and obstruction of justice for lying about their knowledge of the shell companies and for encouraging witnesses to lie to federal agents and to a federal grand jury.

Under the Bank Secrecy Act of 1970 bank officials must file a currency transaction report when customers make cash deposits or withdrawals in excess of
$10,000 per transaction as well as when customers purchase money orders, cashier’s checks, or traveler’s checks in excess of $3,000 per transaction.\(^4\) This requirement is supposed to help track illegal transactions. Of course, all good thieves learn quickly how to outsmart the latest legislation so, in response, money launderers quickly developed tactics known as “structuring” to avoid detection under the Bank Secrecy Act. For example, by making multiple deposits of slightly less than $10,000 among several local banks, money launderers structure their transactions to avoid triggering a currency transaction report.

In 1986 Congress countered by passing the Money Laundering Control Act, which makes it a crime to structure cash transactions to sidestep filing a currency transaction report. Under the Money Laundering Control Act, banks are expected to file a suspicious activity report if officials believe an individual or group is laundering money. The IRS provides the following examples of situations that might trigger the filing of a suspicious activity report: “A customer pays for products or services using musty bills having an unusual chemical-like odor”; “A 16-year old, riding a bicycle, brings bags of cash to a money transmitter to transfer [funds] from New York to Miami”; “A customer, a retired CPA, frequently sends and receives money transfers of more than $2,000 to and from many different people”; and “A customer conducting an $11,000 cash transaction attempts to bribe an MSB [money services business] employee not to file a Currency Transaction Report.”\(^4\) Bank personnel who willfully fail to file reports in compliance with these laws may face felony charges.

The George W. Bush administration passed additional anti-money-laundering legislation directed primarily at terrorist and drug-trafficking activities. But these measures will also hamstring white-collar criminals. Unfortunately, cyber-laundering will probably continue to grow because of the ubiquity of electronic banking and because of the growth of multinational enterprises, international travel and migration, and transnational criminal organizations.

**Tax Crimes**

Money-laundering schemes are developed, in part, to help criminals evade taxes, so it is hardly surprising that tax crimes go hand in hand with money laundering. Individuals being investigated for object crimes such as health care fraud may also be subject to prosecution for tax crimes. Conversely, when tax crimes are the object of investigators, evidence may surface that the suspect has committed other white-collar crimes such as health care fraud.

The three categories of tax offenses are tax evasion, filing a false income tax return, and failure to file a tax return.\(^5\) Evading taxes is a felony, and federal prosecutors use charges of tax evasion as a favorite weapon in their fight against white-collar crime.\(^5\) A general practitioner in a small town who is participating
in a Medicare fraud conspiracy or a pharmacist who is part of a pill-mill scheme might be hard-pressed to explain their high incomes to the IRS or FBI, so they fail to report it, which means they are tax evaders.

White-collar criminals also frequently evade taxes by shifting income and expense deductions between their personal and business endeavors. Health care professionals with separate businesses may take illegal deductions on their corporate tax returns for personal business trips or for home renovations. In addition to income tax evasion, white-collar offenders may be charged with evading sales or property taxes on expensive items purchased with the proceeds from criminal activities.

A person may be charged with filing a false tax return even though the falsification creates no financial loss to the government. A health care provider may pay her fair share of taxes but conceal illegal business interests by misidentifying sources of income on her tax return. Making false statements on a tax return and misleading the government in its taxation efforts is a felony.

Failure to file a federal tax return is a misdemeanor. Such cases usually entail failing to file and pay taxes in a timely fashion, maintaining inadequate tax records, or missing a tax deadline. Some people who fail to file income tax returns are tax protesters. Misdemeanor charges carry a jail sentence of no more than one year. The fines for failing to file a timely tax return, however, may be substantial. These fines include failure-to-file penalties of up to 25 percent of unpaid taxes as well as the loss of any refunds due.52

White-collar criminals who engage in health care fraud may appear respectable, but they may call attention to themselves by living beyond their apparent means (e.g., a general practitioner who practices medicine in a small Midwestern town, lives in a $15 million home, owns luxury European automobiles, and takes frequent vacations to posh resorts). Other white-collar criminals may be deviously deft at maintaining a low profile by hiding major assets such as airplanes, boats, or real estate. As their frauds begin to unravel, however, law enforcement or the tax authorities may use forensic accountants to dig into a criminal's financial affairs.

The goal of forensic accounting is to determine what portion of a person's income came from legal sources and what portion came from illegal sources.53 Forensic accountants have the tedious job of sifting through bank statements, checkbooks, investment portfolios, credit card receipts, and other documents as they try to reconstruct the suspect's financial transactions. The amount of income deemed by forensic accountants to have been derived from illegal sources may then be used as the basis for RICO Act and tax-evasion charges.

