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FRAUD BY FRIGHT: WHITE COLLAR CRIME BY HEALTH CARE PROVIDERS†

PAMELA H. BUCY‡

Fraud by health care providers is one of the most deleterious of all white collar crimes. It is also one of the most difficult to prosecute. In her Article, Professor Bucy compares fraud by health care providers with other types of white collar crime and analyzes the theories of fraud historically used to prosecute health care providers. She concludes that the strongest theory—prosecution for providing unnecessary or substandard health care—is the theory that has been used the least. Professor Bucy suggests ways for prosecutors to use this theory more often and more effectively in order to combat a problem that ravishes human dignity and personal health as well as the national pocketbook.

"I will apply measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice."

Portion of Oath of Hippocrates, Sixth Century B.C.— First Century A.D.; currently administered by many medical schools to graduating medical students.¹

"[I] could make a million dollars out of the suckers"

Statement of owner/operator of cancer clinics regarding cancer patients.²

I knew "if sufficient testing was not done the clinic would not be profitable." I ordered tests that were "not medically necessary. . . . I prostituted my medical license."

Statement of physician testifying as government witness.³

"It [is] fantastic that on some of these patients [I] only saw them once but [I] was submitting bills and reports reflecting numerous visits and treatments."

Statement of physician.⁴

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† One court in finding defendant, a physician, guilty of mail fraud stated: "defendant, with the intent of fraudulent deception, meant to frighten the supposed patient into parting with his money." *United States v. Smith*, 222 F. 165 (E.D. Pa. 1915).

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1. 4 ENCYCLOPEDIA OF BIOETHICS 1731 (1978).

2. *Baker v. United States*, 115 F.2d 533, 540 (8th Cir. 1940), cert. denied, 312 U.S. 695 (1941).

3. *United States v. Mahar*, 801 F.2d 1477, 1485 (6th Cir. 1986).

4. *United States v. Perez*, 489 F.2d 51, 76 (5th Cir. 1973).

Despite his altruistic admonition to physicians, Hippocrates was not naive. He also counseled new physicians that whatever houses they may visit, they should "come for the benefit of the sick, remaining free of all . . . mischief."⁵ A little Hippocratic realism may be appropriate. While the vast majority of health care providers⁶ are exemplary professionals, some are not. We cannot afford to ignore this fact. The cost to the public of the fraud, waste, and abuse by health care providers in the United States is an estimated \$45 billion per year.⁷ While criminal fraud does not account for this entire amount, criminal fraud by health care providers is a serious problem and diverts scarce health care resources.⁸ Moreover, because fraudulent health care providers are often incompetent health care providers,⁹ the harm suffered at their hands may be more than monetary.

A recent emphasis on fraud in health care by policy makers, law enforce-

5. 4 ENCYCLOPEDIA OF BIOETHICS, *supra* note 1, at 1731.

6. Health care providers include medical physicians, osteopathic physicians, chiropractors, podiatrists, nurses, physical and respiratory therapists, hospitals, emergency centers, nursing homes, home nursing associations, and durable medical equipment companies.

This Article does not address fraud by recipients or potential recipients of health care services as reflected in cases such as *United States v. Regner*, 677 F.2d 754 (9th Cir.) (insured attempted to defraud insurance company by misrepresenting facts surrounding automobile accident), *cert. denied*, 459 U.S. 911 (1982); *United States v. Williams*, 545 F.2d 47 (8th Cir. 1976) (insured failed to disclose that he had multiple insurance policies when he applied for another policy); *United States v. Pope*, 415 F.2d 685 (8th Cir. 1969) (insured falsified physician statements that he submitted to insurance company in support of claim), *cert. denied*, 397 U.S. 950 (1970).

7. In 1986 \$458.2 billion was spent on health care expenditures in the United States, BUREAU OF THE CENSUS, U.S. DEPT. OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 1988, at 86 (108th ed. 1988) [hereinafter STATISTICAL ABSTRACT 1988]. Many commentators familiar with medical fraud estimate that ten percent of our health care costs are caused by fraud. *See, e.g., Medicare and Medicaid Fraud: Hearing Before the Subcomm. on Health of the Senate Comm. on Finance*, 96th Cong., 2d Sess. 6 (1980) [hereinafter *Medicare and Medicaid Fraud: Hearing Before Senate Comm. on Finance*] (statement of Oliver B. Revell, Assistant Director, Chief of Criminal Investigative Division, Federal Bureau of Investigation); *Medicare and Medicaid Fraud: Hearing Before the Subcomm. on Health & Long-Term Care of the House Select Comm. on Aging*, 96th Cong., 2d Sess. 1-2 (1980) [hereinafter *Medicaid and Medicare Fraud: Hearing Before House Comm. on Aging*] (opening statement of Chairman Claude Pepper); *Medicare and Medicaid Frauds: Hearing Before the Subcomm. on Health and Long-Term Care of the Senate Special Comm. on Aging*, Pt. 5, 94th Cong., 2d Sess. 534 (1976) [hereinafter *Medicare and Medicaid Frauds: Hearing Before the Senate Comm. on Aging*, Pt. 5] (statement of Frank E. Moss, D., Utah); *House Select Comm. on Aging*, 97th Cong., 2d Sess., *Medicaid Fraud: A Case History in the Failure of State Enforcement III* (Comm. Print 1982) [hereinafter *Medicaid Fraud Case History*]. *But see Oversight of HHS Inspector General's Effort to Combat Fraud, Waste and Abuse: Joint Hearing Before the Senate Comm. on Finance and Senate Select Comm. on Aging*, 97th Cong., 1st Sess. 133 (1981) [hereinafter *Oversight*]. In a 1977 report the Health and Human Services Inspector General estimated losses between \$5.5 to \$6.5 billion to Medicare and Medicaid that were attributable to fraud, waste, and abuse. *Id.* With health care expenditures in 1977 at \$169.9 billion, STATISTICAL ABSTRACT 1988, *supra*, at 86, this estimate represents approximately three to four percent of total expenditures. This estimate, however, covers only fraud, waste, and abuse in governmental programs; it does not encompass fraud, waste, and abuse in private industry. *See Oversight*, *supra*, at 136.

8. *Oversight*, *supra* note 7, at 133.

9. *See, e.g., Medicare and Medicaid Frauds: Hearing Before the Senate Special Comm. on Finance*, Pt. 5, *supra* note 7, at 525 ("[There is] rampant fraud, abuse and maladministration in the Medicaid program and a pattern of reprehensible exploitation of the sick and poor not to mention the taxpayer who is paying the bill.") (statement by Senator Charles H. Percy); *Medicare & Medicaid Frauds: Hearing Before the Subcomm. on Long-Term Care of the Senate Special Comm. on Aging*, Pt. 6, 94th Cong., 2d Sess. 686-87 (1976) [hereinafter *Medicare and Medicaid Frauds: Hearing Before the Senate Comm. on Aging*, Pt. 6] (statements of Nancy Kurke, M.D., staff physician at a Medicaid clinic); *see infra* text accompanying notes 537-57.

ment officials, and private industry¹⁰ has had dramatic ramifications for many in the health care industry. Nevertheless, the academic literature has virtually ignored this area of the law.¹¹ As one seasoned health care fraud investigator stated "[Y]ou have to have guts . . . There is no body of law or procedure and you are . . . going out in an area relatively unexplored."¹² A legal synthesis and

10. Beginning in the 1970s, numerous congressional committees actively investigated fraud in health care. The Senate Committee on Aging alone held over fifty such hearings. *Medicaid Fraud Case History*, *supra* note 7, at 8-9, 14-15 nn.1-8. In response to testimony and evidence consistently indicating that the health care industry was "fraught with fraud," *id.* at III (remarks of Chairman Claude Pepper), Congress created an office in 1976 within the Department of Health and Human Services (HHS) vested solely with the responsibility to conduct a coordinated attack on fraud by health care providers. Pub. L. No. 94-505, 90 Stat. 2429 (1976). In 1972, 1977, 1980, 1981, 1986, and 1987 Congress passed and signed into law anti-health-care fraud and abuse bills. The 1972 Act established criminal penalties for certain types of fraud by health care providers and gave the Secretary of the Department of Health and Human Services (formerly HEW) authority to suspend Medicare payments to providers found to have abused the program. Pub. L. No. 94-603, § 1632, 86 Stat. 1329, 1478 (1972). The 1977 act strengthened the criminal sanctions for Medicare and Medicaid program violations and provided federal funds to the states to establish and operate Medicaid fraud detection units. Pub. L. No. 95-142, §§ 1877, 1909, 91 Stat. 1175, 1180-81 (1977). The Omnibus Budget Reconciliation Act of 1980 extended the federal funding for state Medicaid fraud detection units to expanded categories of providers who could be excluded from the Medicare program if found to abuse the program. Pub. L. No. 96-499, 94 Stat. 2599 (1980) (codified at 42 U.S.C. §§ 1753-1788 (1982)). The Omnibus Budget Reconciliation Act of 1981 authorized the imposition of a civil monetary penalty up to \$2,000 for fraudulent Medicare and Medicaid claims and prohibited providers convicted of filing fraudulent Medicare and Medicaid claims from filing future Medicare claims for reimbursement. Pub. L. No. 97-35, 95 Stat. 357 (1981). The Omnibus Budget Reconciliation Act of 1986 created civil penalties for certain physician incentive payment plans and clarified the basis on which convicted providers may be excluded from Medicare. Pub. L. 99-509, § 9313, 100 Stat. 1874, 2003 (1986). The Omnibus Budget Reconciliation Act of 1987 created civil penalties for providers who fail to provide necessary services for patients. Pub. L. No. 100-203, § 4014, 101 Stat. 1330, 1330-61 to -62 (1987). The Department of Justice designated prosecution of fraudulent health care providers as one of its top priorities in the Carter administration, *Fraud and Racketeering in Medicare and Medicaid: Hearing Before the House Select Comm. on Aging*, 95th Cong., 2d Sess. 11 (1978) [hereinafter *Fraud and Racketeering*] (testimony of United States Attorney General Griffin B. Bell), and reaffirmed this commitment in the Reagan administration. *White Collar Crime (E.F. Hutton): Hearing Before the Senate Comm. on the Judiciary*, Pt. 3, 99th Cong., 2d Sess. 11 (1986) [hereinafter *White Collar Crime*, Pt. 3] (statement of Stephen S. Trott, Assistant Attorney General, Criminal Division, Department of Justice). Numerous states have also begun aggressively to pursue fraudulent health care providers, through both criminal and civil actions. As of September 1986, 38 states had formed investigative units that focus solely on fraud in Medicaid programs. UNITED STATES GENERAL ACCOUNTING OFFICE, FACT SHEET FOR THE CHAIRMAN, SUBCOMM. ON INTERGOVERNMENTAL RELATIONS AND HUMAN RESOURCES, COMM ON GOVERNMENT OPERATIONS, HOUSE OF REPRESENTATIVES MEDICAID: RESULTS OF CERTIFIED FRAUD CONTROL UNITS, H.R. DOC. NO. 87-12FS, 100th Cong., 1st Sess. 6 (1987). Private insurance companies have established fraud detection units staffed with experienced fraud investigators. These units have recovered millions of dollars in fraudulently obtained reimbursement through such tactics as lawsuits against fraudulent providers, recoupment of payments obtained by fraud, and subscriber hot lines. *Medical Benefits*, MED. ECON. D., May 15, 1987, at 3. Private insurance companies have joined with the government to establish a computerized network to pool data on claims filed by health care providers. According to its founders, this network was created because of "the rising concern about those [providers] who fabricate diagnoses, misuse billing codes and use other ploys to increase the payments they or their patients receive from insurance companies and Government programs." N.Y. Times, Dec. 3, 1987, at B20, col. 3.

11. For example, none of the following symposia on legal issues in health care addresses fraud by providers: 17 CUMBERLAND L. REV. 293 (1986-87); 3 NOTRE DAME J.L. ETHICS & PUB. POL'Y 1 (1988); *Special Health Law Issue*, 26 Hous. L. Rev. 1 (1989); *Special Issue: Health Law*, 25 Hous. L. Rev. 471 (1988); *Special Symposium: Market-Oriented Approaches to Achieving Health Policy Goals*, 34 VAND. L. REV. 849 (1981). In the Health Care Symposium sponsored by the *Kentucky Law Journal*, 75 KY. L.J. 439 (1986-87), one student Comment out of seven Articles and Comments addressed this issue.

12. *Medicare and Medicaid Frauds: Joint Hearing Before the Subcomm. on Long-Term Care*

overview is imperative.

This Article examines fraud by health care providers. Part I traces economic and social development of the American health care profession; an understanding of this development is crucial to a thorough analysis of the commission, detection, and prosecution of fraud by health care providers.¹³ The most relevant economic development in this century has been an evolution of the mechanisms by which health care providers are reimbursed. In the twentieth century, third-party fee-for-service reimbursement has expanded. Fueled by concerns over escalating costs, however, critics have attacked this reimbursement mechanism and the remainder of the twentieth century will likely be consumed by efforts to modify and replace it. The major social development that characterizes twentieth century medicine, and which affects the prosecution of fraudulent providers, has been a change in the public's attitude toward health. Skepticism in the early twentieth century was replaced by an almost blind faith that money can buy good health; a distrustful disdain for physicians and hospitals was supplanted by reverent deference to these individuals and institutions. This blind faith and deference may be on the wane, however, as cost-conscious Americans raise the question: Are we getting our money's worth for our health dollars?

Part II discusses the general characteristics of fraud by health care providers as compared with other white collar crimes. Like all white collar crimes, fraud by health care providers is difficult to investigate and prove and therefore it is essential to develop a "theory of the case" that is built upon certain analytical steps. Also, like other white collar crimes, fraud by health care providers can be pursued civilly. Because of this the theoretical and practical problems encountered by the criminal prosecutor and the civil plaintiff will be similar. Moreover, the existence of civil remedies complicates the exercise of prosecutorial discretion and can affect the criminal trial. Although it shares these features with other white collar crimes, the prosecution of fraud by health care providers is unique because it is affected by certain features idiosyncratic to the health care industry; the ambiguous and emotional nature of medicine, the deference to physicians, the complex regulatory scheme that engulfs the health care industry, and the small dollar amount involved in the typical health care transaction.

Part III discusses the theories under which health care provider fraud historically has been prosecuted. This discussion is based upon an analysis of reported federal and state prosecutions of health care providers and upon review of hundreds of unreported prosecutions.¹⁴ Despite the large number of possible

and the Subcomm. on Health of the Elderly of the Senate Special Comm. on Aging, Pt. 1, 94th Cong., 1st Sess. 29 (1975) [hereinafter *Medicare and Medicaid Frauds: Joint Hearing Before the Senate Comm. on Aging, Pt. 1*] (testimony of Paul M. Allen, Chief Deputy Director, Michigan Dept. of Social Services).

13. By far the most significant twentieth century developments in medicine are the scientific advances that have provided control over many diseases. J. BORDLEY & A. HARVEY, *TWO CENTURIES OF AMERICAN MEDICINE* 751, 753-56 (1976). This Article does not attempt to discuss these developments. They are noted only to the extent that they have affected the socioeconomic development of health care, which in turn has influenced fraudulent behavior by providers.

14. The unreported cases reviewed include grand jury investigations conducted and cases tried

prosecuting sovereignties, the various statutory authorities charged, and the many types of providers prosecuted, health care fraud prosecutors have relied on a limited number of theories. This Article identifies and describes these theories, assesses their relative effectiveness, and describes the type of evidence needed to prove each theory. One of the more significant differences among these theories is who they identify as the victim of the fraud. Most of the theories identify the insurer, which paid for the services, as the victim of the fraud. Only one theory, which has limited applicability, has consistently identified the patient as a victim of a provider's fraud. Part III explains why it is important to identify and prove that patients are victims of a provider's fraud and how to do so.

Part IV addresses the future. The dramatic socioeconomic upheaval that the health care industry is experiencing will affect fraud by providers. Some of the theories of fraud discussed in Part III will cease to exist, others will continue in old and new ways. Part IV suggests what these changes will be and what they mean for future criminal and civil actions.

I. THE ECONOMIC AND SOCIAL DEVELOPMENT OF THE AMERICAN HEALTH CARE INDUSTRY

A. Introduction

The economic structure of the health care industry is unlike that of any other industry in the American economy because it is peculiarly immune to market forces.¹⁵ When market forces dominate, suppliers of goods or services profit by obtaining and using resources efficiently and pricing their product below competitors.¹⁶ For market forces to perform optimally, consumers must be sufficiently well informed to decide what goods or services they wish to purchase.¹⁷

by the author during seven years of service as an Assistant United States Attorney, and review of congressional hearings and government publications. Particularly helpful in discussing specific instances of fraud were the semiannual reports to Congress by the Department of Health and Human Services, Office of the Inspector General and the transcripts of the following congressional hearings: *Program Fraud Civil Penalties Act of 1983: Hearing Before the Senate Comm. on Governmental Affairs*, 98th Cong., 1st Sess. 19-20 (1983) [hereinafter *Program Fraud*]; *Fraudulent Medical and Insurance Promotions: Cleveland, Ohio: Hearing Before the Subcomm. on Health and Long-Term Care of the House Select Comm. on Aging*, 97th Cong., 2d Sess. 13-15 (1982) [hereinafter *Fraudulent Medical and Insurance Promotions*]; *Oversight*, *supra* note 7, at 5; *Fraud and Racketeering*, *supra* note 10, at 41-44; *Medicare and Medicaid Frauds: Hearing Before the Senate Special Comm. on Aging*, Pt. 9, 95th Cong., 1st Sess. 1105-31 (1977) [hereinafter *Medicare and Medicaid Frauds: Hearing Before the Senate Special Comm. on Aging*, Pt. 9]; *Medicare and Medicaid Frauds: Hearing Before the Senate Special Comm. on Aging*, Pt. 8, 95th Cong., 1st Sess. 822-60 (1977) [hereinafter *Medicare and Medicaid Frauds: Hearing Before the Senate Special Comm. on Aging*, Pt. 8]; *Medicare and Medicaid Frauds: Hearing Before the Senate Special Comm. on Aging*, Pt. 7, 94th Cong., 2d Sess. 760-64, 787 (1976) [hereinafter *Medicare and Medicaid Frauds: Hearing Before the Senate Special Comm. on Aging*, Pt. 7]; *Medicare and Medicaid Frauds: Joint Hearing Before the Senate Comm. on Aging*, Pt. 1, *supra* note 12, at 16, 22-24, 58-128; *Medicare and Medicaid Frauds: Hearing Before the Subcomm. on Long-Term Care of the Senate Special Comm. on Aging*, Pt. 2, 94th Cong., 2d Sess. 255-61 (1975).

15. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, AM. ECON. REV. 941 (1963); Clark, *The Question of Costs*, in MEDICAL CARE IN THE UNITED STATES 40 (E. Oatman ed. 1978) (statement of John J. O'Connell, a vice-president of Bethlehem Steel).

16. E. GINZBURG, LIMITS OF HEALTH CARE REFORM: THE SEARCH FOR REALISM 45 (1977).

17. See Blumstein & Sloan, *Redefining Government's Role in Health Care: Is a Dose of Compe-*

According to traditional economic theory, when market forces are able to function in an optimal setting, increasing the supply of goods or services decreases the price and, conversely, increasing the price of goods or services decreases the demand.¹⁸ In the health care industry, however, these laws of supply and demand have not worked. As the supply of health care services has increased so has the price and, despite increasing prices, the demand for health care services has not decreased but has escalated tremendously.¹⁹

This aberrational economic behavior is due to several factors. First, the commodity at issue is health, not widgets, and the consumer's appetite for better health, unlike its appetite for widgets, is apparently insatiable.²⁰

A second reason suggested for this aberrational economic behavior is that consumers are rarely well informed about medicine and when it comes to their own or their family's health are unwilling to make judgments about what is or is not a necessary expenditure.²¹ Thus, consumers abdicate their decisionmaking authority to the provider of health care services.²² This provider is usually a physician who will determine whether health services are necessary.²³ Because in the health care industry the provider of services historically has profited as demand increases, there has been no monetary incentive for the provider to control demand.²⁴

By far the most significant reason the health care industry fails to comply with the market forces is the third-party payer reimbursement mechanism.²⁵ Under this mechanism a third-party to the provider-patient relationship, namely

tion *What the Doctor Ordered?*, 34 VAND. L. REV. 849, 902 (1981); see also P. STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 23 (1982) (stressing the independence of buyers and sellers in an optimally efficient market).

18. Feldstein, *The High Cost of Hospitals and What to Do About It*, 48 PUB. INTEREST 40, 43-44 (1977).

19. Friedman & Rakoff, *Health, Health Costs and Public Policy*, in TOWARD A NATIONAL HEALTH POLICY 11 (1977).

20. "[T]he elemental fact is that medical care is about living and dying, something considered by many to be of a rather different character from the purchase of tomatoes." Vladeck, *The Market vs. Regulation: The Case For Regulation*, 59 MILBANK MEMORIAL FUND Q. 209, 211 (1981). The "commodity" sought from a physician is information that is unlike commodities in the competitive market model. The demand for medical services is irregular and unpredictable. Arrow, *supra* note 15, at 948-49.

21. Arrow, *supra* note 15, at 951.

22. *Medicare in Florida: Looking to the Future: Hearing Before the House Select Comm. on Aging*, 98th Cong., 1st Sess. 19 (1983) [hereinafter *Medicare in Florida*] (statement of Hyman Ruchlis, Health Action Comm., Florida Consumers Federation); Clark, *supra* note 15, at 40.

23. Bovbjerg, *Competition Versus Regulation in Medical Care: An Overdrawn Dichotomy*, 34 VAND. L. REV. 965, 967 (1981).

24. Helms, *Towards an Understanding of the Health Delivery Concept*, in HEALTH CARE DELIVERY SYSTEMS IN NORTH AMERICA: THE CHANGING CONCEPTS 48 (J. Murray ed. 1976).

25. See *The Health Care Cost Containment Act: Hearing Before the Senate Committee on the Judiciary*, 98th Cong., 2d Sess. 48 (1984) [hereinafter *Health Care Cost Containment Act*] (statement of Charles F. Rule, United States Deputy Assistant Attorney General, Antitrust Division, Department of Justice); THE AMERICAN ENTERPRISE INSTITUTE FOR PUBLIC POLICY RESEARCH, *RIISING HEALTH COSTS: PUBLIC & PRIVATE RESPONSES* 8 (quoting former Congressman David Stockman) ("[T]hird party insurance that pays for health and hospital care for most Americans is the heart of the system and is particularly perverse because it encourages people to behave in non-economic ways."); R. FEIN, *MEDICAL CARE, MEDICAL COSTS* 168 (1986); Arrow, *supra* note 15, at 962; Blumstein & Sloan, *supra* note 17, at 856-57; Feldstein, *supra* note 18, at 43; Friedman & Rakoff, *supra* note 19, at 12-13; Helms, *supra* note 24, at 48.

an insurance company, pays for health care services. This third-party reimbursement mechanism "affect[s] the behavior of the demanders and suppliers in medical markets."²⁶ Because "individual consumers tend not to worry about the true cost of the resources they are using . . . [and] . . . physicians and hospitals assume that their expenses will be covered by the third-party payers . . . when a third-party is paying the bill, the other two parties have weak incentives to be concerned about cost."²⁷

Compounding this effect on cost is the fee-for-service method of calculating payment that has been perpetuated by third-party payers.²⁸ This method of calculating reimbursement pays the provider per service and reimburses the provider based upon the provider's cost. Under this method, the more services performed and the greater the cost that the provider can justify, the more the provider is reimbursed.²⁹

These characteristics, the nature of the health commodity, the common deference to health care providers, and the third-party payer fee-for-service reimbursement mechanism, render the health care industry immune to market forces. They also directly affect fraud by health care providers. All three characteristics developed in the twentieth century.

B. *Historical Development*

In nineteenth century America most medical care was rendered at home by lay persons.³⁰ Physicians had little, if any, formal training,³¹ and there were virtually no professional licensing requirements.³² Crude medical techniques such as bloodletting and leeches were the dominant methods of medicine and had little therapeutic value.³³ Because this was the extent of medical professional knowledge and training, most people thought that "professional knowledge and training were unneeded in treating most diseases."³⁴ Demand for

26. Helms, *supra* note 24, at 48.

27. Helms, *supra* note 24, at 48.

28. *Health Care Cost Containment Act*, *supra* note 25, at 75 (statement of Joseph H. Reese of the Health Insurance Association of America); Bovbjerg, *supra* note 23, at 970.

29. *Medicare in Florida*, *supra* note 22, at 18 (statement of Hyman Ruchlis, Health Action Comm., Florida Consumers Federation); Jost, *The Necessary and Proper Role of Regulation To Assure the Quality of Health Care*, 25 HOUS. L. REV. 525, 526 (May, 1988); Bovbjerg, *supra* note 23, at 970.

30. P. STARR, *supra* note 17, at 22, 31. Starr's book is an exceptional work on the history of American medicine.

31. C. ROSENBERG, *THE CARE OF STRANGERS: THE RISE OF AMERICA'S HOSPITAL SYSTEM* 18 (1987); P. STARR, *supra* note 17, at 43, 48-49. Rosenberg's work is a fascinating account of the evolution of the hospital as an institution.

32. J. DUFFY, *THE HEALERS: A HISTORY OF AMERICAN MEDICINE* 291-94 (1979); P. STARR, *supra* note 17, at 44, 53.

33. See J. HALLER, *AMERICAN MEDICINE IN TRANSITION, 1840-1910*, at 236-66 (presenting the history of bloodletting as a medical treatment and giving detailed description of techniques employed); C. ROSENBERG, *supra* note 31, at 55 (referring to the "costly" leeches used to draw blood), at 74 (the physician could assure he was "acting in the imitation of nature . . . [because] 'bloodletting and blisters find their archetypes in spontaneous hemorrhage.'" (quoting Address by E. Haskins, Tennessee Medical Society (1887))); P. STARR, *supra* note 17, at 34.

34. P. STARR, *supra* note 17, at 33.

medical services was low and most physicians earned a meager living,³⁵ generally supplemented by a second occupation. Most often the second occupation was farming or operating a drug store, although "[o]ne historian records a doctor who, 'not satisfied with his practice, robbed stagecoaches on the side', . . . was captured in 1855 and sent to prison."³⁶ During this time the demand for hospitals was also low. Because of their rudimentary knowledge of or appreciation for hygiene, hospitals were unsanitary and dangerous places. Few people went to hospitals if they had a choice. As Paul Starr explained: "Hospitals were regarded with dread and rightly so. They were dangerous places; when sick, people were safer at home. The few who became patients went into hospitals because . . . [they] were unlucky enough to fall sick without family, friends or servants to care for them."³⁷

The nineteenth century health care industry was more susceptible to market forces than the health care industry of today because the recipient of the health care services, the patient, paid for those services and thus regulated their demand and price. A market controlled by the patient was disadvantageous for physicians and hospitals for two reasons: the demand for their services was minimal, and patients were unable to pay their bills. The lack of demand stemmed from American attitudes and the cost of health services. The self-reliance that developed from frontier living,³⁸ along with the lack of respect for the health care profession and its claimed expertise, provided little incentive to seek a health care professional's services. Substantial financial disincentives also existed, including the direct cost of seeking health care services, such as the doctor or hospital bill, and the indirect costs of transportation and time lost from work.³⁹ Thus, at the point when market forces affected health care, the patient had philosophical and financial incentives not to use professional health care services. During this period providers had substantial problems collecting bad debts.⁴⁰ The patients, being solely responsible for the payment of any health care services they received, were often unable to pay for these services. If charity did not cover the bill, it was not paid.

The early twentieth century saw profound changes in medicine. Improved hospital hygiene and the advent of antiseptic surgery made hospitals safer.⁴¹ Industrialization separated the work place from the home, which made care for the sick at home more difficult.⁴² Urbanization, paved roads, and the emergence of automobiles made transportation to the health care provider less onerous.⁴³

35. J. DUFFY, *supra* note 32, at 297; P. STARR, *supra* note 17, at 60.

36. P. STARR, *supra* note 17, at 65 (quoting H. SOMERS, DOCTORS, PATIENTS AND HEALTH INSURANCE 548 (1961)).

37. P. STARR, *supra* note 17, at 72; *see also* C. ROSENBERG, *supra* note 31, at 15-16 (explicit and detailed explanation of why people preferred not go to hospitals).

38. P. STARR, *supra* note 17, at 66.

39. P. STARR, *supra* note 17, at 66.

40. P. STARR, *supra* note 17, at 63.

41. C. ROSENBERG, *supra* note 31, at 144-48; P. STARR, *supra* note 17, at 75.

42. P. STARR, *supra* note 17, at 74.

43. J. BORDLEY & A. HARVEY, *supra* note 13, at 105; P. STARR, *supra* note 17, at 68-70.

Antibiotics,⁴⁴ improved diagnostic skills and therapeutic competence,⁴⁵ the establishment of medical schools,⁴⁶ and licensing of physicians⁴⁷ improved public perception of the ability, skills, and prestige of physicians. By 1934 the average net earnings of physicians was four times the average earnings of gainfully employed workers, and medicine ranked as the most prestigious occupation in America.⁴⁸ Increased demand for medical services and increased costs of those services led to support for health insurance. Its proponents argued "that [insurance] would make more predictable and manageable the uncertain and sometimes devastating costs of medical care to individuals."⁴⁹ The first health insurance was introduced in the late 1800s. It was sponsored by individual employers, labor unions, fraternal orders, and consumer groups⁵⁰ and consisted of a contract with physicians who were paid a set amount to treat plan members. These plans were not successful because the medical profession opposed them,⁵¹ they were unavailable to the general public,⁵² and the employer or plan originator controlled the choice of provider.⁵³ Because they were concerned about losing their professional autonomy, physicians resisted health insurance even though unpaid bills led to some economic instability.⁵⁴

The 1929 Depression persuaded most people (including physicians) to support health insurance. Collection of bad debts had become a major problem for physicians during the Depression. People paid their bills to department stores, grocery stores, landlords, and dentists before they paid their doctor bills. Sixty-six percent of physician bills were not paid in 1933.⁵⁵ In addition, the demand for health care services decreased dramatically during the Depression.⁵⁶ Patients saw health insurance as a way to obtain needed health services. Physicians saw health insurance as a way to stimulate use of health care services as well as to help patients pay their bills.⁵⁷ Thus, private health insurance was developed.

The dominant form of health insurance was third-party indemnity.⁵⁸ Patients could see any physician they wished and stay in any hospital their physician chose. Their expenses, or a portion of their expenses, were covered by a

44. E. ACKERKNECHT, *SHORT HISTORY OF MEDICINE* 228-29 (1968); P. STARR, *supra* note 17, at 232; Brockbank & Brockbank, *Pneumonia*, in *THE HISTORY AND CONQUEST OF COMMON DISEASES* 96-97 (W. Belt ed. 1954).

45. E. ACKERKNECHT, *supra* note 44, at 229-30, 236-37; C. ROSENBERG, *supra* note 31, at 288-89; P. STARR, *supra* note 17, at 142.

46. J. DUFFY, *supra* note 32, at 262-70; P. STARR, *supra* note 17, at 122-23.

47. R. DERBYSHIRE, *MEDICAL LICENSURE IN THE UNITED STATES* 8-9 (1969); P. STARR, *supra* note 17, at 104-12, 127.

48. P. STARR, *supra* note 17, at 143.

49. P. STARR, *supra* note 17, at 258.

50. R. FEIN, *supra* note 25, at 12.

51. R. FEIN, *supra* note 25, at 12; P. STARR, *supra* note 17, at 205-06.

52. R. FEIN, *supra* note 25, at 12.

53. R. FEIN, *supra* note 25, at 12; P. STARR, *supra* note 17, at 202.

54. P. STARR, *supra* note 17, at 336.

55. P. STARR, *supra* note 17, at 270.

56. R. FEIN, *supra* note 25, at 13; P. STARR, *supra* note 17, at 295.

57. P. STARR, *supra* note 17, at 272.

58. See P. STARR, *supra* note 17, at 300, 331.

health insurer which was a third-party to the patient-provider relationship. The growth of third-party insurance was facilitated by the passage of special enabling statutes that allowed health and hospital insurance an exemption from the usual reserve requirement for insurance,⁵⁹ by court decisions that restricted the efforts of the American Medical Association to squash those health insurance plans of which it did not approve⁶⁰ and by the emergence of health insurance as the major issue in collective bargaining and an established benefit of employment.⁶¹ As health insurance developed, it utilized the fee-for-service method of determining the amount due to the provider.

In 1929, 3.5% of America's Gross National Product (GNP) went to health care expenditures.⁶² By 1960, 5.3% of America's GNP went to health care expenditures.⁶³ Clearly the expansion of health insurance "increased the share of national income going to health care and stabilized the financing of the whole industry."⁶⁴ There were concerns, however, over the inequitable distribution of health care that resulted from insurance. The elderly, unemployed, self-employed, and low-paid workers were left without health insurance.⁶⁵ In response to these concerns Medicare and Medicaid were signed into law in 1965.⁶⁶ Both programs further perpetuated the third-party payer reimbursement mechanism and the fee-for-service method of determining the amount of reimbursement. Under Medicare and Medicaid, hospitals were paid for each service rendered according to the "reasonable" cost of service rather than to a schedule of negotiated rates.⁶⁷ Physicians' fees were based upon "customary" charges for each service rendered.⁶⁸ It has been suggested that these restrictions have been easily manipulated to favor the health care industry because hospitals and physicians are motivated to increase their costs and charges each year merely to generate higher Medicare and Medicaid reimbursement.⁶⁹ The structure of these programs also introduced a third characteristic of twentieth century health care reimbursement: the assignment of claims. By agreeing to assignment a provider agrees to accept as payment in full whatever Medicare pays on the services that Medicare covers fully.⁷⁰ While the provider can, in some assignment cases, still

59. R. FEIN, *supra* note 25, at 17; P. STARR, *supra* note 17, at 297.

60. *See, e.g., American Medical Ass'n v. United States*, 317 U.S. 519, 536 (1943) (affirming restraint of trade convictions of American Medical Association for its efforts to prevent patronage of group health insurance plan).

61. R. FEIN, *supra* note 25, at 22; P. STARR, *supra* note 17, at 310-11, 313.

62. HISTORICAL STATISTICS OF THE UNITED STATES: COLONIAL TIMES TO 1957, PART I at 74 (1975).

63. *Id.*

64. P. STARR, *supra* note 17, at 334.

65. R. FEIN, *supra* note 25, at 53; P. STARR, *supra* note 17, at 333.

66. Pub. L. No. 89-97, 79 Stat. 290 (1965). Medicare is codified in various sections of Title 42 of the United States Code, primarily at § 1395-1395ll. Medicaid is also codified in various sections of Title 42, primarily at §§ 1396-1396p.

67. 42 U.S.C. § 1395f(b)(1) (1982).

68. *Id.*

69. *Fraudulent Medical and Insurance Promotion*, *supra* note 14, at 74 (statement of Ohio Attorney General William J. Brown); Bovbjerg, *supra* note 23, at 970.

70. 53 Fed. Reg. 20, 924.55 (1988) (to be codified at 42 C.F.R. § 424.55(b)(2)(i) (1987)).

collect a minimal amount from the patient,⁷¹ a provider who is submitting fraudulent claims will not attempt to collect from the patient and thereby exclude her from the billing process.

Medicare, as amended since 1965, provides coverage for some of the health care expenses for the elderly, the disabled, and for persons suffering from end-stage renal disease.⁷² Federally funded and operated, Medicaid was designed to provide health care coverage for the financially needy.⁷³ It is funded from federal and state funds. Each state devises its own Medicaid program within broad, federally mandated parameters, resulting in complex programs. There are fifty-six⁷⁴ separate Medicaid programs, each with "different rules, eligibility requirements, schedules of benefits, and administrative structures."⁷⁵ The federal and state governments do not administer Medicare and Medicaid directly; they contract with insurance companies that receive, evaluate, and pay claims from government funds.⁷⁶

Medicare and Medicaid have expanded tremendously. The third-party fee-for-service reimbursement mechanism quickly proved to be "the central mechanism of medical inflation."⁷⁷ There was no way within this reimbursement system to control the growth of the health care industry and the expenditures required to keep it functioning. For example, in fiscal 1967, its first full calendar year of operation, Medicare covered 20 million Americans and paid \$4.5 billion in benefits. By 1985 Medicare covered 30 million Americans and paid \$70 billion in benefits.⁷⁸

Health care economists have offered many different suggestions for alleviating the cost problem. Despite their different suggested remedies, it is generally agreed that the third-party reimbursement mechanism⁷⁹ and fee-for-service method of computing reimbursement are at fault.⁸⁰ One general approach advocated to reduce the escalation of costs is to return health care to a more competitive model which relies on market forces.⁸¹ The proponents of this view favor reimbursement mechanisms that provide incentives to the patient and the provider to control costs. Another approach advocates greater governmental regulation. The proponents of this view believe that relying on market forces will not correct the problem of escalating costs and will encourage inequitable and un-

71. *Id.* at 924.56 (to be codified at 42 C.F.R. § 424.55(b)(2)(ii) (1987)).

72. 42 U.S.C. § 1395c (1982).

73. *See id.* § 1396 (1982).

74. There is a Medicaid Program in each of the 50 states except Arizona, and in the District of Columbia. Under different regulations there are programs in Puerto Rico, Guam, the Northern Mariana Islands, and the American Virgin Islands. D. SAWYERS, *THE MEDICARE AND MEDICAID DATA BOOK*, 1983, at 2-3.

75. R. FEIN, *supra* note 25, at 110.

76. P. STARR, *supra* note 17, at 375.

77. P. STARR, *supra* note 17, at 385.

78. R. FEIN, *supra* note 25, at 69.

79. *See supra* note 25.

80. *See supra* notes 28-29.

81. Helms, *supra* note 24, at 2; Roseblatt, *Health Care, Markets and Democratic Values*, 34 VAND. L. REV. 1067, 1069-70 (1981) (excellent summary of themes basic to "market" approaches).

wise allocation of health care resources.⁸² Thus far, most of the proposals implemented to address the cost issue reflect an attempt to return to market forces. This effort has been carried forth on two fronts; an attempt to apply market pressure to providers through "diagnosis related groups" (DRGs) and capitation,⁸³ and an attempt to put market pressure on patients through higher copayments and deductibles.

The Social Security Act Amendments passed by Congress in 1983⁸⁴ are a prime example of the attempt to put market pressure on providers. These amendments introduced DRGs.⁸⁵ Under DRG reimbursement, illnesses are assigned to groups, based upon the "estimated relative cost of hospital resources used with respect to discharges classified within each group."⁸⁶ The federal government (the Health Care Financing Administration (HCFA) of the Department of Health and Human Services (HHS)) defined 467 different diagnostic categories and established a formula for reimbursing each hospital a set amount depending on the diagnostic category of the patient's illness.⁸⁷ DRGs reflect a new approach to reimbursement.⁸⁸ Whereas fee-for-service operates retrospectively, by reimbursing a provider after it has rendered the service, the DRGs constitute a prospective payment system (PPS) that informs the provider of the reimbursement for the service prior to the rendering of the service.⁸⁹ The incentive to control costs is obvious: if the provider treats a patient for less than the amount it receives as reimbursement, it makes money, but if the provider treats the patient for more than the amount it receives as reimbursement; it loses money.⁹⁰ It appears that DRGs are effective in controlling health care costs, and other third-party insurers have instituted similar prospective payment systems.⁹¹

"Capitation" plans also aim to curb health care costs by putting economic

82. See, e.g., R. FEIN, *supra* note 25, at 194; Record, *Medical Politics and Medical Prices: The Relation Between Who Decides and How Much It Costs*, in TOWARD A NATIONAL HEALTH POLICY 71, 105-06 (1977).

83. Furrow, *The Ethics of Cost-Containment: Bureaucratic Medicine and the Doctor as Patient-Advocate*, 3 NOTRE DAME J.L. ETHICS & PUB. POL'Y 187, 190 (1988) (capitation is a method of health care service in which the health care provider is paid for a set time period and the member/patient will be treated as often as necessary during that period).

84. Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 65, 77.

85. *Id.*

86. 42 C.F.R. § 412.60(b) (1987).

87. *Hospital Prospective Payment System: Hearing Before the Subcomm. on Health of the Senate Comm. on Finance*, 98th Cong., 1st Sess. 3, 6 (1983).

88. R. FEIN, *supra* note 25, at 87, 88; Newcomer, Wood & Sankar, *Medicare Prospective Payment: Anticipated Effect on Hospitals, Other Community Agencies and Families*, 10 J. HEALTH POL. POL'Y & L. 275, 275 (1985).

89. R. FEIN, *supra* note 25, at 87.

90. *Proposals to Modify Medicare's Physician Payment System: Hearing Before the Subcomm. on Health of the Senate Comm. on Finance*, 99th Cong., 2nd Sess. 9 (1986).

91. PROSPECTIVE PAYMENT ASSESS. COMM'N MEDICARE PROSPECTIVE PAYMENT AND THE AMERICAN HEALTH CARE SYSTEM 86 (1987); *Health Care Cost Containment Act*, *supra* note 25, at 107 (discussing recent finding from a Rand Study "confirming that HMOs [health maintenance organizations] significantly reduce the costs of delivering medical care. The calculated expenditure rate was about 25% less in the HMO than for the fee-for-service group receiving free care. Further, hospitalization rates for HMO enrollees were 40% below the fee-for-service group.") (statement by Robert B. Helms, Acting Assistant Secretary, Department of Health and Human Services).

pressure on providers. These plans reimburse prospectively: prior to the rendering of any service, the provider is informed how much it will be reimbursed.⁹² Unlike DRG's, however, a capitation method of reimbursement pays per patient enrolled in the plan rather than per service rendered. Thus, a provider is paid a set amount for providing a capitation plan member with all health services necessary during a set time period, usually one year.⁹³ If the provider treats a member for less than the fee, it makes money; if it does not, it loses money.⁹⁴ Health Maintenance Organizations (HMOs) are the prevalent type of capitation plans. The HMO is distinguishable from other health care insurance plans that utilize prospective payment. Rather than third-party insurance paying the HMO to treat its members, the typical HMO members make the prepayment themselves.⁹⁵ Because HMO members are both the recipients of and the payers for the services, HMOs also bring market pressures to bear on patients.⁹⁶ Because HMOs take years to develop and require major infusions of capital, the Health Maintenance Organization Resources Act of 1973⁹⁷ was passed, and has been amended, to facilitate the growth of HMOs.⁹⁸ This statute provides financial assistance to developing HMOs⁹⁹ and requires employers to offer an HMO option as one of its health care benefits.¹⁰⁰ After a slow start, the number of HMOs has grown dramatically. In 1971 there were 33 HMOs with 3.6 million subscribers.¹⁰¹ By 1987 there were 663 HMOs with 28.8 million subscribers.¹⁰²

In addition to implementing prospective reimbursement mechanism through DRGs and capitation plans, some of those who favor a return to a system controlled by market forces advocate charging patients larger copayments and deductibles.¹⁰³ This, it is argued, will provide patients with an incentive not to overutilize health care services thus keeping health care costs down.¹⁰⁴ These larger copayments and deductibles have been implemented by public and many private insurance programs.

92. Furrow, *supra* note 83, at 190 ("The capitation principle means that payment is determined in advance for each subscriber to the HMO, and the HMO will lose money if its costs per patient exceed the amount they have calculated.").

93. Furrow, *supra* note 83, at 190.

94. UNITED STATES GENERAL ACCOUNTING OFFICE, MEDICARE—ISSUES RAISED BY FLORIDA HEALTH MAINTENANCE ORGANIZATION DEMONSTRATIONS, 99th Cong., 1st Sess. 44 (1986).

95. R. FEIN, *supra* note 25, at 136; Record, *supra* note 82, at 101.

96. Brown, *Competition and Health Cost Containment: Cautions and Conjectures*, 59 MILBANK MEMORIAL FUND QUARTERLY HEALTH AND SOCIETY 145, 146 (1981).

97. *Federal Health Maintenance Organization Act of 1973*, Pub. L. No. 93-222, 87 Stat. 914 (codified at 42 U.S.C. § 300e (1982)).

98. See Record, *supra* note 82, at 100.

99. 42 C.F.R. §§ 417.110-137 (1987).

100. P. STARR, *supra* note 17, at 400-01.

101. R. FEIN, *supra* note 25, at 137.

102. N.Y. Times, Jan. 21, 1988, at 1, col. 2 & 17, col. 2 (although HMOs have been increasing at a rate of 20% annually, enrollment in these plans rose less than 1% between July 1 and Sept. 30, 1987. This was the smallest increase since 1970. It is not yet clear whether this is a seasonal fluke or the beginning of a move away from HMOs).

103. See Blumstein & Sloan, *supra* note 17, at 894; Feldstein, *supra* note 18, at 52. This approach has been criticized for influencing only the low cost discretionary expenses. See Marmor, Boyer & Greenberg, *Medical Care & Procompetitive Reform*, 34 VAND. L. REV. 1003, 1013 (1981).

104. See J. MEYER, HEALTH CARE COST INCREASES 11-12 (1979).

The social structure of medicine is also changing as the number of providers increases. Between 1970 and 1986 the number of medical physicians increased by 66.1%, the number of osteopathic physicians increased by 90% and the number of podiatrists increased by 54.9%.¹⁰⁵ Cost containment measures have discouraged use of expensive acute care facilities,¹⁰⁶ and encouraged expansion of less expensive facilities and providers such as nursing homes, home health agencies, and durable medical companies.¹⁰⁷ More health care providers than ever now operate in the corporate form.¹⁰⁸ Corporations are purchasing hospitals and nursing homes, almost all of which traditionally have been owned by small groups of individuals.¹⁰⁹ Between 1976 and 1981 ownership of hospitals by corporations increased 68%.¹¹⁰

The managers and administrators of these corporations are a new cadre of health care professionals who are shifting the focus in health care services to profitability.¹¹¹ Humana, Inc., one of the most successful and fastest growing corporate owners of hospitals, has been noted for its "pugnacious management" style and "profit-mongering."¹¹² Humana prefers the more lucrative, privately insured patients to the patients insured by government programs.¹¹³ One commentator has explained: "[w]hen a Humana hospital has empty beds, Medicare and Medicaid patients are better than cold sheets."¹¹⁴

As a result of these changes medicine is becoming more of a business than a

105. BUREAU OF HEALTH PROFESSIONS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, SIXTH REPORT TO THE PRESIDENT AND CONGRESS ON THE STATUS OF HEALTH PERSONNEL IN THE UNITED STATES table 2-1 (1988) (publication number HRS-P-OD-88-1). The final report of the Graduate Medical Education National Advisory Committee (GMENAC), released September 1980, concluded that in 1990 the U.S. would have 70,000 physicians more than needed. Ginzberg, Brann, Hiestand & Ostow, *The Expanding Physician Supply and Health Policy: The Clouded Outlook*, 59 MILBANK MEMORIAL FUND Q. 508, 511 (1981).

106. "Between 1980 and 1983, 73 urban hospitals and 47 rural facilities closed their doors . . . [S]ince the start of prospective payment, those figures have risen to 128 and 116, respectively—an increase approaching 200 percent." McCarthy, *DRGs Five Years Later*, 318 NEW ENG. J. MED. 1683, 1684 (1988) (citing unpublished data). "From fiscal year 1983 through 1987, hospitals reduced the number of full-time equivalent staff members by nearly 114,000. During the same period, they removed more than 45,000 beds from service." *Id.*

107. [F]rom 1977 to 1982 there has been an annual increase of 8.5% in the number of Medicare-certified home health agencies; this increase was especially rapid between 1980 and 1982, when Medicare-certified proprietary agencies increased 241 percent . . . Industry forecasts are for a 13 to 20 percent annual increase in home health services through 1990.

Newcomer, Wood & Sankar, *supra* note 88, at 278; see, e.g., Johnson, *Regulatory Theory and Prospective Risk Assessment in the Limitation of Scope of Practice*, 4 J. LEGAL MED. 447, 447 (1983); Schramm & Gabel, *Prospective Payment: Some Retrospective Observations*, 318 NEW ENG. J. MED. 1681, 1682 (1988).

108. Younger physicians are more willing to work for a corporate health care provider. Whereas almost all physicians with more than 30 years experience are self-employed, this is true for only 60% of those in practice five years or less. L. HARRIS & ASSOCS., MEDICAL PRACTICE IN THE 1980'S: PHYSICIANS LOOK AT THEIR CHANGING PROFESSION 21 (1981); Goldsmith, *The U.S. Health Care System in the Year 2000*, 256 J. A.M.A. 3371, 3372 (1986).

109. P. STARR, *supra* note 17, at 428.

110. P. STARR, *supra* note 17, at 430.

111. P. STARR, *supra* note 17, at 447-48.

112. Kinkead, *Humana's Hard-Sell Hospitals*, FORTUNE, Nov. 17, 1980, at 68-69.

113. *Id.* at 70, 76.

114. *Id.* at 70.

profession, with the danger that commercialism will compromise professionalism.¹¹⁵ Paul Starr has explained this process:

The rise of a corporate ethos in medical care is already one of the most significant consequences of the changing structure of medical care Everywhere one sees the growth of a kind of marketing mentality in health care The organizational culture of medicine used to be dominated by the ideals of professionalism and volunteerism, which softened the underlying acquisitive activity. The restraint exercised by those ideals now grows weaker. The "health center" of one era is the "profit center" of the next.¹¹⁶

C. Conclusion

The major economic change in the health care industry derives from the proliferation of insurance. During the early twentieth century, in the absence of health insurance, patients or charity paid the bills. The Depression motivated patients and health care professionals to seek and support health insurance. Private insurance grew and in 1965 public insurance for the elderly and financially needy was established. These insurance programs utilized third-party, fee-for-service reimbursement. By the 1980s serious concerns over costs developed and new forms of reimbursement, the prospective payment system, and higher copayments and deductibles, were introduced to control spiraling health care costs.