When separating legal from illegal income, forensic accountants take one of two approaches. Using what is known as the net worth method, they may track shifts in a person's net worth by measuring changes in their assets and liabilities. Net worth increases are measured against the suspect's income from legal sources to estimate income from illegal sources. This method is applied to suspects whose
lifestyles appear to be stable (e.g., they have a permanent address, bank and credit card accounts, memberships in church or civic organizations—often pillars in their communities). Many, if not most, health care fraud perpetrators—hospital executives, physicians, attorneys, and pharmacists—fall into the “stable” category.

A second approach—the expenditure method—tracks a suspect’s cash expenditures over a period of time, and it is directed at transient individuals who have few family or community ties and live “fast and loose,” spending their illegal proceeds quickly and carelessly. With the expenditure method, forensic accountants compare a suspect’s income from known legal sources with his or her total expenditures. When the suspect’s expenditures exceed income from legal sources, the difference is assumed to be income from illegal sources.

### Lying, Perjury, and Obstruction of Justice

When law enforcement officers arrive at the door, many perpetrators initially deny knowledge or responsibility for criminal acts. Later, during the investigation or during court proceedings, a defendant may mislead investigators, intimidate potential witnesses, or lie under oath. By trying to cover up their crimes, persons accused of health care fraud may face additional criminal charges.

If someone “knowingly and willfully” lies about material matters made within the jurisdiction of the U.S. federal government, then they have committed a criminal offense under the False Statements Accountability Act (1996). The term “material” refers to any statement having the potential to influence the decision of a government official. This statute has been broadly defined to include both lies of commission (e.g., lying about the treatment provided to a patient) and lies of omission (e.g., concealing the fact one has been banned from a federal health care program).

Anyone who has ever watched Law and Order or other television crime shows knows that you risk perjury charges when you lie under oath during a court, grand jury, or ancillary proceeding. Prosecutors often find it difficult to make a perjury charge stick because the defendant must knowingly and willfully make a false statement about a material fact. Lying under oath about one’s age, for example, is not perjury unless age is material to the testimony. Similarly, absent proof of an intentional deception, a mistaken answer or a lapse of memory during testimony does not constitute perjury. To support a perjury conviction, one witness along with corroborating evidence must show that the testimony was intentionally false and deceptive (the two-witness rule). In some instances, a witness may recant a statement to avoid charges of perjury. Furthermore, an individual can be charged with subornation of perjury if he or she tries to persuade another person to commit perjury.

Obstruction of justice occurs when a defendant interferes with the administration of a judicial, legislative, or administrative proceeding. It might include a
perpetrator’s altering, defacing, or falsifying records, creating false documents to support a fraudulent activity, withholding or destroying documents, denying the existence of documents, or erasing computer files. Obstruction of justice might also include interfering with an agency investigation or a federal audit, threatening or intimidating witnesses, retaliating against witnesses or informants, or attempting to influence jurors or other court officials.59 As an inchoate crime, there is no requirement for the obstruction to have actually taken place.

One tragic instance of obstruction of justice was the murder of an Illinois grand jury witness days before she was scheduled to testify against an Evanston, Illinois, podiatrist. The podiatrist was accused of billing Medicare for foot surgeries he never performed (over six thousand surgeries, netting him over $1.2 million). His ludicrous Medicare billings included 117 phony foot surgeries on a seventy-four-year-old woman who, on learning of this fraud at his trial, remarked: “One hundred seventeen? Wow. I wouldn't be able to walk.” The podiatrist also paid kickbacks to patients and their families in exchange for allowing him to use their Social Security numbers to file false claims.

The podiatrist was sentenced to seventy-eight months in prison for health care fraud, ordered to pay $1.8 million in restitution, and sentenced to death for the woman’s murder.60 At his capital murder sentencing, the fifty-seven-year-old fraudster and murderer, who had remained silent throughout the legal proceedings against him, said in a strong voice to U.S. Federal District Court Judge Ronald Guzman that he did not kill the woman who was scheduled to testify against him. But he was found guilty of invading the disabled nurse’s residence and, at point-blank range, shooting her to death as she sat in her garden. The podiatrist then tried to pin the murder on a gang that frequented the woman’s neighborhood.61 Citing the doctor's mental health problems and drug abuse, his attorneys argued that his death sentence was too severe. He remains, however, on death row at a federal prison in Terre Haute, Indiana.62

The facilitating crimes described here often take center stage in white-collar criminal proceedings. These crimes—conspiracy, mail and wire fraud, money laundering, tax evasion, and perjury—are important prosecutorial weapons in health care fraud cases. In cases where health care fraudsters are habitual criminals, the RICO Act may be used by prosecutors.

The next chapter deals with federal laws—the antikickback, self-referral, HIPAA, and food and drug laws—that were enacted specifically to attack health care fraud and abuse. The false-claims statutes, resurrected after decades of disuse, are also discussed.