The twentieth century saw growing respect for health care providers. This respect was due to many factors; urbanization, effective lobbying by the American Medical Association, high professional standards by most providers, increased competence by providers in fighting disease, and easy access to providers due to insurance. Dramatic sociological changes are currently underway. Health care is becoming a business and is being inundated with large numbers of new providers. The effect these changes will have on the public's respect for providers remains to be seen. As Parts II, III and IV discuss, all of these socioeconomic factors have had, and will likely continue to have, a significant impact on the prosecution of fraudulent health care providers.

115. McCormick, *The Cost Factor in Health Care*, 3 NOTRE DAME J.L. ETHICS & PUB. POL'Y 161, 166 (1988). McCormick noted:

an increasing independence from the values that make health care a human service, one altruistically conceived and delivered [f]actors [such as] depersonalization, market-driven system . . . mean that physicians are enormously preoccupied with forces peripheral to and distinctive from holistic human care. One fears that the result of this will be the gradual transformation of medicine from a profession to a business.

Id.; see, e.g., *Medicare in Florida*, *supra* note 22, at 17 (statement of Hyman Ruchlis, Health Action Committee, Florida Consumers Federation); Ginzberg, *The Monetization of Medical Care*, 310 NEW ENG. J. MED. 1162 (1984); Goldsmith, *supra* note 108 at 3374; Jost, *supra* note 29, at 539; Newcomer, Wood & Sankar, *supra* note 88, at 276; Relman, *Practicing Medicine in the New Business Climate*, 316 NEW ENG. J. MED. 1150, 1150-51 (1987); Relman, *The New Medical Industrial Complex*, 303 NEW ENG. J. MED. 963, 963 (1980).

116. P. STARR, *supra* note 17, at 448.

II. THE FEATURES OF FRAUD BY HEALTH CARE PROVIDERS

A. *Fraud by Health Care Providers is White Collar Crime*

The term "white collar crime" was introduced by Edwin Sutherland in 1939.¹¹⁷ Prior to the introduction of this concept, theories of criminal behavior focused on personal and social pathologies. As a result, criminal justice scholars emphasized "poverty [and] other social conditions and personal traits which are assumed to be associated with poverty" as the causes of crime.¹¹⁸ Sutherland's definition of white collar crime also focused on the criminal actor. According to Sutherland, white collar crime was "crime committed by a person of respectability and high social status in the course of his occupation."¹¹⁹ This definition has been criticized as overly restrictive because it fails to encompass all actors who commit white collar crimes and because it fails to focus on the conduct that constitutes white collar crime.¹²⁰ Most other attempts to define white collar crime have focused on the conduct constituting the crime. The following definition has been heralded as more inclusive and workable: "White collar violations . . . involve the use of a violator's position of significant power, influence or trust in the legitimate order . . . for the purpose of illegal gain, or to commit an illegal act for personal or organizational gain."¹²¹

To date the actors generally recognized as typical white collar criminals are corrupt bank officers, taxpayers, public officials, securities brokers, and general business persons. Health care providers are rarely included in such lists.¹²² This failure to recognize health care providers as potential white collar criminals is surprising. Clearly, fraud by health care providers fits either an "actor" or "conduct" definition of white collar crime. When a health care provider obtains reimbursement by misrepresenting what health care services were provided, the provider has used its position of trust as a professional to obtain an illegal gain.

The failure to recognize fraud by health care providers as a significant subspecialty of white collar crime is also surprising given the estimated pervasiveness of the fraud and the increased efforts to stop it. Convictions of health care providers increased by almost 234% between 1979 and 1986.¹²³ By comparison,

117. Geis & Goff *introduction* to E. SUTHERLAND, *WHITE COLLAR CRIME: THE UNEXPURGATED VERSION* at ix (1983).

118. E. SUTHERLAND, *supra* note 117, at 5.

119. E. SUTHERLAND, *supra* note 117, at 7.

120. A. REISS & A. BIDERMAN, *DATA SOURCES ON WHITE-COLLAR LAW BREAKING* 39-45 (1980); Edelhertz, *The Nature, Impact and Prosecution of White Collar Crime*, in *CRIME AT THE TOP* 44-45 (1978).

121. A. REISS & A. BIDERMAN, *supra* note 120, at 4; cf. Edelhertz, *supra* note 118, at 44.

122. See, e.g., *White Collar Crime: Hearing Before the Senate Comm. on the Judiciary, Pt. 1*, 99th Cong., 2nd Sess. 27 (1986) [hereinafter *White Collar Crime*] (testimony of United States Deputy Attorney General D. Lowell Jensen); *id.* at 102 (testimony of Professor Stanton Wheeler, Yale Law School); M. CLINARD & P. YEAGER, *CORPORATE CRIME* 95-96 (1980); J. CONKLIN, *ILLEGAL BUT NOT CRIMINAL* 3, 5, 15 (1977); Edelhertz, *supra* note 120, at 49-50. But see J. CONKLIN, *supra*, at 44; see, e.g., A. BEQUAI, *WHITE COLLAR CRIME: A 20TH CENTURY CRISIS* 12, 65 (1978).

123. Unpublished data compiled by the office of the Inspector General, Department of Health and Human Services, indicates that in 1979 there were 179 convictions of health care providers and suppliers. In fiscal year ending September 1986 there were 598 such convictions. Letter from Judith Holtz, Director of Public Affairs, Department of Health and Human Services, Office of Inspector

during this same approximate time period, bank embezzlement convictions increased 12%,¹²⁴ income tax fraud convictions increased 79%,¹²⁵ and mail fraud convictions increased 41%.¹²⁶ The efforts to stop fraud by health care providers have not been limited to the criminal arena. Between 1983 and 1987 federal and state governments increased civil collections of money obtained by fraudulent health care providers by almost 700%.¹²⁷

Fraud by health care providers shares three essential features of all white collar offenses: first, it has a hybrid criminal/civil nature; second, it is difficult to investigate and prove; and third, successful prosecution necessitates a careful development of a theory of the case that accomplishes certain goals.

B. *The Hybrid Nature of White Collar Crime*

White collar crime has a hybrid criminal/civil nature.¹²⁸ White collar crime can generally be pursued civilly by a private litigant who is a victim of the crime as well as criminally. Unlike street crime, white collar crime arises out of activities subject to heavy regulation and sanction and thus gives rise to an opportunity for civil litigation under the regulatory provisions.¹²⁹ Forums are already in place to police these regulations and impose these sanctions. For example, a criminal banking fraud may activate civil enforcement by the Internal Revenue Service, the Federal Deposit Insurance Corporation, the Federal Savings and Loan Insurance Corporation, or state agencies such as the Division

General (undated) (available at University of Alabama School of Law Library). These convictions are only those obtained through investigative efforts of Department of Health and Human Services [HHS] and state Medicaid fraud units and do not include convictions obtained through efforts of other agencies such as the Federal Bureau of Investigation, Postal Inspection Service, or local sheriffs' departments.

124. In fiscal year ending June 30, 1979, 757 defendants convicted of bank embezzlement were sentenced. BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, REP. NO. SD-SB-8 SOURCEBOOK OF CRIMINAL JUSTICE STATISTICS—1980 434 table 5.24 (1981) [hereinafter BUREAU OF JUSTICE STATISTICS—1980]. In fiscal year ending June 30, 1986, 850 defendants convicted of bank embezzlement were sentenced. BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, REP. NO. NCJ-105287 SOURCEBOOK OF CRIMINAL JUSTICE STATISTICS—1987 442 table 5.22 (1988) [hereinafter BUREAU OF JUSTICE STATISTICS—1987].

125. In fiscal year ending June 30, 1979, 690 defendants convicted of income tax fraud were sentenced. BUREAU OF JUSTICE STATISTICS—1980, *supra* note 122, at 434 table 5.24. In fiscal year ending June 30, 1986, 1,237 defendants convicted of income tax fraud were sentenced. BUREAU OF JUSTICE STATISTICS—1987, *supra* note 122, at 442 table 5.22.

126. In fiscal year ending June 20, 1979, 1,116 defendants convicted of postal fraud were sentenced. BUREAU OF JUSTICE STATISTICS—1980, *supra* note 124, at 434 table 5.24. In fiscal year ending June 30, 1986, 1,575 defendants convicted of postal fraud were sentenced. BUREAU OF JUSTICE STATISTICS—1987, *supra* note 124, at 442 table 5.22.

127. In 1983 HHS collected \$1,474,100 in civil monetary penalties for fraudulent Medicare and Medicaid claims. In 1987 it collected \$11,678,921 in civil monetary penalties for fraudulent Medicare and Medicaid claims. OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, SEMI-ANNUAL REPORT TO THE CONGRESS, APRIL 1, 1987—SEPTEMBER 30, 1987 at 40. These figures do not include fraudulently obtained overpayments recuperated by government and private insurance programs.

128. Scholars Albert J. Reiss, Jr. and Albert D. Biderman suggest that in the area of fraud "[t]here is little justification . . . for distinguishing between civil and criminal on grounds of culpability or seriousness of sanctions," because the only real differences are in the "standards and procedures by which violations are determined and sanctions imposed." A. REISS & A. BIDERMAN, *supra* note 120, at 2.

129. *White Collar Crime*, *supra* note 122, at 29.

of Finance or the Division of Consumer Affairs. Civil remedies are also a viable option for victims of white collar crimes because, unlike the typical street criminal who is judgment-proof, the white collar criminal often has the resources to pay a civil judgment.

The fact that viable civil and administrative avenues of redress exist for the victim of a white collar crime is significant because the civil plaintiff and the criminal prosecutor will encounter many of the same legal and practical hurdles in proving their case of fraud. Guile and concealment are at the heart of fraud; therefore, proof of fraud will almost always be by circumstantial evidence, regardless of the criminal or civil nature of the forum.¹³⁰ Proof of a high degree of culpability—namely, proof that an actor perpetrated fraud intentionally or with reckless disregard for the truth—is required not only in the criminal forum,¹³¹ but in the civil forum when punitive damages are sought.¹³² On the other hand, while proof of reliance upon the false information is required to prove fraud in a civil case,¹³³ it is generally not required to prove fraud in a criminal case.¹³⁴ In short, despite some differences, the analysis of theories of fraud by health care providers in Part III will be as applicable for the civil plaintiffs as for the criminal prosecutor.

The existence of civil remedies for victims of white collar crime is also significant because it affects the exercise of prosecutorial discretion.¹³⁵ Prosecutorial and judicial resources are limited, and expending these resources to pursue one case necessarily means other cases will never be investigated or prosecuted. As a gatekeeper to these resources, the prosecutor should consider several factors in deciding whether to pursue a particular case when criminal intent is present. One factor is the availability of civil remedies for victims.¹³⁶

130. See, e.g., *United States v. Rodriguez*, 812 F.2d 414, 416 (8th Cir. 1987) (criminal); *United States v. Marquardt*, 786 F.2d 771, 780 (7th Cir. 1986) (same); *United States v. Towers*, 775 F.2d 184, 188 (7th Cir. 1985) (same); *Clear Creek, Inc. v. Royal Am. Corp. (In re Int'l. Resorts Inc.)*, 46 Bankr. 405, 413 (N.D. Ala. 1984) (civil); *In re Porter*, 37 Bankr. 56, 63 (E.D. Va. 1984) (same).

131. See, e.g., *United States v. Gold*, 743 F.2d 800, 821-22 (11th Cir. 1984), *cert. denied*, 469 U.S. 1217 (1985); 1 E. DEVITT & C. BLACKMAR, *FEDERAL JURY PRACTICE & INSTRUCTIONS* § 14.01.

132. See, e.g., *Tetuan v. A.H. Robbins Co.*, 738 P.2d 1210, 1239 (Kan. 1987) (punitive damages awarded to punish wrongdoer for "malicious, vindictive, or willful and wanton invasion of another's rights").

133. See, e.g., *Metropolitan Life Ins. Co. v. Ditmore*, 729 F.2d 1, 4 (1st Cir. 1984); *Stowell v. Ted S. Finkil Inv. Serv.*, 641 F.2d 323, 325 (5th Cir. 1981); *United Am. Bank v. Gunter*, 620 F.2d 1108, 1120 (5th Cir. 1980); *Tetuan*, 738 P.2d at 1230.

134. Reliance is not an element of mail fraud. 18 U.S.C. § 1341 (1982); see, e.g., *United States v. Buchanan*, 633 F.2d 423, 427 (5th Cir. Unit A 1980), *cert. denied*, 451 U.S. 912 (1981); *United States v. Goldberg*, 455 F.2d 479, 481 (9th Cir.), *cert. denied*, 406 U.S. 967 (1972). Nor is reliance an element of the most frequently used false statement statute. 18 U.S.C. § 1001 (1982); see, e.g., *United States v. Norris*, 749 F.2d 1116, 1121 (4th Cir. 1984), *cert. denied*, 471 U.S. 1065 (1985); *Blake v. United States*, 323 F.2d 245, 247 (8th Cir. 1963).

135. H. EDELHERTZ & C. ROGOVIN, *A NATIONAL STRATEGY FOR CONTAINING WHITE-COLLAR CRIME* 4 (1980).

136. Cf. Rakoff, *The Exercise of Prosecutorial Discretion in Federal Business Fraud Prosecutions*, in *CORRIGIBLE CORPORATIONS AND UNRULY LAW* 177-78 (1985) (explaining policy of the Manhattan District Attorney's Office not to prosecute business fraud cases already subject to civil litigation because the criminal case might be used as a weapon in the civil litigation and because of the need to preserve scarce prosecutorial resources. The author questions whether this policy deters criminal wrongdoing).

In many instances prosecutorial resources are better used to prosecute the case that involves many victims, none of whom are cognizant of civil remedies, or capable of pursuing civil remedies on their own, than the case that involves only one or a few victims who are capable of pursuing civil remedies. In addition to affecting the prosecutor's initial decision whether to pursue or decline prosecution, the existence of civil remedies may continue to influence a prosecutor's judgment as to how best to try the criminal case.¹³⁷ The prosecutor may purposely choose a theory of the case that maximizes the recovery for the victims under the Victim and Witness Protection Act,¹³⁸ or simply increases the victims' chances for success in private civil lawsuits by means of collateral estoppel¹³⁹ or public disclosure of evidence at trial.

An exceptionally large number and variety of civil remedies are available to pursue the fraudulent health care provider: malpractice lawsuits brought by patients based upon fraud;¹⁴⁰ tort and breach of contract lawsuits brought by insurance companies based upon fraud;¹⁴¹ administrative actions brought by the United States Postal Service to enjoin fraudulent schemes being conducted through the U.S. mails;¹⁴² suspension of payments by Medicare fiscal intermediaries to recover amounts previously paid to a provider and later determined to have been fraudulently obtained by the provider;¹⁴³ civil lawsuits by the federal government under the False Claims Act to collect damages caused by a defendant's fraud;¹⁴⁴ administrative actions brought by the Department of Health and Human Services under the Civil Monetary Penalties Law to recover damages caused by a provider's fraud¹⁴⁵ or to recollect payments already made

137. The civil litigant cannot, of course, use the grand jury process for the civil lawsuit. *United States v. Baggot*, 463 U.S. 476, 480 (1983); *United States v. Sells Eng'g, Inc.*, 463 U.S. 418, 427 (1983).

138. Victim and Witness Protection Act of 1982, Pub. L. No. 97-291, 96 Stat. 1248 (1982); see 18 U.S.C. § 3579(a)(1) (1982) ("The court, when sentencing a defendant [convicted of all title 18 offenses and certain title 49 offenses] may order . . . that the defendant make restitution to any victim of the offense.").

139. See, e.g., *United States v. Diamond*, 657 F. Supp. 1204, 1205 (S.D.N.Y. 1987); *United States v. Zulli*, 418 F. Supp. 252, 254 (E.D. Pa. 1975).

140. See, e.g., *Vidrine v. Enger*, 752 F.2d 107 (5th Cir. 1984); *Duncan v. Leeds*, 742 F.2d 989 (6th Cir. 1984); *Moses v. Miller*, 268 P.2d 900 (Okla. 1954); *Krestich v. Stefanez*, 243 Wis. 1, 9 N.W.2d 130 (Wis. 1943).

141. See, e.g., *Metropolitan Life Ins. Co. v. Adler*, 1988-1 Trade Cas. (CCH) ¶ 67, 907 (S.D.N.Y.) (plaintiff sought damages under Racketeer Influenced and Corrupt Organizations, 18 U.S.C. § 1961 (1982) for physician's fraud, court denied defendant's motion for summary judgment); *Ralston v. Capper*, 569 F. Supp. 1575 (E.D. Mich. 1983) (court denied defendant's motion to dismiss class action brought under RICO by former patients of an osteopathic physician, who alleged they were harmed by defendant's fraudulent provision of medical services).

142. 39 U.S.C. § 3005 (1982); see, e.g., *Peak Laboratory v. United States Postal Service*, 556 F.2d 1387 (5th Cir. 1977); *United States Health Club, Inc. v. Major*, 292 F.2d 665 (3d Cir.), cert. denied, 368 U.S. 896 (1961); *Owen Laboratories, Inc. v. Schroeder*, 284 F.2d 445 (7th Cir. 1960); *Schere v. Christenberry*, 179 F. Supp. 900 (S.D.N.Y. 1959).

143. 42 C.F.R. §§ 405.370-.876 (1987); see, e.g., *Klein v. Heckler*, 761 F.2d 1304 (9th Cir. 1985); *Mount Sinai Hosp., Inc. v. Weinberger*, 517 F.2d 329 (5th Cir. 1975), cert. denied, 425 U.S. 935 (1976); *Szekely v. Florida Medical Ass'n*, 517 F.2d 345 (5th Cir. 1975); *Neurological Assocs. v. Bowen*, 658 F. Supp. 468 (S.D. Fla. 1987); *Krebsbach v. Heckler*, 617 F. Supp. 548 (D. Neb. 1985); *Barsh v. Blue Cross & Blue Shield*, 434 F. Supp. 755 (D.S.C. 1977).

144. 31 U.S.C.A. § 3729 (1986); see, e.g., *United States v. Halper*, 664 F. Supp. 852 (S.D.N.Y. 1987); *United States v. Zulli*, 418 F. Supp. 252 (E.D. Pa. 1975).

145. 42 U.S.C. § 1320a-7a (1982 & Supp. VI 1986); see, e.g., *Chapman v. United States Dep't of*

to a provider and later determined to be fraudulent;¹⁴⁶ *qui tam* civil lawsuits by state governments under the False Claims Act to collect damages caused by a provider's fraud;¹⁴⁷ civil actions brought by a state in its own capacity to recover damages because of a provider's fraud;¹⁴⁸ *qui tam* civil actions brought by private individuals pursuant to the False Claims Act to recover damages caused by a provider's fraud;¹⁴⁹ administrative actions by the Department of Health and Human Services to terminate providers from participation in the Medicare program for improperly provided Medicare services;¹⁵⁰ administrative actions by states to terminate providers from the Medicaid program because of a provider's fraud;¹⁵¹ and administrative actions by State Boards of Registration to revoke a provider's professional license because of fraud by the provider.¹⁵²

The licensing requirements for health care professionals provide some of these civil remedies, but licensing requirements are common to many fields. What truly distinguishes the health care industry, and accounts for this plethora of civil remedies, is the existence of the federal and state governments as third-party insurers. Because of their unique bill-paying role, the federal and state governments become the direct financial victims of even the smallest fraud. Thus, when a provider misrepresents the nature of the services provided to one patient, even if the amount at issue is only a few dollars, the federal government is the financial victim if the patient was covered by Medicare. Both the federal and state governments are financial victims if the patient is covered by Medicaid.

When a governmental agency is the financial victim, it arguably is more appropriate to forgo prosecution and allow the victim to pursue civil or administrative options. After all, there is only one victim, the government, and that victim can bring civil suit. Moreover, it is possible to coordinate civil and criminal actions so that if the decision is made to drop the criminal action it is with the assurance that a civil action will proceed.¹⁵³

Health & Human Servs., 821 F.2d 523, 525 (10th Cir. 1987); *Mayers v. United States Dep't of Health & Human Servs.*, 806 F.2d 995, 997 (11th Cir. 1986), *cert. denied*, 108 S. Ct. 82 (1987); *Griffon v. United States Dep't of Health & Human Servs.*, 802 F.2d 146, (5th Cir. 1986).

146. See, e.g., *United States v. Kass*, 740 F.2d 1493 (11th Cir. 1984) (contract theory); *United States v. Diaz*, 740 F.2d 1491 (11th Cir. 1984) (same).

147. 31 U.S.C. § 3729 (1982); see, e.g., *United States ex rel. Woodard v. Country View Care Center, Inc.*, 797 F.2d 888 (10th Cir. 1986); *United States ex rel. Wisconsin v. Dean*, 729 F.2d 1100 (7th Cir. 1984); *United States ex rel. Fahner v. Alaska*, 591 F. Supp. 794 (N.D. Ill. 1984).

148. See, e.g., *Oklahoma v. Children's Shelter, Inc.*, 604 F. Supp. 867 (W.D. Okla. 1985) (complaint alleged violations of 18 U.S.C. §§ 1961-68 (1982) (RICO)); *In re Garay*, 89 N.J. 104, 444 A.2d 1107 (1982) (applying N.J. STAT. ANN. § 30:4D-17(e) (West 1976)); *State v. Estate of Frankel*, 65 A.D.2d 788, 410 N.Y.S.2d 321 (N.Y. App. Div. 1978).

149. 31 U.S.C. § 3730(c) (1982); see, e.g., *United States ex rel. Davis v. Long's Drugs, Inc.*, 411 F. Supp. 1144 (S.D. Cal. 1976).

150. 42 C.F.R. § 1004 (1987); see, e.g., *Papendick v. Bowen*, 658 F. Supp. 1425 (W.D. Wis. 1987).

151. See, e.g., *Lang v. Berger*, 427 F. Supp. 204 (S.D.N.Y. 1977); *Medical Servs. Admin. v. Duke*, 378 So. 2d 685 (Ala. 1979); *In re Kaplan*, 178 N.J. Super. 487, 429 A.2d 590 (N.J. Sup. Ct. App. Div. 1981); *Eisenberg v. Commonwealth Dep't of Pub. Welfare*, 86 Pa. Commw. 358, 485 A.2d 511 (1984), *modified*, 512 Pa. 181, 516 A.2d 333 (1986).

152. See, e.g., *Feldstein v. Board of Registration*, 387 Mass. 339, 439 N.E.2d 824 (1982); *Kaplan v. Department of Registration & Educ.*, 46 Ill. App. 3d 968, 361 N.E.2d 626 (Ill. App. Ct. 1977).

153. But see *supra* note 137 (prosecutor cannot use the grand jury process to aid in a related civil lawsuit).

While it may be appropriate to decline criminal prosecution in favor of civil redress if the federal or a state government is the financial victim of the fraud, the fact that patients are also the victims of fraudulent health care providers may weigh in favor of criminal prosecution. When a number of patients are victims of a fraudulent and incompetent health care provider, it may be difficult for them to organize independently and develop an appropriately inclusive cause of action. These patients will rarely have the medical expertise to determine that a fraud has occurred or the resources to investigate the fraud. Even though the damage sustained due to incompetent medical care may be emotionally or even physically wrenching, recovery for the patient's individual financial loss could well be minimal. When this is true, these individuals will not have the financial incentive to seek civil redress. As long as fraudulent and incompetent providers are allowed to practice, more patients will fall victim to their fraud and incompetence. Because a criminal conviction will often ensure that a provider will lose its professional license,¹⁵⁴ a criminal prosecution may be the best vehicle to prevent the convicted provider from jeopardizing future patients.

C. *The Difficulty of Investigating and Proving White Collar Crime*

White collar crimes, in general, are difficult to investigate and prove.¹⁵⁵ White collar crime is rarely self-evident.¹⁵⁶ Victims of assaults know immediately when they have been assaulted, but victims of fraud may never know they have been defrauded.¹⁵⁷ This failure to realize that one has been defrauded is due, in part, to the fact that the perpetrator is usually in a position of trust with the victim.¹⁵⁸ Because of this relationship, a fraud victim has no reason to suspect criminal activity, even when circumstances occur that would otherwise make the victim suspicious.

The patient-physician relationship epitomizes such trust.¹⁵⁹ "Often in pain, fearful of death, the sick have a special thirst for reassurance and vulnerability to belief."¹⁶⁰ As one Blue Cross official said, "Americans canonize doctors."¹⁶¹ A

154. See, e.g., *Emory v. Texas State Bd. of Medical Examiners*, 748 F.2d 1023 (5th Cir. 1984); *Bockman v. Arkansas State Medical Bd.*, 304 F.2d 359, 360 (8th Cir. 1962); *Rosen v. Louisiana State Bd. of Medical Examiners*, 318 F. Supp. 1217 (E.D. La. 1970), *vacated*, 412 U.S. 902 (1973), *aff'd*, 419 U.S. 1098 (1974) (when the underlying criminal statute was found unconstitutional, physician's license was restored); *Katz v. Alabama State Bd. of Medical Examiners*, 351 So. 2d 890, 891 (Ala. 1977).

155. *White Collar Crime*, *supra* note 122, at 27 (testimony of United States Deputy Attorney General D. Lowell Jensen); M. CLINARD & P. YEAGER, *supra* note 122, at 95; J. CONKLIN, *supra* note 122, at 17-18 (1977); P. FINN & A. HOFFMAN, *PROSECUTION OF ECONOMIC CRIME* 4 (1976); J. GARDINER & T. LYMAN, *THE FRAUD CONTROL GAME* 87 (1984).

156. *White Collar Crime*, *supra* note 122, at 27 (testimony of United States Deputy Attorney General D. Lowell Jensen); P. FINN & A. HOFFMAN, *supra* note 155, at 4.

157. A. BEQUAI, *supra* note 122, at 13; E. SUTHERLAND, *supra* note 117, at 232; Edelhertz, *supra* note 120, at 51.

158. *White Collar Crime*, *supra* note 122, at 27 (testimony of United States Deputy Attorney General D. Lowell Jensen).

159. See, e.g., Arrow, *supra* note 15, at 965; Mechanic, *Some Dilemmas in Health Care Policy*, 59 MILBANK MEMORIAL FUND Q. 1, 4 (1981) ("Feeling highly dependent on such relationships, the typical patient has a strong need to see [his own physician] as an ally."); Marmor, Boyer & Greenberg, *supra* note 103, at 1003.

160. P. STARR, *supra* note 17, at 5.

recent Gallup poll reveals that Americans respect physicians more than any other occupation.¹⁶² This deference, a twentieth century phenomenon, can have a very real effect on any attempt to prove fraud. One sees it in the attitudes of jurors and courts. For example, a New York appellate court reversed the conviction of a physician because it did not believe a wealthy physician would defraud the government, saying

Perhaps the most questionable [part of the Government's case] is the realism of a theory that a doctor, specializing in obstetrics and gynecology who . . . had a practice so extensive that he delivered more babies than any other doctor in the hospital with which he was affiliated, who during the years in question . . . billed Medicaid for over \$100,000 a year . . . he would steal a few hundred dollars . . .¹⁶³

The ambiguous nature of medicine perpetuates this deference. Unlike banking, securities, taxation, or, to some extent, labor relations, where legally appropriate behavior is carefully and precisely delineated, appropriate behavior in the practice of medicine is unclear and subjective.¹⁶⁴ History has shown that a medical procedure seen today as fraudulent quackery may be recognized as an important cure in the future.¹⁶⁵

In some instances the prosecutor may find that this deference is a blessing in disguise. For example, in *State v Carr*¹⁶⁶ the prosecutor was allowed to introduce "graphic evidence regarding the defendant's sexual relationships with [some of his patients], the suicidal tendencies and deaths of these women, and the explicit descriptions of [their] deteriorating physical condition."¹⁶⁷ Although not relevant to the offenses charged, the court held that this evidence was "particularly important . . . because of the medical issues involved and the deference and respect which would ordinarily be given to a physician's opinion."¹⁶⁸ Similarly, in *United States v. Johnson*¹⁶⁹ physician-defendant was charged with understating her income to the Internal Revenue Service by \$120,000 but claimed that her "inadvertent mistake" occurred because she was an "altruistic healer of the sick, whose concerns lay elsewhere than attending to her financial interests and resulting legal responsibilities."¹⁷⁰ In response, the government was allowed to introduce a study of the defendant's billings for Medicaid services which revealed that she billed four times as many services per patient than did any other Virginia doctor.¹⁷¹

161. Clark, *supra* note 15, at 40.

162. N.Y. Times, Aug. 22, 1976, at 32, col. 7.

163. People v. Alizadeh, 87 A.D.2d 418, 428, 452 N.Y.S.2d 425, 431 (N.Y. App. Div. 1982).

164. R. FEIN, *supra* note 25, at 131; J. GARDINER & T. LYMAN, *supra* note 155, at 87 (1984); Donabedian, *The Quality of Medical Care*, in MEDICINE IN A CHANGING SOCIETY 85-86 (1972); Friedman & Rakoff, *supra* note 19, at 3-4.

165. See, e.g., West v. United States, 68 F.2d 96, 98 (10th Cir. 1933).

166. 95 N.M. 755, 626 P.2d 292, cert. denied, 454 U.S. 853 (1981).

167. *Id.* at 772, 626 P.2d at 309.

168. *Id.* at 767, 626 P.2d at 304.

169. 634 F.2d 735 (4th Cir. 1980).

170. *Id.* at 736.

171. *Id.* at 736-37.

In addition to the unsuspecting naivete of victims, the fact that the crime is usually hidden in voluminous documentary materials also makes white collar crime difficult to investigate and prove.¹⁷² It is often necessary to follow a lengthy paper trail simply to discover what occurred. This paper trail is especially arduous in the health care field because of complex and rapidly changing regulations. As one expert noted, "The billing process itself, and the paperwork necessary to monitor numerous and complex third-party insurance contracts—with varying co-insurance, deductibles, and maximum benefit schedules and with widely varying coverage and criteria for major medical payments—boggle[s] the mind . . . [I]t assuredly confuses both patients and their doctors."¹⁷³

While many white collar crimes involve complex statutes and regulations, the complexity of regulations in the health care industry is exacerbated by several facts unique to this industry. Health care regulations change more often than those in most fields.¹⁷⁴ In addition, a single provider usually deals simultaneously with multiple third-party providers and is subject to the varied and often inconsistent rules and regulations promulgated by each. Because of the third-party reimbursement mechanism, all providers must utilize these voluminous, changing, inconsistent rules and regulations to obtain reimbursement for performing even a minor procedure. To prove even the smallest fraud involves tracking hundreds of such regulations.

The complexity of the regulations gives rise to a credible defense by otherwise intelligent, informed professionals that they simply did not understand or were unaware of essential regulations that govern their day-to-day transactions.¹⁷⁵ Such ignorance of the law is uniformly recognized as a defense to specific intent crimes,¹⁷⁶ a category including many fraud offenses.¹⁷⁷ Such a defense was successful in *People v. Alizadeh*.¹⁷⁸ The New York appellate court reversed the conviction of Dr. Alizadeh for submitting fraudulent bills for obstetric services, finding that the bills were not the result of criminal fraud but "represented an honest error in judgment in interpreting an unfamiliar billing system."¹⁷⁹ More often, however, this defense has not been successful. For ex-

172. *White Collar Crime*, *supra* note 122, at 27 (testimony of United States Deputy Attorney General D. Lowell Jensen).

173. *Mechanic*, *supra* note 159, at 7-8.

174. Because of the complexity of the Medicare and Medicaid programs and the attempt by all insurers, public and private, to address the problem of rising costs, the regulations governing health care have been changing rapidly. For example, between 1980 and 1987, Congress enacted more than 30 laws governing just the Medicare program. Roper, *Balancing Efficiency and Quality—Toward Market-Based Health Care*, 3 NOTRE DAME J.L. ETHICS & PUB. POL'Y 169, 171 (1988).

175. J. GARDINER & T. LYMAN, *supra* note 155, at 106. For examples of defendants who assert that they merely misunderstood applicable regulations and are not guilty of criminal fraud, see *United States v. Larm*, 824 F.2d 780, 782 (9th Cir. 1987); *United States v. Smith*, 523 F.2d 771, 779 (5th Cir. 1975); *United States v. Peterson*, 488 F.2d 645, 649 n.7 (5th Cir. 1974).

176. See, e.g., *United States v. Davis*, 583 F.2d 190, 194 (5th Cir. 1978); *United States v. Schilleci*, 545 F.2d 519, 523-24 (5th Cir. 1977).

177. See, e.g., *United States v. Kent*, 608 F.2d 542, 545 n.3 (5th Cir. 1979), *cert. denied*, 446 U.S. 936 (1980); *United States v. Perlstein*, 576 F.2d 531, 537 (3d Cir. 1978).

178. 87 A.D.2d 418, 431, 452 N.Y.S.2d 425, 426 (N.Y. App. Div. 1982).

179. *Id.* at 430, 452 N.Y.S.2d at 433.

ample, in *United States v. Collins*,¹⁸⁰ although the government's evidence showed that the applicable regulations and forms were "in chaos" and "technical and confusing,"¹⁸¹ the United States Court of Appeals for the Sixth Circuit still found sufficient evidence to convict a nursing home operator, holding the applicable forms were sufficient to put the defendant on notice as to the information requested.¹⁸²

It is not surprising that the reported cases reveal little success with this "confusion defense" because these cases reflect only instances in which a grand jury has found probable cause or instances where a petit jury has found proof beyond a reasonable doubt to establish that the offense occurred. In short, the reported cases have already excluded most occasions where such a defense is applicable and credible. The real impact of the complex rules and regulations is felt when cases are declined for prosecution because of the complex regulatory structure. Testimony before congressional committees reviewing fraud by health care providers has repeatedly emphasized that the complexity of the applicable rules and regulations makes fraudulent health care providers extremely difficult to prosecute and accounts for many decisions not to prosecute.¹⁸³

Another reason white collar crime is difficult to investigate and prove is that it is often "hidden within an organization."¹⁸⁴ This makes it difficult to find out what went on and particularly difficult to find evidence of a defendant's intent.¹⁸⁵ In the health care field, fraud occurs when false bills are submitted for reimbursement by the provider to the third-party payer. This billing process usually involves a number of people apart from the provider, such as a receptionist, billing clerk, nurse, or computer billing service. Once the claim reaches the provider it is again processed by multiple individuals and computer services. To hold the provider responsible for the false statements in the bills requires a step-by-step analysis of the billing process and proof that the provider personally knew false information was included in the bills finally submitted.¹⁸⁶

A review of the reported cases indicated that like the "confusion defense," a defense that places the blame on others in the organization had little chance of success. The Eleventh Circuit's treatment in *United States v. Hilliard*¹⁸⁷ is a typical judicial reaction to such a claim. The appellant, a nursing home administrator, argued that her conviction for submitting false claims should be reversed because it was her codefendant who actually submitted the false Medicare

180. 596 F.2d 166 (6th Cir. 1979).

181. *Id.* at 168.

182. *Id.*

183. *Fraudulent Medical and Insurance Promotions*, *supra* note 14, at 67 (statement of Ohio Attorney General William J. Brown); *Oversight*, *supra* note 7, at 4 (introduction).

184. *White Collar Crime*, *supra* note 122, at 103 (testimony of Professor Stanton Wheeler, Yale Law School).

185. *White Collar Crime*, *supra* note 122, at 103 (testimony of Professor Stanton Wheeler, Yale Law School).

186. *Medicare & Medicaid Frauds: Joint Hearing Before the Senate Comm. on Aging, Pt. 1*, *supra* note 12, at 21 (statement of Paul M. Allen, Chief Deputy Director, Michigan Department of Social Services).

187. 752 F.2d 578, 581 (11th Cir. 1985).

claims. The United States Court of Appeals for the Eleventh Circuit summarily dismissed this argument and affirmed the conviction on the ground that there was evidence sufficient for a reasonable juror to find appellant was aware of and participated in the scheme to defraud Medicare.¹⁸⁸ Like the other difficulties in proving fraud by health care providers, the impact of the organizational structure is felt in the decision not to prosecute certain cases. Richard Kusserow, the chief federal law enforcement officer charged with prosecuting fraudulent health care providers, stated that:

Particularly with the health-care practitioners, we find that the most standard defense they come up with is the fact that they are healers and not businessmen [and] they will lay it off on their clerical staffs and say that they were really too busy dealing the medical problems to pay much attention to the business side.¹⁸⁹

A last factor complicating proof that a health care provider has committed fraud is unique among white collar crimes. Often each criminal transaction by a health care provider involves a de minimis amount of money.¹⁹⁰ Felony prosecutions have been reported where the losses resulting from the fraud were as small as \$882.21,¹⁹¹ \$2,156.60,¹⁹² and \$809.00.¹⁹³ The amount of money per fraudulent transaction is small because the standard billing process in the health care industry requires an itemization of each service or each component of a service. Such itemization is perpetuated, in part, by the fee-for-service method of calculating reimbursement that necessitates incremental billing. As a result of this billing practice, each false claim submitted by a provider may involve only a few cents of fraud. The prosecutor must plead and prove many such fraudulent transactions to reach a large aggregate loss.

Generally, these smaller amounts reflect only the tip of the iceberg of the dollar loss actually caused by a provider's fraud.¹⁹⁴ However the evidence that the amount at issue is only the "tip of the iceberg" may never get to the jury. When it does not, the de minimis character of the fraudulent transaction adversely affects the prosecution of fraudulent providers for even when presented with overwhelming evidence of intentional fraud, the de minimis amount of loss makes it difficult for a jury to convict.

To overcome the problem caused by the de minimis dollar loss in a single

188. *Id.* at 581; see also *United States v. Blazewicz*, 459 F.2d 442, 443 (6th Cir. 1972) (in affirming the conviction of a physician for submitting false claims to Medicare, the court noted that "[a]pparently the jury rejected the defense that [the physician] did not authorize the filing of the claims . . ."); *United States v. Witschner*, 624 F.2d 840, 842 (8th Cir. 1980) (in affirming the conviction of an attorney for submitting false insurance claims, court noted that attorney's defense at trial, which was rejected by the jury, was that his clients' physician falsified the claims without the attorney's knowledge).

189. *Program Fraud*, *supra* note 14, at 7 (testimony of Hon. Richard P. Kusserow).

190. *Oversight*, *supra* note 7, at 117 (statement of Donald P. Zerendow, Chief, Massachusetts Medicaid Fraud Control Unit).

191. See *United States v. Larm*, 824 F.2d 780, 782 (9th Cir. 1987).

192. *United States v. Matanky*, 482 F.2d 1319, 1324 (9th Cir.), *cert. denied*, 414 U.S. 1039 (1973).

193. *State v. Page*, 32 N.C. App. 478, 480, 232 S.E.2d 460, 461 (1977).

194. *Matanky*, 482 F.2d at 1324 n.3.

transaction, the investigation must expand to include hundreds of false claims submitted by a provider. In addition to increasing the dollar amount of the fraud, expanding the case may also benefit the prosecution by revealing a more extensive pattern of fraud by the provider. Expanding the case to include additional de minimis transactions, however, is often as difficult as expanding the investigation of other white collar crimes to include multi-million dollar transactions.¹⁹⁵

Although certain features of white collar crime by health care providers make these crimes difficult to investigate, other features of health care provider fraud may assist the prosecutor in proving such fraud. One feature is a type of evidence which is uniquely available in the health care industry because of the presence and resources of the third-party payer. Known as a "peer group analysis," this evidence results from comparing the billing history of the defendant provider to peer providers.¹⁹⁶ A large computerized data base with information on many providers is necessary for a credible comparison, and third-party payers maintain such data bases. An aberrational service history on the part of one provider, when compared to that of its peer providers, can help target fraudulent providers for further investigation. Such a comparison also can be potent trial evidence.¹⁹⁷

In *United States v. Russo*¹⁹⁸ two osteopathic physicians were convicted for misrepresenting the type of service they allegedly provided to patients.¹⁹⁹ The parties introduced a peer group comparison conducted by Blue Cross/Blue Shield in an analysis of its data base. The comparison demonstrated that of the claims for the five procedures at issue filed by 10,000 physicians in the same geographical area, the two defendants submitted twenty-eight percent of the total claims.²⁰⁰ The court found this evidence relevant to the charges that the defendants misrepresented the services for which they claimed reimbursement.²⁰¹

A second feature unique to fraud by health care providers that may make these prosecutions, if not less complex, at least more likely to succeed is the presence of patients as victims of the fraud. The victim of many white collar crimes—often a corporation, conglomerate, governmental entity, or business

195. *Oversight*, *supra* note 7, at 116 (statement of Donald P. Zerendow, Chief, Massachusetts Medicaid Fraud Control Unit) ("Once a provider sets up his pattern, he does it routinely and to the extent of thousands of dollars, but the problems of proof relating to hundreds and thousands of invoices is sometimes enormous, complex and very difficult."); *Program Fraud*, *supra* note 14, at 36 (testimony of Paul McGrath, United States Assistant Attorney General, Civil Division, Department of Justice) ("[T]he biggest litigation burden on us now is the smaller case. The reason is that it may cost us, in terms of our resources, in terms of auditors and other costs of litigation, as much to put together a \$50,000 fraud case as a \$5 million fraud case, . . .").

196. *United States v. Alexander*, 748 F.2d 185, 188 (4th Cir. 1984), *cert. denied*, 472 U.S. 1027 (1985).

197. *Id.* at 188-89. *But see* *People v. Louie*, 158 Cal. App. 3d Supp. 28, 45, 205 Cal. Rptr. 247, 260-61 (Cal. App. Dep't Super. Ct. 1984) (conviction reversed; court found peer comparison evidence insufficient to convict physician).

198. 480 F.2d 1228 (6th Cir. 1973).

199. *Id.* at 1232.

200. *Id.* at 1234-36.

201. *Id.* at 1243.

person—is often perceived by the public or a jury as just as greedy and ruthless as the defendant. In short, the victim of many white collar crimes does not engender much sympathy. By comparison, all too often the victim of the fraudulent health care provider is not only the third-party payer that lost money, but also the patient who, by definition, is ill, perhaps old, and who received inadequate, incompetent, or unnecessary medical services.²⁰² By incorporating the patient as a victim into the theory of the case, it is possible to overcome many of the the problems otherwise presented in prosecutions of health care providers while also demonstrating a more accurate portrayal of the harm caused by the provider's fraud.

D. Conclusion: Developing A Theory of the Case

A number of features of white collar crime distinguish it from street crime. The fact that white collar crime can be pursued civilly affects the prosecutor's initial decision whether to proceed criminally and may affect the manner in which the criminal case is tried. White collar crime is difficult to investigate and prove. It is not self-evident, is usually perpetrated by someone in a position of trust, involves tracing multiple transactions through voluminous documents and complex regulations, and requires piercing an organizational structure to determine an individual's culpability.

Fraud by health care providers shares these features of other white collar crimes. It also exhibits unique features. One such feature is the small amount of money involved in the single fraudulent health care transaction. This characteristic makes prosecution even more difficult. Two other features, the unique evidence available because of the resources of the third-party payer, and the victimization of patients by a fraudulent provider, potentially aid in the prosecution of fraudulent health care providers.

To overcome the difficulties in prosecuting health care providers while capitalizing on the strengths of such cases, the prosecutor should carefully craft the theory of the case. Devising an optimal theory of the case requires deciphering the facts, re-assembling the facts in a comprehensible manner, and determining whether the resulting scenario is a criminal offense under applicable statutes.²⁰³ Ideally the theory of the case, while maximizing clarity and jury appeal, will also allow integration of available and especially powerful evidence and minimize the impact of potential defenses. Any one factual situation lends itself to multiple potential theories and any one theory usually can be charged as an offense under

202. See *infra* text accompanying notes 502-73 (discussing provision of unnecessary or standard medical care as fraudulently).

203. *White Collar Crime*, *supra* note 122, at 27 (testimony of United States Deputy Attorney General D. Lowell Jensen); *id* at 192 (testimony of Kenneth E. Carlson) ("With a white collar crime it is often hard to tell whether a particular action is a crime."). For examples of cases in which courts discuss a party's "theory" of the case, see *United States v. Alexander*, 748 F.2d 185, 188-89 (1984) (court determines whether the evidence was sufficient to support conviction under both of the federal government's theories of guilt); *United States v. Varoz*, 740 F.2d 772, 775 (10th Cir. 1984); *State v. Sword*, 713 P.2d 432, 434 (Haw. 1986) (conviction set aside because government failed to prove the elements of the theory charged).

a variety of criminal statutes. Part III discusses the theories used historically to prosecute fraudulent health care providers.

III. THEORIES OF FRAUD BY HEALTH CARE PROVIDERS

The analysis in this part of the Article rests on a comprehensive search²⁰⁴ of all officially reported²⁰⁵ opinions of prosecutions²⁰⁶ of health care providers.²⁰⁷ The first reported successful prosecution of a health care provider was of

204. The following computer searches were used:

I. Westlaw (yielded 14,496 cases)

A. Search 1

1. *Data Bases*: All Feds (1945-Present), All Feds (1789-1945), Allstates, A.G., CJ-TP.

2. *Search Command*: The following topic numbers were inserted at the (*) in the search command; [*] and Fraud! and physician dentist osteopath optometrist podiatrist hospital "nursing home" pharmacist clinic and medicare medicaid patient:

(a) constitutional law (92); (b) criminal law (110); (c) conspiracy (91); (d) commerce (83); (e) drugs and Narcotics (138); (f) forgery (181); (g) fraud (184); (h) hospitals (204); (i) indictment and information (210); (j) physicians and surgeons (299); (k) post office (306); (l) social security and public welfare (356); (m) poisons (304)

B. Search 2 (yielded 2252 cases)

1. *Data Bases*: Allstates

2. *Search Command*: Physician therapist chiro! osteo! optometrist dentist hospital "nursing home" clinic pharmacist nurs! podiatrist and kickback or remunerat!

II. Lexis (yielded 802 cases)

A. *Libraries*: Gen Fed, States

B. *File*: Courts, Omni

C. *Search Command*: The following statutory sections were inserted at the * of the following search command; [*] and Fraud! and physician or dentist or osteopath or optometrist or podiatrist or hospital or nursing home or pharmacist or clinic and medicare or medicaid or patient:

1. 18 PRE/5 231, 232, 233, 234, 235, 286, 287, 371, 641, 1001, 1341, 1343, 1961, 1962, 1963, 1964, 1965, 2341, 4241.
2. 21 PRE/5 841, 842, 843, 848, 351, 352, 353.
3. 26 PRE/5 3793, 7201, 7206.
4. 42 PRE/5 408, 1395, 1396.

205. "Officially reported" cases refers to all cases published in the West Publishing Company reporters. Although West Publishing Company is privately owned, it has received the official, and unofficial, approval of federal and state courts. See Vestal, *A Survey of Federal District Court Opinions: West Publishing Company Reports*, 20 Sw. L.J. 63, 76-77 (1966). While the methodology and resulting statistics include only reported cases, the discussion portion of this Article will also refer to unreported cases.

206. For purposes of this search a "prosecution" is the filing of charges by indictment or information. Therefore opinions dealing with issues raised in pretrial motions are included as are all opinions addressing issues raised after conviction. Reported opinions dealing with issues raised in cases at the grand jury investigation stage have not been included.

Prosecutions of health care providers charged with health care fraud are the only prosecutions included. Thus, health care providers charged with street crimes, tax fraud, perjury or other such offenses are not included.

207. These cases represent only a sample of all prosecutions of health care providers. This sample does not include reported cases that may be outside the search methodology discussed above. Also, by definition, it does not include unreported prosecutions such as unpublished opinions. This limitation should primarily affect cases decided after 1971 because the movement toward limited publication of judicial opinions began after a report issued by the Federal Judicial Center in 1971. Weaver, *The Precedential Value of Unpublished Judicial Opinions*, 39 MERCER L. REV. 477, 478

a physician in Philadelphia in 1915.²⁰⁸ Between 1908 and 1988, 301 prosecutions of health care providers have been reported. Sixty-three percent of these prosecutions occurred in federal courts under thirty different statutes. Mail fraud, 18 U.S.C. § 1341 (1982), was the most widely used federal statute, followed by false statement, 18 U.S.C. § 1001 (1982), and conspiracy, 18 U.S.C. § 371 (1982). RICO (Racketeer Influenced and Corrupt Organizations), 18 U.S.C. § 1961-68 (1982), a prosecutor's powerhouse, was used surprisingly little, in only four cases. Thirty-seven percent of the total reported prosecutions occurred in state courts under twenty different types of statutes. Four states dominated the prosecutions with fifty percent of all state prosecutions occurring in New York, California, Michigan, and New Jersey. Almost half of the states (twenty-two) reported no prosecutions of health care providers. The most commonly prosecuted state offenses were controlled substance offenses, Medicaid fraud, larceny, and conspiracy.

Of the reported prosecutions, twenty-six percent resulted in reversal of at least part of a conviction. The most common reason for reversal was trial errors by the prosecutor (thirty-six percent of reversals). The next most common reason for reversal was insufficiency of the evidence (twenty-eight percent of reversals).

Twenty different types of providers were prosecuted as defendants, but three types accounted for most (sixty-seven percent) of the convictions: forty-seven percent of the defendants were physicians, ten percent were pharmacists, and ten percent were nursing homes or nursing home employees. Corporate defendants were named in six percent of the prosecutions. This is a surprisingly low number of corporate defendants given the fact that many of the individual defendants operated their fraud through health care corporations.

The sentence given to the convicted provider was disclosed in thirty-seven percent (one hundred and fourteen) of the reported cases. In fifty percent of these instances restitution or fines or both were ordered. The largest amount of restitution ordered was \$686,349.00. A physician in Puerto Rico, convicted for submitting false cost reports, received this distinction, along with twenty years imprisonment.²⁰⁹ In seventy-four percent of the cases where the sentence was disclosed, the court ordered some period of incarceration. The sentences ranged

(1988). This sample also does not include indicted health care providers who pled guilty or were acquitted.

These factors may skew this sample toward inclusion of especially complex cases. Unpublished opinions generally do not discuss complex legal issues. Reynolds & Richman, *The Non-precedential Precedent—Limited Publication and No-Citation Rules in the U.S. Court of Appeals*, 78 COLUM. L. REV. 1167, 1176 (1978); Vestal, *Reported Opinions in the Federal District Courts: Analysis and Suggestions*, 52 IOWA L. REV. 379, 392-94 (1966). Also, because defendants are unlikely to plead guilty when there are complex legal issues or when the evidence of guilt is unclear, the cases in the sample collected for this Article may be biased toward more complex prosecutions. On the other hand, to the extent acquittals are more likely to occur when the government's proof is inadequate or suffers other problems, the cases in this sample may fail to disclose some of the complexities and subtleties in prosecuting health care providers.

208. *United States v. Smith*, 222 F. 165 (E.D. Pa. 1915).

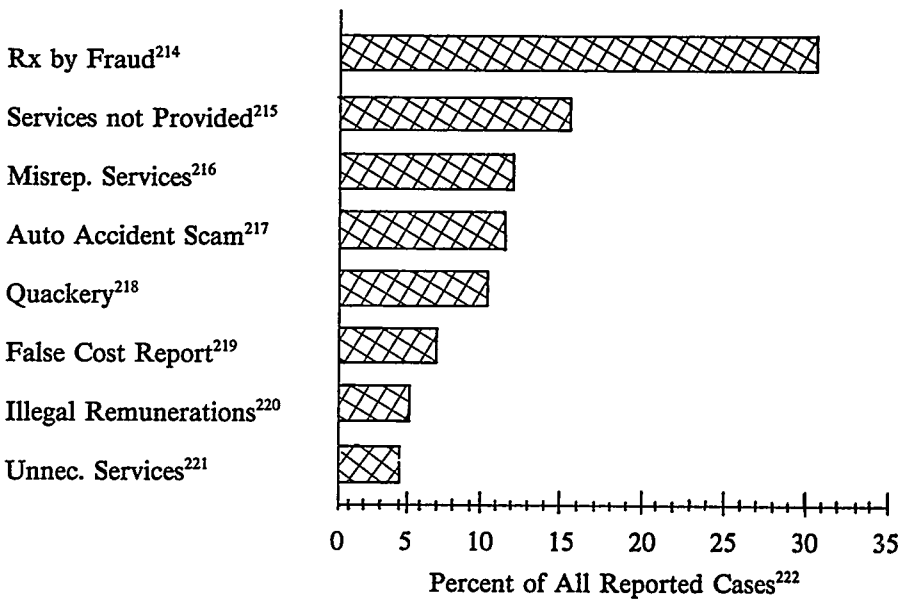
209. *United States v. Alemany Rivera*, 781 F.2d 229, 231 (1st Cir. 1985), *cert. denied*, 475 U.S. 1086 (1986).

from one day to twenty-five years.²¹⁰ The average term of imprisonment was fifty-four months. This compares to a current average sentence for bank robbers of 164.6 months,²¹¹ for car thieves of 55 months²¹² and for distributors of controlled substances of 81.2 months.²¹³

While the above statistics are interesting, this Article will address an observation that is based upon an in-depth analysis of these opinions. This observation is three-fold. First, despite the large number of prosecuting jurisdictions, the variety of providers as defendants, and the diversity of statutory violations charged, all reported prosecutions of health care providers utilize a limited number of theories of fraud. The second observation is that the theory which is the most strategically advantageous for the prosecution has been used the least. The third observation is that the frequency of prosecutions increased dramatically when the government became a third-party payer through the Medicare and Medicaid programs.

Table 1 identifies the theories of fraud used historically to prosecute health care providers and notes the frequency with which each theory has been used:

Table 1 Utilization of Fraud Theories



210. See *United States v. Zicree*, 605 F.2d 1381, 1384 (5th Cir. 1979) (one year sentence for doctor's secretary, modified to require one day incarceration plus probation), *cert. denied*, 445 U.S. 966 (1980); *United States v. Mahar*, 801 F.2d 1477, 1482 n.8 (6th Cir. 1986) (twenty-five years and a two year special parole term).

211. BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, REP. NO. SD-SB-8 SOURCEBOOK OF CRIMINAL JUSTICE STATISTICS—1986 at 444 table 5.23 (1987).

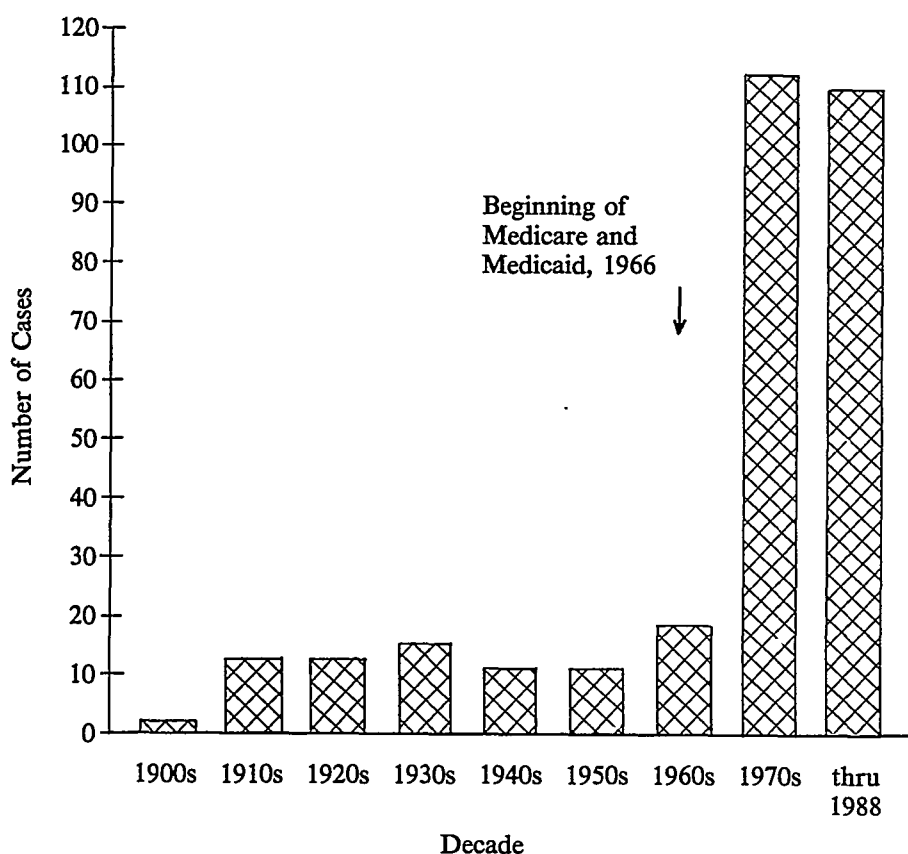
212. *Id.*

213. *Id.*

214. Listed in reverse chronological order: *United States v. Vamos*, 797 F.2d 1146 (2d Cir.

Table 2 demonstrates the chronological distribution of the reported prosecutions.

Table 2 Reported Prosecutions of Health Care Providers



1986), *cert. denied*, 479 U.S. 1036 (1987); United States v. Krebs, 788 F.2d 1166 (6th Cir.), *cert. denied*, 479 U.S. 930 (1986); United States v. Norris, 780 F.2d 1206 (5th Cir. 1986); United States v. Blanton, 730 F.2d 1424 (11th Cir. 1984); State v. Sway, 15 Ohio St. 3d 112, 472 N.E.2d 1065 (1984); United States v. Leichtling, 684 F.2d 553 (8th Cir. 1982), *cert. denied*, 459 U.S. 1201 (1983); United States v. Voorhies, 663 F.2d 30 (6th Cir. 1981), *cert. denied*, 456 U.S. 929 (1982); United States v. Goldstein, 695 F.2d 1228 (10th Cir. 1981), *cert. denied*, 462 U.S. 1132 (1983); Carnes v. State, 406 So. 2d 523 (Fla. Ct. App. 1981); State v. Carr, 95 N.M. 755, 626 P.2d 292 (N.M. Ct. App.), *cert. denied*, 95 N.M. 669, 625 P.2d 1186, *cert. denied*, 454 U.S. 853 (1981); United States v. Seelig, 622 F.2d 207 (6th Cir.), *cert. denied*, 449 U.S. 869 (1980); United States v. Rogers, 609 F.2d 834 (5th Cir. 1980); United States v. Smurthwaite, 590 F.2d 889 (10th Cir. 1979); United States v. Hill, 589 F.2d 1344 (8th Cir.), *cert. denied*, 442 U.S. 919 (1979); United States v. Kirk, 584 F.2d 773 (6th Cir.), *cert. denied*, 439 U.S. 1048 (1978); United States v. Roy, 574 F.2d 386 (7th Cir.), *cert. denied*, 439 U.S. 857 (1978); Commonwealth v. West, 261 Pa. Super. 246, 396 A.2d 380 (1978); State v. Best, 292 N.C. 294, 233 S.E.2d 544 (1977); United States v. Fellman, 549 F.2d 181 (10th Cir. 1977); People v. Alford, 73 Mich. App. 604, 251 N.W.2d 314 (1977), *aff'd*, 405 Mich. 570, 275 N.W.2d 484 (1979); Commonwealth v. Shelhorse, 252 Pa. Super. 475, 381 A.2d 1305 (1977); Haney v. State, 544 S.W.2d 384 (Tex. Crim. App. 1976); State v. Vaccaro, 142 N.J. Super. 167, 361 A.2d 47 (N.J. Super. Ct. App. Div.), *cert. denied*, 71 N.J. 518, 366 A.2d 674 (1976); United States v. Elizay, 527 F.2d 1306 (6th Cir. 1976); United States v. Moore, 423 U.S. 122 (1975); McLean v. State, 527 S.W.2d 76 (Tenn. 1975); United States v. Carroll, 518 F.2d 187 (6th Cir. 1975); People v. Downes, 394 Mich.

17, 228 N.W.2d 212 (1975); *United States v. Rosenberg*, 515 F.2d 190 (9th Cir.), *cert. denied*, 423 U.S. 1031 (1975); *United States v. Black*, 512 F.2d 864 (9th Cir. 1975); *United States v. Green*, 511 F.2d 1062 (7th Cir.), *cert. denied*, 423 U.S. 1031 (1975); *State v. Lawrence*, 264 S.C. 3, 212 S.E.2d 52 (1974), *cert. denied*, 422 U.S. 1025 (1975); *State v. Vinson*, 298 So. 2d 505 (Fla. Dist. Ct. App. 1974), *aff'd*, 345 So. 2d 711 (Fla. 1977); *People v. Kurland*, 33 Cal. App. 3d 197, 117 Cal. Rptr. 216 (Cal. Ct. App. 1974); *United States v. Larson*, 507 F.2d 385 (9th Cir. 1974); *United States v. Badia*, 490 F.2d 296 (1st Cir. 1973); *United States v. Jobe*, 487 F.2d 268 (10th Cir. 1973), *cert. denied*, 416 U.S. 955 (1974); *United States v. Leigh*, 487 F.2d 206 (5th Cir. 1973); *United States v. Barte*, 479 F.2d 484 (10th Cir. 1973); *United States v. Collier*, 478 F.2d 268 (5th Cir. 1973); *United States v. Warren*, 453 F.2d 738 (2d Cir.), *cert. denied*, 406 U.S. 944 (1972); *State v. Jacobs*, 18 Ariz. App. 471, 503 P.2d 826 (1972); *State v. Gilmore*, 76 Wash. 2d 293, 456 P.2d 344 (1969); *White v. United States*, 399 F.2d 813 (8th Cir. 1968); *State v. Webb*, 261 Iowa 1151, 156 N.W.2d 299 (1968); *State v. Bridges*, 398 S.W.2d 1 (Mo. 1966); *People v. Meyer*, 216 Cal. App. 2d 618, 31 Cal. Rptr. 285 (Cal. Dist. Ct. App. 1963); *People v. Lawrence*, 198 Cal. App. 2d 54, 18 Cal. Rptr. 196 (Cal. Dist. Ct. App. 1962); *Brown v. United States*, 250 F.2d 745 (5th Cir.), *cert. denied*, 356 U.S. 938 (1958); *People v. Nunn*, 46 Cal. 2d 460, 296 P.2d 813, *cert. denied*, 352 U.S. 883 (1956); *Neill v. United States*, 225 F.2d 174 (8th Cir. 1955); *McBride v. United States*, 225 F.2d 249 (5th Cir. 1955), *cert. denied*, 350 U.S. 934 (1956); *People v. Greenwood*, 139 N.Y.S.2d 654 (Co. Ct.), *aff'd*, 309 N.Y. 926, 132 N.E.2d 308 (1955); *People v. Braddock*, 41 Cal. 2d 794, 264 P.2d 521 (1953), *cert. denied*, 348 U.S. 837 (1954); *United States v. Tammassello*, 160 F.2d 348 (2d Cir. 1947); *Wesson v. United States*, 164 F.2d 50 (8th Cir. 1947); *Devine v. State*, 151 Tex. Crim. 179, 206 S.W.2d 247 (Tex. Crim. App. 1947); *United States v. Brandenburg*, 155 F.2d 110 (3d Cir. 1946); *United States v. Abdallah*, 149 F.2d 219 (2d Cir.), *cert. denied*, 326 U.S. 724 (1945); *Mitchell v. United States*, 143 F.2d 953 (10th Cir. 1944); *United States v. Lindenfeld*, 142 F.2d 829 (2d Cir.), *cert. denied*, 323 U.S. 761 (1944); *Direct Sales Co. v. United States*, 319 U.S. 703 (1943); *Nigro v. United States*, 117 F.2d 624 (8th Cir. 1941); *Lambert v. United States*, 101 F.2d 960 (5th Cir. 1939); *Heller v. United States*, 104 F.2d 446 (4th Cir. 1939); *Smith v. State*, 214 Ind. 169, 13 N.E.2d 562, (1938); *Towbin v. United States*, 93 F.2d 86 (10th Cir. 1938); *United States v. Anthony*, 15 F. Supp. 553 (S.D. Cal. 1936); *Du Vall v. United States*, 82 F.2d 382 (9th Cir. 1936); *People v. Guagliata*, 362 Ill. 427, 200 N.E. 169, *cert. denied*, 298 U.S. 667 (1936); *MacLafferty v. United States*, 77 F.2d 715 (9th Cir. 1935); *Strader v. United States*, 72 F.2d 589 (10th Cir. 1934); *Bush v. United States*, 16 F.2d 709 (5th Cir. 1927); *Boyd v. United States*, 271 U.S. 104 (1926); *Linder v. United States*, 268 U.S. 5 (1925); *Aiton v. United States*, 3 F.2d 992 (9th Cir. 1925); *Manning v. United States*, 287 F. 800 (8th Cir. 1923); *United States v. Behrman*, 258 U.S. 280 (1922); *Barbot v. United States*, 273 F. 919 (4th Cir. 1921); *Harris v. United States*, 273 F. 785 (2d Cir.), *cert. denied*, 257 U.S. 646 (1921); *Hoyt v. United States*, 273 F. 792 (2d Cir. 1921); *Oliver v. United States*, 267 F. 544 (C.C.A.W. Va. 1920); *Jin Fuey Moy v. United States*, 254 U.S. 189 (1920); *Rothman v. United States*, 270 F. 31 (2d Cir. 1920); *Trader v. United States*, 260 F. 923 (3d Cir.), *cert. denied*, 251 U.S. 555 (1919); *Thompson v. United States*, 258 F. 196 (C.C.A. Mo.), *cert. denied*, 251 U.S. 553 (1919); *Melanson v. United States*, 256 F. 783 (C.C.A. Tex. 1919); *United States v. Doremus*, 249 U.S. 86 (1919); *Webb v. United States*, 249 U.S. 96 (1919); *United States v. Joseph Fleming & Son Co.*, 251 F. 932 (D. Pa. 1918); *Thurston v. United States*, 241 F. 335 (1917).

215. Listed in reverse chronological order: *State v. Cargille*, 507 So. 2d 1254 (La. Ct. App. 1987); *United States v. Lamport*, 787 F.2d 474 (10th Cir.), *cert. denied*, 479 U.S. 846 (1986); *Commonwealth v. Wu*, 343 Pa. Super. 108, 494 A.2d 7 (1985); *United States v. Colletta*, 602 F. Supp. 1322 (E.D. Pa.), *aff'd*, 770 F.2d 1076 (3d Cir. 1985); *People v. Blasquez*, 165 Cal. App. 3d 408, 211 Cal. Rptr. 335 (Cal. Ct. App. 1985); *United States v. Hilliard*, 752 F.2d 578 (11th Cir. 1985); *United States v. Sanders*, 749 F.2d 195 (5th Cir. 1984); *United States v. Varoz*, 740 F.2d 772 (10th Cir. 1984); *Worthington v. United States*, 726 F.2d 1089 (6th Cir.) (direct appeal at 698 F.2d 820 (6th Cir. 1983), *cert. denied*, 469 U.S. 827 (1984); *People v. Chaitin*, 94 A.D.2d 705, 462 N.Y.S.2d 61 (N.Y. App. Div. 1983); *State v. Beatty*, 64 N.C. App. 511, 308 S.E.2d 65 (1983); *United States v. Abadi*, 706 F.2d 178 (6th Cir.), *cert. denied*, 464 U.S. 821 (1983); *United States v. Mitlo*, 557 F. Supp. 520 (W.D. Penn.), *cert. denied*, 464 U.S. 1018 (1983); *People v. American Medical Centers, Ltd.*, 118 Mich. App. 135, 324 N.W.2d 782 (1982), *cert. denied*, 464 U.S. 1009 (1983); *United States v. Hershenow*, 680 F.2d 847 (1st Cir. 1982); *People v. Montesano*, 84 A.D.2d 369, 446 N.Y.S.2d 813 (N.Y. App. Div. 1982); *People v. Einstein*, 106 Ill. App. 3d 526, 435 N.E.2d 1257 (Ill. App. Ct. 1982); *Commonwealth v. Askin*, 306 Pa. Super. 529, 452 A.2d 851 (1982), *modified by*, 502 Pa. 575, 467 A.2d 820 (1983); *United States v. Sherer*, 653 F.2d 334 (8th Cir.), *cert. denied*, 454 U.S. 1034 (1981); *State v. Kennedy*, 105 Wis. 2d 625, 314 N.W.2d 884 (Wis. Ct. App. 1981); *State v. Mark*, 94 Wash. 2d 520, 618 P.2d 73 (1980); *United States v. Johnson*, 634 F.2d 735 (4th Cir. 1980), *cert. denied*, 451 U.S. 907 (1981); *United States v. Adler*, 623 F.2d 1287 (8th Cir. 1980); *State v. Marshall*, 25 Wash. App. 240, 606 P.2d 278 (1980); *United States v. Abrams*, 615 F.2d 541 (1st Cir. 1980); *United States v. Wilson*, 490 F. Supp. 713 (E.D. Mich. 1980), *cert. denied*, 639 F.2d 314

(1981); *United States v. Halper*, 590 F.2d 422 (2d Cir. 1978); *United States v. Herberman*, 583 F.2d 222 (5th Cir. 1978); *United States v. Berdick*, 555 F.2d 1329 (5th Cir.), *cert. denied*, 434 U.S. 1010 (1977); *United States v. Beasley*, 550 F.2d 261 (5th Cir.), *cert. denied*, 434 U.S. 938 (1977); *State v. Page*, 32 N.C. App. 478, 232 S.E.2d 460 (1977); *United States v. Gordon*, 548 F.2d 743 (8th Cir. 1977); *United States v. Evans*, 559 F.2d 244 (5th Cir. 1977), *cert. denied*, 435 U.S. 1015 (1978), *cert. denied*, 435 U.S. 945 (1978); *United States v. Radetsky*, 535 F.2d 556 (10th Cir.), *cert. denied*, 429 U.S. 820 (1976); *United States v. Holt*, 529 F.2d 981 (4th Cir. 1975); *United States v. Cacioppo*, 517 F.2d 22 (8th Cir. 1975); *People v. Slocum*, 52 Cal. App. 3d 867, 125 Cal. Rptr. 442 (Cal. Ct. App. 1975); *People v. Cobbs*, 53 Cal. App. 3d 937, 126 Cal. Rptr. 494 (Cal. Ct. App. 1975); *United States v. Catena*, 500 F.2d 1319 (3d Cir.), *cert. denied*, 419 U.S. 1047 (1974); *United States v. Mantanky*, 482 F.2d 1319 (9th Cir.), *cert. denied*, 414 U.S. 1039 (1973); *State v. Fellman*, 187 Neb. 767, 193 N.W.2d 775 (1972); *United States v. Blazewicz*, 459 F.2d 442 (6th Cir. 1972); *United States v. Katz*, 455 F.2d 496 (5th Cir. 1972); *United States v. Chakmakis*, 449 F.2d 315 (5th Cir. 1971); *People v. Thayer*, 63 Cal. 2d 635, 47 Cal. Rptr. 78, (1965), *cert. denied*, 384 U.S. 908 (1966).

216. Listed in reverse chronological order: *United States v. Cegelka*, 853 F.2d 627 (8th Cir. 1988); *State v. Romero*, 533 So. 2d 1264 (La. Ct. App. 1988); *People v. Asar*, 136 A.D. 2d 712, 523 N.Y.S.2d 910 (N.Y. App. Div. 1988); *Commonwealth v. Stein*, 363 Pa. Super. 410, 546 A.2d 36 (Pa. Super. Ct. 1987); *State v. Heath*, 513 So. 2d 493 (La. Ct. App. 1987); *United States v. Larm*, 824 F.2d 780 (9th Cir. 1987), *cert. denied*, 108 S. Ct. 1057 (1988); *State v. Quinn*, 43 Wash. 896, 719 P.2d 936 (Wash. Ct. App. 1986); *State v. Sword*, 68 Haw. 348, 713 P.2d 432 (1986); *Sheriff of Clark County v. Spagnola*, 101 Nev. 508, 706 P.2d 840 (1985); *People v. Reitman*, 128 Misc. 2d 744, 492 N.Y.S.2d 324 (N.Y. Co. Ct. 1985); *United States v. Brown*, 763 F.2d 984 (8th Cir.), *cert. denied*, 474 U.S. 905 (1985); *State v. Dorn*, 145 Vt. 606, 496 A.2d 451 (1985); *United States v. Alexander*, 748 F.2d 185 (4th Cir. 1984), *cert. denied*, 472 U.S. 1027 (1985); *United States v. Gold*, 743 F.2d 800 (11th Cir. 1984), *cert. denied*, 469 U.S. 1217 (1985); *People v. Kendzia*, 103 A.D.2d 999, 478 N.Y.S.2d 209 (N.Y. App. Div. 1984); *People v. Lee*, 134 Mich. App. 278, 351 N.W.2d 294 (1984); *State v. Griffon*, 448 So. 2d 1287 (La. 1984); *Ex Parte Hunte*, 436 So. 2d 806 (Ala. 1983); *State v. Hughes*, 433 So. 2d 88 (La. 1983); *United States v. Huckaby*, 698 F.2d 915 (8th Cir. 1982), *cert. denied*, 460 U.S. 1070 (1983); *People v. Alizadeh*, 87 A.D.2d 418, 452 N.Y.S.2d 425 (N.Y. App. Div. 1982); *State v. McDermitt*, 406 So. 2d 195 (La. 1981); *State v. Dean*, 105 Wis. 2d 390, 314 N.W.2d 151 (Wis. Ct. App. 1981); *United States v. Wilson*, 639 F.2d 314 (6th Cir. 1981); *People v. Bovee*, 92 Mich. App. 42, 285 N.W.2d 53 (1979); *United States v. Edgewood Health Care Center, Inc.*, 608 F.2d 13 (1st Cir. 1979), *cert. denied*, 444 U.S. 1046 (1980); *United States v. Winkle*, 587 F.2d 705 (5th Cir.), *cert. denied*, 444 U.S. 827 (1979); *People v. Weinfield*, 65 A.D.2d 911, 410 N.Y.S.2d 472 (N.Y. App. Div. 1978); *United States v. Precision Medical Laboratories, Inc.*, 593 F.2d 434 (2d Cir. 1978); *United States v. Rousseau*, 534 F.2d 584 (5th Cir. 1976); *United States v. Mekjian*, 505 F.2d 1320 (5th Cir. 1975); *United States v. Peterson*, 488 F.2d 645 (5th Cir.), *cert. denied*, 414 U.S. 828 (1974); *United States v. Russo*, 480 F.2d 1228 (6th Cir. 1973), *cert. denied*, 414 U.S. 1157 (1974); *People v. Rossi*, 11 A.D.2d 379, 230 N.Y.S.2d 7 (N.Y. App. Div. 1962); *State v. Greco*, 29 N.J. 94, 148 A.2d 164 (1959); *Commonwealth v. Litman*, 187 Pa. Super. 537, 144 A.2d 592 (1958).

217. Listed in reverse chronological order: *United States v. Kaplan*, 832 F.2d 676 (1st Cir. 1987), *cert. denied*, 108 S. Ct. 1080 (1988); *United States v. Krown*, 809 F.2d 144 (1st Cir. 1987); *United States v. Jackson*, 761 F.2d 1541 (11th Cir. 1985); *United States v. Warren*, 747 F.2d 1339 (10th Cir. 1984); *United States v. Gamble*, 737 F.2d 853 (10th Cir. 1984); *United States v. Strong*, 702 F.2d 97 (6th Cir. 1983); *United States v. Nichols*, 695 F.2d 86 (5th Cir. 1982); *United States v. Drury*, 687 F.2d 63 (5th Cir. 1982), *cert. denied*, 461 U.S. 943 (1983); *United States v. Lebovitz*, 506 F. Supp. 249 (W.D. Pa. 1980), *aff'd*, 669 F.2d 894 (3d Cir. 1982), *cert. denied*, 456 U.S. 929 (1982); *United States v. Tager*, 638 F.2d 167 (10th Cir. 1980); *State v. Olkon*, 299 N.W.2d 89 (Minn. 1980), *cert. denied*, 449 U.S. 1132 (1981); *United States v. Witschner*, 624 F.2d 840 (8th Cir.), *cert. denied*, 440 U.S. 994 (1980); *United States v. Zicree*, 605 F.2d 1381 (5th Cir. 1979), *cert. denied*, 445 U.S. 966 (1980); *Glassman v. State*, 377 So. 2d 208 (Fla. Dist. Ct. App. 1979); *United States v. Schaffer*, 599 F.2d 678 (5th Cir. 1979); *United States v. Del Valle*, 587 F.2d 699 (5th Cir.), *cert. denied*, 442 U.S. 909 (1979); *United States v. Reamer*, 589 F.2d 769 (4th Cir. 1978), *cert. denied*, 440 U.S. 980 (1979); *United States v. Boscia*, 573 F.2d 827 (3d Cir.), *cert. denied*, 436 U.S. 911 (1978); *United States v. Cady*, 567 F.2d 771 (8th Cir. 1977), *cert. denied*, 435 U.S. 944 (1978); *State v. Toscano*, 74 N.J. 421, 378 A.2d 755 (1977); *State v. Poganski*, 257 N.W.2d 578 (Minn. 1977); *United States v. Perkal*, 530 F.2d 604 (4th Cir.), *cert. denied*, 429 U.S. 821 (1976); *United States v. Reicin*, 497 F.2d 563 (7th Cir.), *cert. denied*, 419 U.S. 996 (1974); *United States v. Britton*, 500 F.2d 1257 (8th Cir. 1974); *United States v. Parkman*, 488 F.2d 1392 (5th Cir. 1973), *cert. denied*, 416 U.S. 983 (1974); *United States v. Perez*, 489 F.2d 51 (5th Cir. 1973), *cert. denied*, 417 U.S. 945 (1974); *United States v. Medansky*, 486 F.2d 807 (7th Cir. 1973), *cert. denied*, 415 U.S. 989 (1974); *United States v. Silvern*, 494 F.2d 355 (7th Cir. 1973); *United States v. Kaplan*, 470 F.2d 100 (7th Cir. 1972), *cert. denied*, 410 U.S. 966 (1973); *United States v. Thomas*, 463 F.2d 1061 (7th Cir. 1972); *United States*

v. Shuford, 454 F.2d 772 (4th Cir. 1971); *People v. Scofield*, 17 Cal. App. 3d 1018, 95 Cal. Rptr. 405 (1971); *United States v. Sternback*, 402 F.2d 353 (7th Cir. 1968), *cert. denied*, 393 U.S. 1082 (1969); *Everitt v. United States*, 306 F.2d 839 (5th Cir. 1962), *cert. denied*, 372 U.S. 920 (1963); *People v. Benson*, 206 Cal. App. 2d 519, 23 Cal. Rptr. 908 (Cal. Dist. Ct. App. 1962), *cert. denied*, 374 U.S. 806 (1963), *overruled by People v. Perez*, 44 Cal. Rptr. 326, 62 Cal. 2d 769, 401 P.2d 934 (1965); *People v. Kayne*, 268 Mich. 186, 255 N.W. 758 (1934).

218. Listed in reverse chronological order: *People v. Brych*, 203 Cal. App. 3d 1068, 250 Cal. Rptr. 402 (Cal. Ct. App. 1988); *Sorce v. State*, 736 S.W.2d 851 (Tx. Ct. App. 1987); *United States v. Keller*, 784 F.2d 1296 (5th Cir. 1986); *United States v. Lott*, 630 F. Supp. 611 (E.D. Va.), *aff'd*, 795 F.2d 82 (4th Cir. 1986); *People v. Varas*, 110 A.D. 2d 646, 487 N.Y.S.2d 577 (N.Y. App. Div. 1985); *People v. Burroughs*, 35 Cal. 3d 824, 678 P.2d 894, 210 Cal. Rptr. 319 (1984); *People v. Privitera*, 74 Cal. App. 3d 936, 141 Cal. Rptr. 764, *vacated*, 23 Cal. 3d 697, 153 Cal. Rptr. 431, 591 P.2d 919, *cert. denied*, 444 U.S. 949 (1979); *State v. Hoffman*, 558 P.2d 602 (Utah 1976); *United States v. Maturo*, 536 F.2d 427 (D.C. Cir. 1976); *United States v. Vecchiarello*, 536 F.2d 420 (D.C. Cir. 1976), *aff'd*, 569 F.2d 656 (D.C. Cir. 1977); *People v. Eckley*, 33 Cal. App. 3d 91, 108 Cal. Rptr. 52 (Cal. Ct. App. 1973); *People v. Chatfield*, 272 Cal. App. 2d 141, 77 Cal. Rptr. 118 (Cal. Ct. App. 1969), *cert. denied*, 402 U.S. 951 (1971); *United States v. Taller*, 394 F.2d 435 (2d Cir.), *cert. denied*, 393 U.S. 839 (1968); *United States v. Andreadis*, 366 F.2d 423 (2d Cir. 1966), *cert. denied*, 385 U.S. 1001 (1967); *United States v. DeWelles*, 345 F.2d 387 (7th Cir.), *cert. denied*, 382 U.S. 833 (1965); *People v. Chapman*, 207 Cal. App. 2d 557, 24 Cal. Rptr. 568 (Cal. Dist. Ct. App. 1962); *People v. Marsh*, 58 Cal. 2d 732, 376 P.2d 300, 26 Cal. Rptr. 300 (Cal. 1962); *People v. Schmitt*, 155 Cal. App. 2d 87, 317 P.2d 673 (Cal. Dist. Ct. App. 1957); *People v. Schroeder*, 132 Cal. App. 2d 1, 281 P.2d 297 (Cal. Dist. Ct. App. 1955); *United States v. Kaadt*, 171 F.2d 600 (7th Cir. 1948); *Baker v. United States*, 115 F.2d 533 (8th Cir. 1940), *cert. denied*, 312 U.S. 692 (1941); *United States v. Lee*, 107 F.2d 522 (7th Cir. 1939), *cert. denied*, 309 U.S. 659 (1940); *Barnhill v. United States*, 96 F.2d 116 (10th Cir. 1938); *West v. United States*, 68 F.2d 96 (10th Cir. 1933); *Commonwealth v. Johnson*, 312 Pa. 140, 167 A. 344 (1933); *Stunz v. United States*, 27 F.2d 575 (8th Cir. 1928); *Kar Ru Chemical Co. v. United States*, 264 F. 921 (9th Cir. 1920); *United States v. Smith*, 222 F. 165 (E.D. Pa. 1915); *Moses v. United States*, 221 F. 863 (2d Cir.), *cert. denied*, 238 U.S. 629 (1915); *Bruce v. United States*, 202 F. 98 (8th Cir. 1912); *Dyar v. United States*, 186 F. 614 (5th Cir. 1911); *Hibbard v. United States*, 172 F. 66 (7th Cir. 1909).

219. Listed in reverse chronological order: *Greco v. State*, 307 Md. 470, 515 A.2d 220 (Md. Ct. App. 1986); *United States v. Alemany Rivera*, 781 F.2d 229 (1st Cir. 1985), *cert. denied*, 475 U.S. 1086 (1986); *McKennie v. State*, 439 So. 2d 706 (Ala. Crim. App. 1982), *rev'd*, 439 So. 2d 713 (Ala. 1983); *Commonwealth v. Minkin*, 14 Mass. App. Ct. 911, 436 N.E.2d 955, *appeal denied*, 386 Mass. 1104, 438 N.E.2d 75 (1982); *United States v. Simon*, 510 F. Supp. 232 (E.D. Pa. 1981); *People v. Notey*, 423 N.Y.S.2d 947, 72 A.D.2d 279 (1980); *State v. Hoffman*, 82 N.J. 184, 412 A.2d 120 (1980); *Frye v. State*, 369 So.2d 892 (Ala. Crim. App. 1979); *United States v. Huber*, 603 F.2d 387 (2d Cir. 1979), *cert. denied*, 445 U.S. 927 (1980); *United States v. Collins*, 596 F.2d 166 (6th Cir. 1979); *United States v. Jones*, 587 F.2d 802 (5th Cir. 1979); *United States v. Braunstein*, 474 F. Supp. 1 (D.N.J. 1978); *People v. Severino*, 63 A.D.2d 1010, 406 N.Y.S.2d 105 (1978); *United States v. Cella*, 568 F.2d 1266 (9th Cir. 1977); *Commonwealth v. Cerveney*, 373 Mass. 345, 367 N.E.2d 802 (1977), *overruled by Commonwealth v. Crocker*, 384 Mass. 353, 424 N.E.2d 524 (1981); *United States v. Nemes*, 555 F.2d 51 (2d Cir. 1977); *People v. Wolf*, 59 A.D. 2d 547, 397 N.Y.S.2d 131 (N.Y. App. Div. 1977); *State v. Rudd*, 259 N.W.2d 567 (Minn. 1977), *cert. denied*, 435 U.S. 996 (1978); *People v. Christiano*, 87 Misc. 2d 962, 386 N.Y.S.2d 620 (1976); *People v. Loughrey*, 149 N.J. Super. 264, 373 A.2d 703 (N.J. Super. Ct. App. Div. 1977); *United States v. Smith*, 523 F.2d 771 (5th Cir. 1975), *cert. denied*, 429 U.S. 817 (1976).

220. Listed in reverse chronological order: *People v. Warden*, 141 A.D.2d 913, 529 N.Y.S.2d 230 (1988); *United States v. Sadlier*, 649 F. Supp. 1560 (D. Mass. 1986); *United States v. Lipkis*, 770 F.2d 1447 (9th Cir. 1985); *United States v. Universal Trade & Indus., Inc.*, 695 F.2d 1151 (9th Cir. 1982); *United States v. Duz-Mor Diagnostic Laboratory, Inc.*, 650 F.2d 223 (9th Cir. 1981); *United States v. Stewart Clinical Laboratory, Inc.*, 652 F.2d 804 (9th Cir. 1981); *People v. Forham*, 84 A.D.2d 792, 443 N.Y.S.2d 881 (1981); *United States v. Perlstein*, 632 F.2d 661 (6th Cir. 1980), *cert. denied*, 449 U.S. 1084 (1981); *United States v. Ruttenberg*, 625 F.2d 173 (7th Cir. 1980); *United States v. Hancock*, 604 F.2d 999 (7th Cir.), *cert. denied*, 444 U.S. 991 (1979); *United States v. Weingarden*, 468 F. Supp. 410 (E.D. Mich. 1979), *aff'd sub nom. United States v. Tapert*, 625 F.2d 111 (6th Cir.), *cert. denied*, 449 U.S. 1034 (1980); *United States v. Porter*, 591 F.2d 1048 (5th Cir. 1979); *People v. Liberman*, 94 Misc. 2d 737, 405 N.Y.S.2d 559 (N.Y. Crim. Ct. 1978); *United States v. Zacher*, 586 F.2d 912 (2d Cir. 1978); *People v. Lerner*, 90 Misc. 2d 513, 394 N.Y.S.2d 514 (N.Y. Sup. Ct. 1977).

221. Listed in reverse chronological order: *United States v. Goldberg*, 862 F.2d 101 (6th Cir. 1988); *United States v. Campbell*, 845 F.2d 1374 (6th Cir.), *cert. denied*, 109 S. Ct. 259 (1988);

A. "Rx by Fraud": Violations of Statutes Regulating Controlled Substances

To the extent fraud is a misrepresentation, omission, or concealment calculated to deceive, providers commit fraud when they acquire a controlled substance by falsely alleging it is for legitimate medical purposes, or when they prescribe a controlled substance that is not for legitimate medical purposes. This theory is the most widely used theory of fraud in prosecuting health care providers.

*United States v. Moore*²²³ exemplifies this type of fraud.²²⁴ Moore, a physician, was convicted of knowingly distributing and dispensing a controlled substance in violation of 21 U.S.C. § 841(a)(1) (1982).²²⁵ The evidence showed that Moore dispensed methadone, a drug that requires careful monitoring to prevent addiction, in a manner contrary to generally accepted medical practices.²²⁶

United States v. Sblendorio, 830 F.2d 1382 (7th Cir. 1987), *cert. denied*, 108 S. Ct. 1034 (1988); *United States v. Azad*, 809 F.2d 291 (6th Cir. 1986), *cert. denied*, 481 S. Ct. 1004 (1987); *United States v. Mahar*, 801 F.2d 1477 (6th Cir. 1986); *United States v. Greber*, 760 F.2d 68 (3d Cir.), *cert. denied*, 474 U.S. 998 (1985); *In re Wayne County Prosecutor*, 121 Mich. App. 798, 329 N.W.2d 510 (1982); *United States v. Furman*, 507 F. Supp. 848 (D. Md.), *rev'd*, 672 F.2d 914 (1981); *United States v. Ziperstein*, 601 F.2d 281 (7th Cir. 1979), *cert. denied*, 444 U.S. 1031 (1980); *United States v. Talbott*, 460 F. Supp. 253 (S.D. Ohio), *aff'd*, 590 F.2d 192 (6th Cir. 1978); *People v. Rehman*, 253 Cal. App. 2d 119, 61 Cal. Rptr. 65 (1967), *cert. denied*, 390 U.S. 947 (1968); *People v. Bowman*, 156 Cal. App. 2d 784, 320 P.2d 70 (Cal. Dist. Ct. App. 1958); *Hughes v. United States*, 231 F. 50 (5th Cir.), *cert. denied*, 242 U.S. 640 (1916).

222. Often multiple theories of fraud were used in the prosecution of one case. In such instances, the case is included in only the category corresponding to the dominant theory discussed in the opinion. However, any case that referred to the "unnecessary services" theory was included in that category even though other theories appeared to dominate the opinion. There was insufficient information in the following cases to determine the theory of fraud used (listed in chronological order): *State v. Fiorilla*, 226 N.J. Super. 81, 543 A.2d 958 (N.J. Super. Ct. App. Div. 1988); *State v. Lizzi*, 199 Conn. 462, 508 A.2d 16 (1986); *People v. Louie*, 158 Cal. App. 3d Supp. 28, 205 Cal. Rptr. 247 (1984); *Romani v. State*, 429 So. 2d 332 (Fla. Dist. Ct. App. 1983); *State v. Karwacki*, 1 Haw. App. 157, 616 P.2d 226 (1980); *United States v. Schaffer*, 600 F.2d 1120 (5th Cir. 1979); *United States v. Bernstein*, 546 F.2d 109 (5th Cir. 1977); *People v. Brown*, 132 Cal. Rptr. 217, 61 Cal. App. 3d 476 (Cal. Ct. App. 1976); *United States v. Carey*, 475 F.2d 1019 (9th Cir. 1973); *United States v. Kraude*, 467 F.2d 37 (9th Cir.), *cert. denied*, 409 U.S. 1076 (1972); *Smith v. Superior Court*, 5 Cal. App. 3d 260, 85 Cal. Rptr 208 (1970).

223. 423 U.S. 122 (1975).

224. Other examples of health care providers indicted for using a professional license to traffic in controlled substances include: *Boyd v. United States*, 271 U.S. 104 (1926); *United States v. Behrman*, 258 U.S. 280 (1922); *Jin Fuey Moy v. United States*, 254 U.S. 189 (1920); *Webb v. United States*, 249 U.S. 96 (1919); *United States v. Krebs*, 788 F.2d 1166 (6th Cir.), *cert. denied*, 479 U.S. 930 (1986); *United States v. Blanton*, 730 F.2d 1425 (11th Cir. 1984); *United States v. Voorhies*, 663 F.2d 30 (6th Cir. 1981), *cert. denied*, 456 U.S. 929 (1982); *United States v. Smurthwaite*, 590 F.2d 889 (10th Cir. 1979); *United States v. Fellman*, 549 F.2d 181 (10th Cir. 1977); *United States v. Carroll*, 518 F.2d 187 (6th Cir. 1975); *United States v. Rosenberg*, 515 F.2d 190 (9th Cir.), *cert. denied*, 423 U.S. 1031 (1975); *United States v. Green*, 511 F.2d 1062 (7th Cir.), *cert. denied*, 423 U.S. 1031 (1975); *United States v. Larson*, 507 F.2d 385 (9th Cir. 1974); *United States v. Badia*, 490 F.2d 296 (1st Cir. 1973); *United States v. Jobe*, 487 F.2d 268 (10th Cir. 1973), *cert. denied*, 416 U.S. 955 (1974); *United States v. Leigh*, 487 F.2d 206 (5th Cir. 1973); *United States v. Bartee*, 479 F.2d 484 (10th Cir. 1973); *United States v. Collier*, 478 F.2d 268 (5th Cir. 1973); *United States v. Warren*, 453 F.2d 738 (2d Cir.), *cert. denied*, 406 U.S. 944 (1972); *White v. United States*, 399 F.2d 813 (8th Cir. 1968); *Brown v. United States*, 250 F.2d 745 (5th Cir.), *cert. denied*, 356 U.S. 938 (1958); *United States v. Abdallah*, 149 F.2d 219 (2d Cir.), *cert. denied*, 326 U.S. 724 (1945); *People v. Greenwood*, 139 N.Y.S.2d 654 (Co. Ct.), *aff'd*, 309 N.Y. 926, 132 N.E.2d 308 (1955); *State v. Lawrence*, 264 S.C. 3, 212 S.E.2d 52 (1974), *cert. denied*, 422 U.S. 1025 (1975).

225. *Moore*, 423 U.S. at 124.

226. *Id.* at 126-27.

[Moore] gave inadequate physical examinations or none at all. He ignored the results of tests he did make. He [took no precautions against methadone's] misuse and diversion. He did not regulate the dosage at all, prescribing as much and as frequently as the patient demanded. He did not charge for medical services rendered, but graduated his fee according to the number of tablets desired. In practical effect, he acted as a large-scale "pusher"—not as a physician.²²⁷

In this instance, as with most defendants charged under this theory, the provider was improperly distributing the controlled substance to his patients. In a few cases prosecuted under this theory, however, the provider was improperly prescribing controlled substances for his own consumption.²²⁸

In *Moore* the Supreme Court put to rest a defense routinely raised to prosecutions under this theory. Most controlled substance statutes contain two levels of penalties: lesser penalties for those individuals who are registered under the statute and who fail to comply with the registration requirements, and stiffer penalties for other violations, such as distribution. When prosecuted for offenses that carry the stiffer penalties, registrants argued that they could be prosecuted only for the offenses that carry the lesser penalties because these were the only offenses specifically applicable to registrants. The Supreme Court rejected this argument, noting that the distribution statute reaches "any person" and that the current statute had been passed to strengthen the prior statute that had already been interpreted to apply to registrants.²²⁹ By the time the Supreme Court rejected this argument in *Moore* it had been rejected in almost every federal circuit court.²³⁰

Most state courts have followed suit in interpreting controlled substance statutes that have a two-track offense structure like the federal statute and have held that registrants are not immune from prosecution under the general provisions of the statute.²³¹ The state courts that have allowed the character of the violator to determine which offense shall apply have interpreted statutes that provide essentially the same penalties for both offenses.²³²

Many of the cases prosecuted under this theory are investigated by undercover officers posing as patients.²³³ These officers generally testify as to the cur-

227. *Id.* at 142-43.

228. See, e.g., *United States v. Hill*, 589 F.2d 1344 (8th Cir.), *cert. denied*, 442 U.S. 919 (1979); *United States v. Tommasello*, 160 F.2d 348 (2d Cir. 1947); *People v. Kurland*, 33 Cal. App. 3d 197, 117 Cal. Rptr. 216 (1973); *State v. Gilmore*, 76 Wash. 2d 293, 456 P.2d 344 (1969).

229. *Moore*, 423 U.S. at 341-42.

230. *Id.* at 341 n.7.

231. See, e.g., *State v. Vinson*, 298 So. 2d 505 (Fla. Dist. Ct. App. 1974), *aff'd*, 345 So. 2d 711 (Fla. 1977); *People v. Alford*, 73 Mich. App. 604, 251 N.W.2d 314 (1977), *aff'd*, 405 Mich. 570, 275 N.W.2d 484 (1979); *State v. Vaccaro*, 142 N.J. Super. 167, 361 A.2d 47 (N.J. Super. App. Div.), *cert. denied*, 71 N.J. 518, 366 A.2d 647 (N.J. 1976); *State v. Carr*, 95 N.M. 755, 626 P.2d 292 (N.M. Ct. App.), *cert. denied*, 454 U.S. 853 (1981).

232. See, e.g., *State v. Best*, 292 N.C. 294, 233 S.E.2d 544 (1977); *McLean v. State*, 527 S.W.2d 76 (Tenn. 1975); *Haney v. State*, 544 S.W.2d 384 (Tex. Crim. App. 1976).

233. See, e.g., *United States v. Carroll*, 518 F.2d 187, 188 (6th Cir. 1975) (McAllister, J., dissenting) (exploring some of the problems with undercover investigations in this context); *United States v. Rosenberg*, 515 F.2d 190, 192 (9th Cir.), *cert. denied*, 423 U.S. 1031 (1975); *Best*, 292 N.C. at 295-97, 233 S.E.2d at 545-47; *United States v. Green*, 511 F.2d 1062, 1064 (7th Cir.), *cert. denied*, 423

sory or nonexistent examinations they received from the provider prior to receiving a prescription for the controlled substance²³⁴ and to the form of payment made to the provider (flat rate cash fee for each prescription).²³⁵ The defendants' statements to these undercover officers can be devastating evidence. When one agent told the defendant-physician that he never used Ritalin (a controlled substance), "but he just sold it," the defendant gave the officer prescriptions for Ritalin and replied "everybody has to make a living."²³⁶ Employees of the provider can also provide detailed and substantial evidence that a provider is in effect distributing drugs, not practicing medicine.²³⁷ In any of these cases, medical expert testimony will be needed to prove that the controlled substances dispensed could not be for legitimate medical purposes.²³⁸ As the United States Court of Appeals for the Tenth Circuit noted, "expert testimony with respect to recognized medical standards and methods of treating patients, such as those for whom the prescriptions were furnished, [will be] admissible because of its bearing upon the intent and purpose with which the prescriptions were issued."²³⁹

As with any expert testimony about proper medical treatment, the expert testimony in these cases should conclusively show that the prescriptions in question were not in the usual course of a professional practice.²⁴⁰ A series of cases in the early twentieth century dealing with physicians who dispensed morphine to drug addicts demonstrates this. Experts were equivocal in assessing the legitimate medical purpose of prescriptions of morphine. This led to acquittals.²⁴¹ For example, in *Linder v. United States*²⁴² the Supreme Court found that the evidence was insufficient to prove that the prescription was not in good faith despite expert testimony that the prescription was not medically indicated, and reversed the conviction of Dr. Linder, a physician, for prescribing morphine and cocaine to a drug addict.²⁴³ The court explained that:

The [drug addict-patients of the defendant] are diseased and proper subjects for such treatment, and we cannot possibly conclude that a physician acted improperly or unwisely or for other than medical purposes solely because he has dispensed to one of them, in the ordinary

U.S. 1031 (1975); *United States v. Jobe*, 487 F.2d 268, 269 (10th Cir. 1973), *cert. denied*, 416 U.S. 955 (1974); *United States v. Badia*, 490 F.2d 296, 297 (1st Cir. 1973); *United States v. Bartee*, 479 F.2d 488, 485 (10th Cir. 1973).

234. *Badia*, 490 F.2d at 297; *Jobe*, 487 F.2d at 269; *Bartee*, 479 F.2d at 485.

235. *United States v. Larson*, 507 F.2d 385, 387 (9th Cir. 1974).

236. *Green*, 511 F.2d at 1066.

237. *See, e.g., id.* at 1062, 1064-65.

238. *See, e.g., id.* at 1072-73; *United States v. Bartee*, 479 F.2d 484, 488 (10th Cir. 1973); *United States v. Best*, 292 N.C. 294, 298-99, 233 S.E.2d 544, 547-48 (1977); *State v. Lawrence*, 264 S.C. 3, 14-16, 212 S.E.2d 52, 56-58 (1974) (approving part of expert testimony used but condemning testimony that was expert's personal opinion as not relevant to the issues before the court), *cert. denied*, 422 U.S. 1025 (1975).

239. *Strader v. United States*, 72 F.2d 589, 592 (10th Cir. 1934).

240. *See id.*

241. *See, e.g., United States v. Anthony*, 15 F. Supp. 553 (S.D. Cal. 1936); *cf. Towbin v. United States*, 93 F.2d 861 (10th Cir. 1938) (evidence insufficient to prove prescriptions were not issued in the usual course of a professional practice).

242. 268 U.S. 5 (1925).

243. *See id.* at 18.

course and in good faith, four small tablets of morphine or cocaine for relief of conditions incident to addiction.²⁴⁴

The quantity of controlled substances dispensed and the degree of monitoring by the physician seemed to be critical factors to the *Linder* court in assessing the bona fide nature of the prescription.²⁴⁵

Most federal prosecutions utilizing this theory charge violations of the Controlled Substances Act, 21 U.S.C. sections 841,²⁴⁶ 843²⁴⁷ and 846.²⁴⁸ The older federal cases in which this theory was used were prosecuted under the Harrison Anti-Narcotic Act.²⁴⁹ State prosecutions using this theory have alleged violations of state controlled substances statutes.²⁵⁰ Because the drug industry is so heavily regulated, any distribution offense by a provider will often involve additional criminal violations as the provider attempts to conceal criminal activity or simply fails to accurately report actual activity. This is aptly shown in *United States v. Vamos*²⁵¹ in which Dr. Vamos was prosecuted for directing the creation of fictitious patient records in an attempt to account for the excessive amounts of drugs distributed.²⁵² False documentation can be prosecuted as a violation of 18 U.S.C. § 1341 (1982) if the mails were used to file the falsified records, as a violation of 18 U.S.C. § 1001 (1982) if the statement is submitted to Medicare or Medicaid, or as a violation of 21 U.S.C. § 843 (1982), which makes it an offense to "knowingly and intentionally . . . furnish false or fraudulent material information . . . in any application, report, record, or other document

244. *Id.*

245. *Id.* at 18-22.

246. See, e.g., *United States v. Goldstein*, 695 F.2d 1228 (10th Cir. 1981), *cert. denied*, 462 U.S. 1132 (1983); *United States v. Carroll*, 518 F.2d 187 (6th Cir. 1975); *United States v. Green*, 511 F.2d 1062 (7th Cir.), *cert. denied*, 423 U.S. 1031 (1975); *United States v. Larson*, 507 F.2d 385 (9th Cir. 1974).

247. See, e.g., *United States v. Leichtling*, 684 F.2d 553 (8th Cir. 1982), *cert. denied*, 459 U.S. 1201 (1983); *United States v. Hill*, 589 F.2d 1344 (8th Cir.), *cert. denied*, 442 U.S. 919 (1979).

248. See, e.g., *United States v. Vamos*, 797 F.2d 1146 (2d Cir. 1986), *cert. denied*, 479 U.S. 1036 (1987); *United States v. Krebs*, 788 F.2d 1166 (11th Cir.), *cert. denied*, 479 U.S. 930 (1986); *Larson* 507 F.2d at 385.

249. 38 Stat. 785, ch 1, 38 Stat. 785 (1914); see, e.g., *Direct Sales Co. v. United States*, 319 U.S. 703 (1943); *United States v. Behrman*, 258 U.S. 280 (1922); *Jin Fuey Moy v. United States*, 254 U.S. 189 (1921) (opinion sets forth the Harrison Anti-Narcotic Act, 38 Stat. 785, ch. 1, 38 Stat. 785 (1914)); *McBride v. United States*, 225 F.2d 249, 250 (5th Cir. 1955), *cert. denied*, 350 U.S. 934 (1956).

250. See, e.g., *State v. Vaccaro*, 142 N.J. Super. 167, 171-72, 361 A.2d 47, 50 (N.J. Super. Ct. App. Div. 1987) (N.J. REV. STAT. § 24: 21-19 (repealed 1987)), *cert. denied*, 71 N.J. 518, 366 A.2d 647 (1976); *State v. Carr*, 95 N.M. 755, 626 P.2d 292, 295 (N.M. Ct. App.) (N.M. STAT. ANN. §§ 30-31-1 to -40 (1978)), *cert. denied*, 454 U.S. 853 (1981); *People v. Alford*, 73 Mich. App. 604, 609, 251 N.W.2d 314, 319 (1977) (MICH. STAT. ANN. §§ 18.1070(41) (repealed 1978)), *aff'd*, 405 Mich. 570, 275 N.W.2d 484 (1979); *State v. Best*, 292 N.C. 294, 305, 233 S.E.2d 544, 554 (1987) (court reversed conviction; holding that prosecution is proper under N.C. GEN. STAT. § 90-108 (1985) but improper under N.C. GEN. STAT. § 90-95(a)(1) (1985)).

251. 797 F.2d 1146 (2d Cir. 1986); see also *United States v. Blanton*, 730 F.2d 1425, 1434 (11th Cir. 1984) (defendant-physician convicted for violating 21 U.S.C. § 842(a)(5) (1982) for failing to maintain proper records of the controlled substances in his possession); *State v. Vaccaro*, 142 N.J. Super. 167, 172, 361 A.2d 47, 49 (N.J. Super. Ct. App. Div. 1987) (defendant convicted for failure to properly keep records and maintain inventories of controlled dangerous substances, as well as dispensing and selling controlled substances).

252. *Vamos*, 797 F.2d at 1148-49.

required to be made, kept or filed under [the Controlled Substances Act]."²⁵³

In summary, health care professionals who are licensed to prescribe or acquire controlled substances commit fraud when they falsely represent information necessary to acquire or prescribe the controlled substance. Generally the fraud in cases prosecuted using this theory is straightforward and easy to prove. Problems with these cases occur not because of the theory used but because of traditional difficulties encountered with some of the types of evidence routinely employed in these cases; that is, undercover operations, which sometimes raise an entrapment defense; medical expert testimony, which is subject to attack because of the inexact nature of proper medicine; and insider witnesses, who may also have criminal culpability. To overcome these problems a prosecutor must prove a pattern of treatment for many patients where it clearly appears that the medical care rendered is not legitimate but serves only as a front for distribution of controlled substances.

B. *Billing for Services Not Provided*

Of the eight theories of fraud, billing for services not provided is one of the easiest theories to charge, explain, and prove. This theory has the second highest rate of usage in the reported cases.²⁵⁴ The success of this theory depends upon the type of service at issue. Services detectable by physical examination and services a patient would likely recall if they have been performed are best suited for this theory. By the same token, if the delivery of the service cannot be confirmed or if the service is so routine that a patient would be unlikely to recall it, this theory should not be used.

*United States v. Gordon*²⁵⁵ demonstrates that this theory works well when the services, if performed, are detectable by subsequent examination. Defendant, a podiatrist, was convicted of submitting claims to Medicare for services he did not perform. The Government called as a witness a podiatry expert who testified that his subsequent physical examination of defendant's patients indicated that the services had not been performed.²⁵⁶ *United States v. Varoz*²⁵⁷ exemplifies a major pitfall with such expert testimony. In this case, a podiatry expert testifying as a government witness stated that, in his opinion, certain services were not performed on the patients in question.²⁵⁸ However, this expert based his opinion on the lack of documentation in the file, not on a physical examination of the patient.²⁵⁹ The Tenth Circuit found such evidence insufficient and set aside the conviction.²⁶⁰ The court noted that sufficient expert testimony to prove this theory should be based upon the expert's review of

253. 21 U.S.C. § 843 (1982).

254. See *supra* Table 1 accompanying notes 214-222.

255. 548 F.2d 743 (8th Cir. 1977).

256. *Id.* at 744.

257. 740 F.2d 772 (10th Cir. 1984).

258. *Id.* at 776.

259. *Id.* at 776-77.

260. *Id.*

unambiguous physical evidence.²⁶¹

Subsequent physical evidence will also corroborate whether a service was in fact provided when the service at issue involves a tangible item, such as durable medical equipment. In *United States v. Hershenow*²⁶² a pharmacist was convicted for billing for surgical equipment he never supplied. Evidence showed that the equipment allegedly sold required the patient's presence to be fitted.²⁶³ Patients testified they had never been to the pharmacy to be fitted for equipment and had never received the equipment.²⁶⁴

*People v. American Medical Centers*²⁶⁵ illustrates that this theory is also easy to prove when the services at issue are especially intrusive and of a nature that patients would tend to recall. In this case, defendant-physicians were convicted for billing Medicaid for "direct laryngoscopies" that had never been performed.²⁶⁶ A direct laryngoscopy is an examination of exterior and interior of the larynx using an instrument that is inserted down a patient's throat.²⁶⁷ The patients testified that they did not undergo this procedure.²⁶⁸

The majority of reported cases using this theory, however, involved intangible, fungible, or nonmemorable services. Visits to patients²⁶⁹ and disbursements of medicine²⁷⁰ are the most common examples. The nonrendering of these services is hard to prove since they usually occur in such a large volume that recalling whether one of many services was not rendered may be difficult for a patient.²⁷¹ Even if the volume is not large, the patient may have been too ill

261. *Id.* at 778; see also *Gordon*, 548 F.2d at 744 (court held the evidence of a podiatry expert was unambiguous when he examined defendant's patients, then testified that the patients never received the services allegedly provided by defendant based upon his personal observations).

262. 680 F.2d 847 (1st Cir. 1982). For other examples of cases in which the service allegedly provided involved tangible items, see *United States v. Evans*, 559 F.2d 244, 245 (5th Cir. 1977) (defendants who operated a company that sold and leased respiration equipment were convicted for billing Medicare for equipment never supplied to patients), *cert. denied*, 434 U.S. 1015 (1978); *United States v. Beasley*, 550 F.2d 261, 264 (5th Cir.) (defendants, officers of a nonprofit health services foundation were convicted for submitting claims to the State of Louisiana for allegedly constructing mobile medical clinics that were never built), *cert. denied*, 434 U.S. 938 (1977).

263. *Hershenow*, 680 F.2d at 862.

264. *Id.*

265. 118 Mich. App. 135, 324 N.W.2d 782 (1982), *cert. denied*, 464 U.S. 1009 (1983).

266. *Id.* at 139, 324 N.W.2d at 787.

267. *TABER'S CYCLOPEDIA MEDICAL DICTIONARY* 931 (15th ed. 1985).

268. *American Medical Centers*, 118 Mich. App. at 149, 324 N.W.2d at 791; *cf.* *State v. Cargille*, 507 So. 2d 1254, 1260 (La. Ct. App. 1987) (although not explicitly stated by the court, proof of fraud would likely require testimony from patients; procedure requiring stool specimen would have been particularly memorable).

269. See, e.g., *United States v. Hilliard*, 752 F.2d 578, 579 (11th Cir. 1985); *United States v. Mitlo*, 714 F.2d 294, 295 (3d Cir.), *cert. denied*, 464 U.S. 1018 (1983); *United States v. Jones*, 587 F.2d 802, 804 (5th Cir. 1979); *United States v. Cacioppo*, 517 F.2d 22, 23 (8th Cir. 1975); *United States v. Catena*, 500 F.2d 1319, 1321 (3d Cir.), *cert. denied*, 419 U.S. 1047 (1974); *United States v. Matanky*, 482 F.2d 1319, 1323 (9th Cir.), *cert. denied*, 414 U.S. 1039 (1973); *United States v. Katz*, 455 F.2d 496, 497 (5th Cir.), *cert. denied*, 408 U.S. 923 (1972); *United States v. Chakmakis*, 449 F.2d 315, 317 (5th Cir. 1971).

270. See, e.g., *United States v. Sanders*, 749 F.2d 195, 197 (5th Cir. 1984); *United States v. Ziperstein*, 601 F.2d 281, 285 (7th Cir. 1979), *cert. denied*, 444 U.S. 1031 (1980); *State v. Beatty*, 64 N.C. App. 511, 512, 308 S.E.2d 65, 66, *disc. rev. denied*, 309 N.C. 823, 310 S.E.2d 354 (1983); *State v. Marshall*, 25 Wash. App. 240, 242, 606 P.2d 278, 280 (1980).

271. See, e.g., *Matanky*, 482 F.2d 1321, 1323 (defendant-physician billed for visits allegedly made to elderly patients two to three times per week over a two year period).

during the treatment to testify, beyond a reasonable doubt, that the provider did not provide a service as alleged.²⁷² Moreover, these types of services leave no tangible evidence after the fact to indicate whether the service was provided.

The reported cases reveal various ways these problems are overcome. Often the patient is able to confirm credibly that the visit was not made or medicine not dispensed.²⁷³ Corroboration of the patient's testimony generally is necessary, however. Patient charts,²⁷⁴ witnesses such as the patient's relatives,²⁷⁵ hospital staff²⁷⁶ or employees of the defendant,²⁷⁷ evidence that the provider's office hours and holidays conflict with dates services allegedly were rendered,²⁷⁸ and peer group comparisons showing that the number of services billed by a defendant is incredible compared to similarly situated providers²⁷⁹ can corroborate patient testimony.

In federal actions brought under this theory of fraud defendants have been charged with making false statements,²⁸⁰ conspiracy,²⁸¹ mail fraud,²⁸² Medicare or Medicaid fraud,²⁸³ and RICO.²⁸⁴ In state cases using this theory defendants have been charged with larceny,²⁸⁵ Medicaid fraud,²⁸⁶ and obtaining money by

272. *Id.* at 1324-25 (credibility of patient-witnesses attacked because they were schizophrenic, or suffered from alcoholism or "mental problems").

273. *See, e.g.*, *United States v. Hilliard*, 752 F.2d 578, 581 n.3 (11th Cir. 1985); *see also* *United States v. Mitlo*, 714 F.2d 294, 295 (3d Cir.) (patient served as confidential informant for government and, while wearing monitoring equipment, discussed with defendant the fact that defendant submitted Medicaid claims that falsely inflated number of patient visits to defendant's office), *cert. denied*, 464 U.S. 1018 (1983).

274. *Hilliard*, 752 F.2d at 581 n.3.

275. *United States v. Katz*, 455 F.2d at 496, 498 (5th Cir.), *cert. denied*, 408 U.S. 923 (1972).

276. *Id.*

277. *People v. Scofield*, 17 Cal. App. 3d 1018, 1023-24, 95 Cal. Rptr. 405, 407-08 (1971); *State v. Beatty*, 64 N.C. App. 511, 515, 308 S.E.2d 65, 67, *disc. rev. denied*, 309 N.C. 823, 310 S.E.2d 354 (1983).

278. *See, e.g.*, *United States v. Adler*, 623 F.2d 1287, 1289 (8th Cir. 1980); *United States v. Catena*, 500 F.2d 1319, 1325 n.9 (3d Cir.), *cert. denied*, 419 U.S. 1047 (1974).

279. *United States v. Alexander*, 748 F.2d 185, 188 (4th Cir. 1984), *cert. denied*, 472 U.S. 1027 (1985); *United States v. Russo*, 480 F.2d 1228, 1233-36, 1239-44 (6th Cir. 1973), *cert. denied*, 414 U.S. 1157 (1974); *cf.* *United States v. American Medical Centers*, 118 Mich. App. 135, 142, 324 N.W.2d 782, 787 (1982) (peer group comparison introduced by the prosecution but not allowed into evidence), *cert. denied*, 464 U.S. 1009 (1983).

280. 18 U.S.C. § 287 (1982); *see, e.g.*, *Beasley v. United States*, 550 F.2d 261, 263 (5th Cir.), *cert. denied*, 434 U.S. 938 (1977). Other actions are brought under 18 U.S.C. § 1001 (1982). *See, e.g.*, *United States v. Halper*, 590 F.2d 422, 424 (2d Cir. 1978); *United States v. Blazewicz*, 459 F.2d 442, 443 (6th Cir. 1972); *United States v. Chakmakis*, 449 F.2d 315, 316 (5th Cir. 1971). Finally, some actions are prosecuted under the Social Security Act, 42 U.S.C. § 408(c) (1982). *See, e.g.*, *United States v. Holt*, 529 F.2d 981, 982 n.1 (4th Cir. 1975); *United States v. Cacioppo*, 517 F.2d 22, 23 (8th Cir. 1975); *United States v. Katz*, 455 F.2d 496, 497 (5th Cir.), *cert. denied*, 408 U.S. 923 (1972).

281. 18 U.S.C. § 371 (1982); *see, e.g.*, *United States v. Jones*, 587 F.2d 802, 804 (5th Cir. 1979); *Beasley*, 550 F.2d at 263.

282. 18 U.S.C. § 1341 (1982); *see, e.g.*, *United States v. Hilliard*, 752 F.2d 578, 579 (11th Cir. 1985); *United States v. Mitlo*, 714 F.2d 294, 295, *cert. denied*, 464 U.S. 1018 (1983); *United States v. Colletta*, 602 F. Supp. 1322, 1324 (E.D. Pa.), *aff'd*, 770 F.2d 1076 (3d Cir. 1985).

283. 42 U.S.C.A. § 1320a-7b(b) (West Supp. 1988) (previously 42 U.S.C. §§ 1395nn, 1396h (1982)); *see, e.g.*, *United States v. Larm*, 824 F.2d 780, 782 (9th Cir. 1987), *cert. denied*, 108 S. Ct. 1057 (1988); *United States v. Sanders*, 749 F.2d 195, 196 (5th Cir. 1984); *United States v. Varoz*, 740 F.2d 772, 774 (10th Cir. 1984); *United States v. Gordon*, 548 F.2d 743, 744 (8th Cir. 1977); *Holt*, 529 F.2d at 981, 982 n.1.

284. *United States v. Worthington*, 698 F.2d 820 (6th Cir. 1983).

285. *See* *State v. Marshall*, 25 Wash. App. 240, 241, 606 P.2d 278, 279 (1980).

fraud.²⁸⁷ Billing for services not rendered is not a forgery offense. As noted by the Washington Court of Appeals in *State v. Marshall*,²⁸⁸ when a defendant signs claims falsely alleging that services were performed, he is making a false statement, not committing forgery.²⁸⁹

In summary, the "services not rendered" theory is easier to prove when there is unambiguous, objective evidence that the health care provider did not perform the disputed service. Such evidence exists when a service leaves physical manifestations, involves supplying a tangible item, or is so intrusive, painful, or time-consuming that the patient would remember it. This theory is more difficult to prove when the disputed services are fungible, performed in large numbers, or administered to patients incapable of accurately recalling their treatment. In these instances, which constitute the majority of the reported prosecutions using this theory, the patients are rarely credible witnesses and documentary or testimonial corroboration that services were not rendered is essential.

C. *Misrepresenting the Nature of Services Provided*

Misrepresenting the nature of services provided is one of the easiest theories to prove as long as the prosecutor can confirm which services were actually provided. Cases brought under this theory can be divided into two groups, each highlighting a different aspect of the compensation scheme used by third-party payers. The first group reflects the fact that medical insurance compensates for some but not all services. The second group of cases reflects the fact that medical insurance compensates more highly for some services than for others.

In the first group of cases, the services rendered by the provider were not compensable services under the patients' insurance coverage. There are a variety of cases in this group: a podiatrist who represented to Medicare that he treated patients for complex and compensable podiatric ailments when in fact he had merely trimmed toenails or performed other noncompensable services;²⁹⁰ optometrists who sold noncompensable sunglasses to patients but claimed they had supplied compensable cataract eye-glasses;²⁹¹ physicians who represented that they provided compensable injections for joint pain but actually supplied non-compensable injections of routine vitamins or medicines;²⁹² a shoe store proprietor who claimed he supplied compensable orthopedic shoes "to be attached to a

286. See, e.g., *State v. Cargille*, 507 So. 2d 1254, 1254 (La. Ct. App. 1987); *State v. Beatty*, 64 N.C. App. 511, 513, 308 S.E.2d 65, 66, *disc. rev. denied*, 309 N.C. 823, 310 S.E.2d 354 (1983); *Commonwealth v. Wu*, 343 Pa. Super. 108, 111, 494 A.2d 7, 8 (1985).

287. *State v. Page*, 32 N.C. App. 478, 480, 232 S.E.2d 460, 461, *disc. rev. denied*, 292 N.C. 643, 235 S.E.2d 64 (1977).

288. 25 Wash. App. 240, 606 P.2d 278 (1980).

289. *Id.* at 241-42, 606 P.2d at 279-80.

290. *United States v. Rousseau*, 534 F.2d 584, 585 (5th Cir. 1976).

291. *United States v. Gold*, 743 F.2d 800, 808-09 (11th Cir. 1984), *cert. denied*, 469 U.S. 1217 (1985).

292. See, e.g., *United States v. Mekjian*, 505 F.2d 1320, 1322-23 (5th Cir. 1975); *United States v. Russo*, 480 F.2d 1228, 1233 (6th Cir. 1973), *cert. denied*, 414 U.S. 1157 (1974).

leg brace," but in fact supplied ordinary, noncompensable street shoes;²⁹³ a podiatrist who represented that he treated patients during an office visit, but only spoke to them over the telephone;²⁹⁴ a physician who billed Medicare for allergy shots that he allegedly administered but that were actually administered by a nurse.²⁹⁵

In the second group of cases prosecuted under this theory the provider supplied one type of compensable service but billed for a more expensive compensable service. In *State v. Griffon*²⁹⁶ a pharmacist was convicted for billing Medicare for expensive brand-name drugs instead of the generic drugs he dispensed.²⁹⁷ Other cases in this group include a medical laboratory that billed for "manual" blood tests when "automated" blood tests were performed,²⁹⁸ a physician who billed for visits with a single patient when the physician saw a number of patients in the same visit,²⁹⁹ a psychiatrist who misrepresented the length of psychiatric evaluations of patients,³⁰⁰ and a nursing home administrator-owner who misrepresented the level of care given to patients.³⁰¹

*State v. Dorn*³⁰² presents a variation in which a pharmacist supplied compensable drugs to Medicaid patients but charged the Medicaid program a higher cost for these drugs than he charged other patients.³⁰³ The Vermont Supreme Court found that the Medicaid claims submitted by defendant for reimbursement falsely certified that the reimbursement reflected the pharmacist's "usual and customary charge" to the general public.³⁰⁴

The evidence used to prove fraud in either of the two groups of cases that use the "misrepresenting the nature of services provided" theory is similar to the evidence used to prove the "services not provided" theory. Under both theories, plaintiffs may introduce patient testimony concerning services actually re-

293. *United States v. Yosevitch*, No. 83-1896 (E.D. Pa. Apr. 12, 1983), *aff'd*, 745 F.2d 49 (3d Cir. 1984).

294. *Commonwealth v. Stein*, 363 Pa. Super. 410, 412, 526 A.2d 411, 411 (1987), *rev'd on other grounds*, — Pa. —, 546 A.2d 36 (1988).

295. *United States v. Larm*, 824 F.2d 780, 782 (9th Cir. 1987), *cert. denied*, 108 S. Ct. 1057 (1988).

296. 448 So. 2d 1287 (La. 1984).

297. *Id.* at 1289. For other cases in which the defendant billed for brand name drugs but dispensed generic drugs, see *United States v. Brown*, 763 F.2d 984, 989 (8th Cir.), *cert. denied*, 474 U.S. 905 (1985); *State v. Heath*, 513 So. 2d 493, 495 (La. Ct. App. 1987); *People v. Asar*, 136 A.D.2d 712, 713, 523 N.Y.S.2d 910, 911 (1988); *People v. Kendzia*, 103 A.D.2d 999, 1000, 478 N.Y.S.2d 209, 210 (1984); *cf. In re Rozas Gibson Pharmacy of Eunice, Inc.*, 382 So. 2d 929 (La. 1980) (pharmacy had no expectation of privacy in its records; records could be subpoenaed during investigation of pharmacist accused of billing Medicaid for brand name drugs instead of the generic drugs dispensed).

298. *See, e.g., United States v. Precision Medical Laboratories, Inc.*, 593 F.2d 434, 438 (2d Cir. 1978).

299. *People v. Lee*, 134 Mich. App. 278, 283, 351 N.W.2d 294, 297 (1984).

300. *State v. Dean*, 105 Wis. 2d 390, 393, 314 N.W.2d 151, 154 (Wis. Ct. App. 1981).

301. *United States v. Huckaby*, 698 F.2d 915, 916 (8th Cir. 1982), *cert. denied*, 460 U.S. 1070 (1983).

302. 145 Vt. 606, 496 A.2d 451 (1985).

303. *Id.* at 611, 496 A.2d at 453.

304. *Id.* at 612, 496 A.2d at 454.

ceived,³⁰⁵ documentary or testimonial corroboration of what services were provided,³⁰⁶ evidence that the provider's office hours and schedule conflicted with representations regarding when services were provided,³⁰⁷ and statements by the defendant demonstrating knowledge of or intent to defraud.³⁰⁸ As with the "services not rendered" theory, testimony by expert witnesses who examined the patient and found no evidence that the defendant provided the service in question is helpful.³⁰⁹ Because of one of the major problems encountered in using this theory, experts have been used in these cases in an unusual way. Billing codes the providers use to designate the services supplied are often confusing. This can result in a credible defense by the provider that it did not intend to bill incorrectly for services but simply misinterpreted or was confused by the billing codes.³¹⁰ In response to this defense, the government has been allowed to introduce expert testimony regarding the proper interpretation of billing codes.³¹¹

In federal cases using this theory defendants have been charged with making false statements,³¹² mail fraud,³¹³ conspiracy,³¹⁴ and Medicare or Medicaid fraud.³¹⁵ In state courts defendants have been charged with theft by fraud,³¹⁶

305. See, e.g., *United States v. Russo*, 480 F.2d 1228, 1233 (6th Cir. 1973), *cert. denied*, 414 U.S. 1157 (1974); *State v. Griffon*, 448 So. 2d 1287, 1289 (La. 1984); cf. *Dorn*, 145 Vt. at 614-15, 496 A.2d at 456 (patient testified she had been charged lower rate for drug than what defendant billed Medicaid).

306. See *Dorn*, 145 Vt. at 611, 496 A.2d at 454.

307. See *United States v. Adler*, 623 F.2d 1287, 1289 (8th Cir. 1980). But see *People v. Lee*, 134 Mich. App. 278, 290, 351 N.W.2d 294, 300 (1984) (court warned against relying exclusively on such evidence).

308. See, e.g., *United States v. Alexander*, 748 F.2d 185, 188 (4th Cir. 1984) (defendant directed that urine specimens be discarded and not tested), *cert. denied*, 472 U.S. 1027 (1985); *United States v. Gold*, 743 F.2d 800, 810 (11th Cir. 1984) (defendant told employee that she did not want to hear about illegal Medicare billings); *United States v. Precision Medical Laboratories, Inc.*, 593 F.2d 434, 440 (2d Cir. 1978) (defendant directed that patients' names be omitted from laboratory print-outs); *Griffon*, 448 So. 2d at 1292 (defendant ordered pharmacists to fill prescriptions with generic drugs and bill for brand name drugs).

309. *United States v. Rousseau*, 534 F.2d 584, 585 (5th Cir. 1976); *Russo*, 480 F.2d at 1237.

310. See, e.g., *United States v. Larm*, 824 F.2d 780, 784 (9th Cir. 1987) (Wiggins, J., dissenting) (conviction should be reversed because of confusing regulations), *cert. denied*, 108 S. Ct. 1057 (1988); *Sheriff v. Spagnola*, 101 Nev. 508, 514, 706 P.2d 840, 844 (1985) (dismissals of indictments affirmed on ground that Medicaid regulations were ambiguous); *State v. Greco*, 29 N.J. 94, 102, 148 A.2d 164, 169 (1959) (conviction of physician for misrepresenting his qualifications to become a Medicaid provider reversed because applicable regulations confusing); *People v. Alizadeh*, 87 A.D.2d 418, 431-32, 452 N.Y.S.2d 425, 432-33 (1982) (conviction reversed in part because billing codes were confusing and evidence was insufficient to sustain the verdict); *Commonwealth v. Stein*, — Pa. —, 546 A.2d 36, 40 (1988) (dismissal of indictment affirmed because Medicaid regulations were ambiguous).

311. See *Gold*, 743 F.2d at 817; *Spagnola*, 101 Nev. at 511-12, 706 P.2d at 842-43.

312. 18 U.S.C. § 1001 (1982); see, e.g., *United States v. Winkle*, 587 F.2d 705, 709 (5th Cir.), *cert. denied*, 444 U.S. 827 (1979); *United States v. Mekjian*, 505 F.2d 1320, 1324 (5th Cir. 1975); *United States v. Peterson*, 488 F.2d 645, 646-47 (5th Cir.), *cert. denied*, 419 U.S. 828 (1974). Other actions are brought under 18 U.S.C. § 287 (1982). See, e.g., *United States v. Alexander*, 748 F.2d 185, 190 (4th Cir. 1984), *cert. denied*, 472 U.S. 1027 (1985); *Gold*, 743 F.2d at 805; *United States v. Precision Medical Laboratories, Inc.*, 593 F.2d 434, 438 (2d Cir. 1978).

313. 18 U.S.C. § 1341 (1982); see, e.g., *Alexander*, 748 F.2d at 185; *United States v. Edgewood*, 608 F.2d 13 (1st Cir. 1979), *cert. denied*, 444 U.S. 1046 (1980); *United States v. Russo*, 480 F.2d 1228, 1231 (6th Cir. 1973), *cert. denied*, 414 U.S. 1157 (1974).

314. 18 U.S.C. § 371 (1982); see, e.g., *Gold*, 743 F.2d at 805.

315. 42 U.S.C.A. § 1320a-7b(b) (West Supp. 1988) (previously 42 U.S.C. §§ 1395nn, 1396h (1982)); see, e.g., *United States v. Larm*, 824 F.2d 780, 782 (9th Cir. 1987), *cert. denied*, 108 S. Ct.

obtaining money under false pretenses,³¹⁷ schemes to defraud Medicaid,³¹⁸ grand larceny,³¹⁹ offering a false instrument for filing,³²⁰ and misbranding of drugs.³²¹

In summary, defendants charged for misrepresenting the nature of services rendered fall into two groups. In one group of cases providers represented that they provided compensable services when they did not. In the other group, providers represented that they provided one type of compensable service when they had provided a less remunerative but still compensable service.

This theory presents the prosecutor with several potential problems. Unlike the cases charged under the "services not provided" theory, some services in these cases actually were provided. If the services actually provided are not significantly different from the services falsely alleged to have been provided, it is difficult to prove intentional fraud. When the services are similar, patients have difficulty differentiating between the alleged service and the actual service provided. Also, it may be difficult to obtain clear documentary proof in patient charts or other provider records that clarify which service was provided. Lastly, if the billing code or description of the actual service provided is similar to the billing code for the service falsely alleged to have been provided, there could be legitimate, or at least credible, confusion on the part of the provider. Complex reimbursement regulations thus hamper prosecution under this theory. Of these two types of cases charged under this theory, the first group, in which the provider billed for compensable services when noncompensable services were provided, is less subject to these potential problems. The reason for this is obvious: the difference between the noncompensable service actually provided and the compensable service billed generally will be greater than the difference between two compensable services, both in terms of physical impact on patient care and the billing code (there would be no billing code for a noncompensable service).

D. *Auto Accident Scams*

The fourth pattern of fraud that occurs in the health care field is the "auto accident scam." These cases combine the "services not provided" and "misrepresenting the nature of services" theories. Because of the large number of these cases and the customized approach these defendants take in committing fraud, the "auto accident scam" warrants treatment as a separate theory of fraud. In

1057 (1988); *United States v. Brown*, 763 F.2d 984, 989 (8th Cir.), *cert. denied*, 474 U.S. 905 (1985); *United States v. Huckaby*, 698 F.2d 915, 916 (8th Cir. 1982), *cert. denied*, 460 U.S. 1070 (1983); *United States v. Rousseau*, 534 F.2d 584 (5th Cir. 1976).

316. *State v. Dean*, 105 Wis. 2d 390, 392, 314 N.W.2d 151, 153 (Wis. Ct. App. 1981).

317. *Sheriff v. Spagnola*, 101 Nev. 508, 509, 706 P.2d 840, 841 (1985); *State v. Greco*, 29 N.J. 94, 96, 148 A.2d 164, 167 (1959).

318. *See, e.g., State v. Griffon*, 448 So. 2d 1287, 1289 (La. 1984); *State v. McDermitt*, 406 So. 2d 195, 198 (La. 1981); *People v. Lee*, 134 Mich. App. 278, 280, 351 N.W.2d 294, 296 (1984); *Commonwealth v. Stein*, 363 Pa. Super. 410, 412, 526 A.2d 411, 412 (1987), *rev'd on other grounds*, — Pa. —, 546 A.2d 36 (1988).

319. *People v. Alizadeh*, 87 A.D.2d 418, 419, 452 N.Y.S.2d 425, 426 (1982).

320. *People v. Asar*, 136 A.D.2d 712, 714, 523 N.Y.S.2d 910, 911 (1988).

321. *People v. Kendzia*, 103 A.D.2d 999, 478 N.Y.S.2d 209 (1984).

these cases, health care providers will be only one of many actors.³²²

Most of these cases involve automobile accidents, but other types of accidents, real or fabricated, also have been used to generate false insurance claims.³²³ *United States v. Perez*,³²⁴ exemplifies the auto accident scam. In this state-wide fraud, "recruiters" solicited "hitters" whose function was to drive the "hitter" automobile in each collision.³²⁵ The driver of the hitter automobile was to be liable for causing the accident.³²⁶ Drivers and riders were solicited to occupy the target automobile.³²⁷ Pregnant women were heavily recruited for the target automobiles because they "could claim pregnancy related injuries which would be both hard to disprove and easily settleable with the insurance carriers."³²⁸ According to a prearranged schedule, the hitter vehicle would strike the target vehicle.³²⁹ The occupants of the target vehicle, feigning injuries, would be sent to a particular doctor who would generate a medical history for treatment of nonexistent injuries.³³⁰ These individuals would then visit a participating lawyer who would demand payment from the appropriate insurance company.³³¹ As shown by one such scheme in Florida, which generated over one million dollars per year,³³² this type of fraud can be lucrative for its participants.

There are many cases similar to *Perez* in which a staged automobile accident is part of the scheme to defraud.³³³ In a few instances undercover officers fabricated accidents and then went for treatment to physicians who were under suspicion of participating in fraudulent schemes.³³⁴ In most of the reported cases, however, actual automobile accidents occurred and the individuals involved were referred to the defendant-physician who generated the false insur-

322. See, e.g., *United States v. Krown*, 809 F.2d 144, 145 (1st Cir. 1987) (attorney, chiropractor, internist); *United States v. Tager*, 638 F.2d 167, 168 (10th Cir. 1980) (attorneys, doctors, automobile repairmen); *United States v. Thomas*, 463 F.2d 1061, 1062 (7th Cir. 1972) (physician and attorney); *State v. Olkon*, 299 N.W.2d 89, 92 (Minn. 1980) (attorney was only defendant but physician was implicated), *cert. denied*, 449 U.S. 1132 (1981).

323. See, e.g., *United States v. Nichols*, 695 F.2d 86 (5th Cir. 1982) (cafe bartender, patrons, physician, and an attorney charged as coconspirators in a scheme to fabricate an accident at Banana's Cafe in Dallas, involving patrons of the cafe who claimed to be injured when a ceiling fan fell on their table).

324. 489 F.2d 51 (5th Cir.), *cert. denied*, 417 U.S. 945 (1974).

325. *Id.* at 55.

326. *Id.*

327. *Id.*

328. *Id.*

329. *Id.*

330. *Id.*

331. *Id.*

332. *United States v. Del Valle*, 587 F.2d 699, 701 (5th Cir.), *cert. denied*, 442 U.S. 909 (1979).

333. See, e.g., *United States v. Jackson*, 761 F.2d 1541, 1542 (11th Cir. 1985); *United States v. Strong*, 702 F.2d 97, 98 (6th Cir. 1983); see also *United States v. Kaplan*, 470 F.2d 100, 101 (7th Cir. 1972) (reversed because of government's failure to disclose pertinent information), *cert. denied*, 410 U.S. 966 (1973); *Glassman v. State*, 377 So. 2d 208, 209 (Fla. Dist. Ct. App. 1979) (reversed because of prosecutor's comments).

334. See, e.g., *United States v. Warren*, 747 F.2d 1339, 1340 (10th Cir. 1984); *United States v. Gamble*, 737 F.2d 853, 854 (10th Cir. 1984); *People v. Benson*, 206 Cal. App. 2d 519, 522, 23 Cal. Rptr. 908, 910 (1962), *cert. denied*, 374 U.S. 806 (1963); *State v. Olkon*, 299 N.W.2d 89, 93 (Minn. 1980), *cert. denied*, 374 U.S. 806 (1963).

ance claims.³³⁵ In some of these cases the accident victims never knew false insurance claims were generated or submitted;³³⁶ in other cases the accident victims began to participate in the scheme after the accident had occurred.³³⁷

One characteristic common to all cases prosecuted under this theory is that there are always a number of participants in the fraud. This can be advantageous for the prosecution. As the number of participants increases, so does the opportunity to acquire as witnesses insiders who offer complete and accurate views of the fraud scheme and the participants.³³⁸ In addition, the prosecution can use the conspiracy charge when there are multiple participants. This charge allows the government to group the tangentially involved participants with those involved more heavily. Moreover, a charge of conspiracy facilitates the introduction of otherwise inadmissible hearsay evidence such as statements of coconspirators.³³⁹

Although the involvement of a number of participants is advantageous to the prosecution in the above respects, multiple participants also create problems. The first problem encountered in most conspiracy cases with many participants is how to define the conspiracy. The second problem concerns the credibility of insiders who have become government witnesses. A third problem, proving each defendant's knowledge, is presented by many cases in which multiple defendants are charged.

Determining whether there is a single conspiracy or multiple conspiracies is

335. *United States v. Krown*, 809 F.2d 144, 145, 147 (1st Cir. 1987); *United States v. Hershenow*, 680 F.2d 847, 850 (1st Cir. 1982); *United States v. Reicin*, 497 F.2d 563, 565 (7th Cir.), *cert. denied*, 419 U.S. 996 (1974); *United States v. Sternback*, 402 F.2d 353, 354 (7th Cir. 1968), *cert. denied*, 393 U.S. 1082 (1969); *People v. Benson*, 206 Cal. App. 2d 519, 23 Cal. Rptr. 908 (1962), *cert. denied*, 376 U.S. 806 (1963).

336. *See, e.g.*, *United States v. Reamer*, 589 F.2d 769, 770 (4th Cir. 1978), *cert. denied*, 440 U.S. 980 (1979); *United States v. Shuford*, 454 F.2d 772, 775 (4th Cir. 1977).

337. *See, e.g.*, *United States v. Zicree*, 605 F.2d 1381, 1383-84 (5th Cir. 1979), *cert. denied*, 445 U.S. 966 (1980); *United States v. Cady*, 567 F.2d 771, 774 (8th Cir. 1977), *cert. denied*, 435 U.S. 944 (1978).

338. *See, e.g.*, *Krown*, 809 F.2d at 145 (chiropractor and internist testified to attorney's involvement); *United States v. Jackson*, 761 F.2d 1541, 1543 (11th Cir. 1985) (passengers and drivers in staged car accidents testified to defendant-physician's involvement); *United States v. Strong*, 702 F.2d 97, 99 (6th Cir. 1983) (same); *Hershenow*, 680 F.2d at 862 (accident victims and former business partner of pharmacist provided testimony linking the pharmacist to scheme); *United States v. Lebovitz*, 669 F.2d 894, 899-900 (3d Cir.) (physician in another, uncharged scheme with defendant allowed to testify pursuant to Federal Rule of Evidence 404(b)), *cert. denied*, 456 U.S. 929 (1982); *United States v. Witschner*, 624 F.2d 840, 842 (8th Cir.), *cert. denied*, 449 U.S. 994 (1980) (physician-coconspirator testified to attorney's involvement); *United States v. Reamer*, 589 F.2d 769, 770 n.3 (4th Cir. 1978) (convicted physician testified to attorney's involvement), *cert. denied*, 440 U.S. 980 (1979); *United States v. Del Valle*, 587 F.2d 699, 704 (5th Cir.) (secretaries of attorney testified as to how scheme operated), *cert. denied*, 442 U.S. 909 (1979); *United States v. Cady*, 567 F.2d 771, 774 (8th Cir. 1977) (chiropractor and accident victims testified as to attorney's role), *cert. denied*, 435 U.S. 944 (1978); *United States v. Perkal*, 530 F.2d 604, 607 (4th Cir.) (attorney testified to physician's involvement), *cert. denied*, 429 U.S. 821 (1976); *Reicin*, 497 F.2d at 565 (physician who participated in the scheme testified to attorney's involvement); *United States v. Silvern*, 494 F.2d 355, 357 (7th Cir. 1973) (codefendants, physician, and police officer testified to attorney's involvement); *United States v. Thomas*, 463 F.2d 1061, 1062 (7th Cir. 1972) (physician pled guilty and testified to attorney's involvement).

339. "A conspiracy charge is a favorite weapon in the prosecutor's arsenal. Among its other attributes, it allows the introduction of otherwise inadmissible testimony." *United States v. Nichols*, 695 F.2d 86, 89 (5th Cir. 1982).

crucial because a variance in the number of conspiracies charged and proven could result in a reversal of the conviction. As the Supreme Court explained in *Kotteakos v. United States*,³⁴⁰ "[t]he problem is not merely one of variance between indictment and proof,"³⁴¹ but involves the "right" of a criminal defendant "not to be tried *en masse* for the conglomeration of distinct and separate offenses committed by others."³⁴² The Court noted that special caution was needed in assessing the prejudice caused by improper pleading of the conspiracy charge because of "the greater looseness generally allowed for specifying the [conspiracy] offense and its details, for receiving proof, and generally in the conduct of the [conspiracy] trial."³⁴³

Determining the number of conspiracies in the automobile accident scam cases is especially difficult. The many participants in the fraud often have never met each other. The fraud involves various types of transactions, such as the automobile accidents, the hospital or doctor's office visits, the conference with the attorney, and the submission of false claims. The automobile accident scam often spans a large geographical area and time period. All of these characteristics complicate a determination of the appropriate scope of a conspiracy charge. *United States v. Perez*³⁴⁴ exemplifies this difficulty. In *Perez* twenty-one defendants were named in the indictment and over fifty-five people participated in a state-wide scheme including thirty-five staged automobile collisions, hundreds of doctors' visits, and thousands of false claims over a nine month time period.³⁴⁵ One issue raised on appeal was whether the scheme constituted one conspiracy, as charged, or multiple conspiracies. Defendants argued that the evidence proved multiple conspiracies and that the variance between the proof and the charge was fatal and necessitated reversal.³⁴⁶ The United States Court of Appeals for the Fifth Circuit ruled that the evidence established one conspiracy.³⁴⁷ The court rejected the traditional "spokes, wheels, hubs, rims or chains" approach,³⁴⁸ and stated that although "there is no requirement that every defendant must participate in every transaction in order to find a single conspiracy . . . the prohibited activity . . . [must] be committed in furtherance of a common objective."³⁴⁹

The court found a common objective of all participants to use the mails to defraud insurance companies through the staging of automobile collisions.³⁵⁰

340. 328 U.S. 750 (1946).

341. *Id.* at 774.

342. *Id.* at 775.

343. *Id.* at 776.

344. 489 F.2d 51 (5th Cir. 1973).

345. *Id.* at 62 n.19, 83-84; see also *United States v. Zicree*, 605 F.2d 1381, 1384 (5th Cir. 1979) (scheme spanned 5 1/2 years, had 11 participants, and involved 33 car accidents), *cert. denied*, 445 U.S. 966 (1980); *United States v. Sternback*, 402 F.2d 353, 355 (7th Cir. 1968) (in accidents over a 2 1/2 years period, 9 different law firms and 13 insurance companies victimized), *cert. denied*, 393 U.S. 1082 (1969).

346. *Perez*, 489 F.2d at 57.

347. *Id.* at 61.

348. *Id.* at 64.

349. *Id.* at 62.

350. *Id.* at 58.

The court also held that all the participants had to know that multiple collisions were part of the scheme because otherwise the scheme could not be profitable.³⁵¹ The court rejected the defense's argument that the various ways in which the conspiracy was conducted indicated the existence of multiple conspiracies. Instead, this variety indicated to the court an intentional effort by the organizers to avoid detection.³⁵² The Fifth Circuit's single conspiracy position in *Perez* is typical of the position taken by most courts that have considered the scope of the automobile accident scam.³⁵³

The second problem encountered in prosecuting automobile accident scams occurs when other participants in the scam ("insiders") testify as government witnesses. Insiders often have criminal culpability and, whether or not given immunity, their credibility will be attacked and may be suspect in the eyes of the jury and court.³⁵⁴ One prosecutor candidly explained to a jury the problems of "insider" witnesses:

The employees in many cases are the best evidence and the worst evidence. They are the best evidence because they . . . were there. . . . They . . . knew what was happening, not only to the patients but [also] to the Medicare claims being submitted to the Government. They are the worst witnesses because whatever else you say about these people, no matter how honestly they testified . . . from the stand, at the time this was going on they either participated in it or they saw it going on and did nothing to stop it.³⁵⁵

A third problem in using this theory of prosecution is encountered in any case with multiple participants. The prosecution must prove that all participants had actual knowledge of the criminal activity. Participants may assert that they were blindly led by the other participants.³⁵⁶ As shown in *United States v. Drury*,³⁵⁷ such a defense may have merit. After a bench trial, the court acquitted defendant of conspiracy charges because the government had failed to prove beyond a reasonable doubt that defendant knew of the fraud committed

351. *Id.* at 63-64.

352. *Id.* at 63.

353. *Cf. United States v. Zicree*, 605 F.2d 1381, 1384 (5th Cir. 1979) (government brought one count of conspiracy relating to 33 different accident victims against 11 defendants), *cert. denied*, 445 U.S. 966 (1980); *United States v. Boscia*, 573 F.2d 827, 834 (3d Cir.) (all transactions part of one scheme to defraud insurer), *cert. denied*, 436 U.S. 911 (1978).

354. *See, e.g., United States v. Medansky*, 486 F.2d 807, 809 (7th Cir. 1973) (codefendant impeached with contradictions in his testimony and disclosure of his guilty plea), *cert. denied*, 415 U.S. 989 (1974).

355. *United States v. Schaffer*, 600 F.2d 1120, 1122 n.1 (5th Cir. 1979). The jury convicted the physician-defendant on 71 counts of Medicare fraud. *Id.* at 1121.

356. *See, e.g., United States v. Nichols*, 695 F.2d 86, 93 (5th Cir. 1982) (physician claimed to be an innocent bystander who had no knowledge of the conspiracy); *United States v. Witschner*, 624 F.2d 840, 842 (8th Cir.) (attorney blamed physician for the scheme), *cert. denied*, 449 U.S. 994 (1980); *Boscia*, 573 F.2d at 834 (physician argued that he knew nothing of the staged accidents); *United States v. Perkal*, 530 F.2d 604, 607-08 (4th Cir.) (physician blamed scheme on attorney), *cert. denied*, 429 U.S. 821 (1976); *United States v. Reicin*, 497 F.2d 563, 566-67 (7th Cir.) (attorney blamed scheme on physician), *cert. denied*, 419 U.S. 996 (1974); *United States v. Silvern*, 494 F.2d 355, 360 (7th Cir. 1973) (in an interesting twist, defendant-attorney argued that his coconspirator's testimony should not be credited because the coconspirator was not fully informed of the entire scheme).

357. 687 F.2d 63 (5th Cir. 1982), *cert. denied*, 461 U.S. 943 (1983).

by the other defendants.³⁵⁸ In *United States v. Shuford*³⁵⁹ the United States Court of Appeals for the Fourth Circuit reversed the conviction of an attorney who allegedly participated in an automobile accident scam. The court found that the attorney had been prohibited from producing evidence showing he had not known about the false medical bills submitted by a coconspirator.³⁶⁰

Generally, however, a common pattern of accidents, treatments, or claims will overcome such a claim of ignorance of illegality. For example, in *United States v. Perez*³⁶¹ the United States Court of Appeals for the Fifth Circuit rejected defendant-physicians' claims that they were misled by their patients.³⁶² The court found such a defense incredible given the common characteristics of the patients and the medical care rendered. The court stated, "The appellant doctors were repeatedly visited by uninjured patients complaining of similar neck and back related injuries sustained in rear-end collisions in the same general locale and repeatedly referred to them by the same lawyers. For these nonexistent injuries minimal treatment was administered and inflated bills were submitted."³⁶³

Federal prosecutors have charged accident scam participants with mail fraud³⁶⁴ and conspiracy.³⁶⁵ State prosecutors have pursued accident scam fraud as a theft offense³⁶⁶ or as presentation of a false insurance claim.³⁶⁷

In summary, the "automobile accident scam" is a well-developed fraud usually involving many participants over a large geographical area and extended

358. *Id.* at 64; *cf.* *United States v. Dumas*, 688 F.2d 84, 87-88 (10th Cir. 1982) (although this case was prosecuted using the "Rx by fraud" theory, the reversal aptly demonstrates what occurs when there is inadequate evidence of a defendant's awareness of the scope of an alleged conspiracy).

359. 454 F.2d 772 (4th Cir. 1971).

360. *Id.* at 779-80.

361. 489 F.2d 51 (5th Cir. 1973), *cert. denied*, 417 U.S. 945 (1974).

362. *Id.* at 77.

363. *Id.* at 73; *see also* *United States v. Kaplan*, 832 F.2d 676, 679 (1st Cir. 1987) (court rejected attorney's claim that he did not know of the falsity of medical claims he submitted on behalf of patients allegedly involved in car accidents), *cert. denied*, 108 S. Ct. 1080 (1988); *United States v. Boscia*, 573 F.2d 827, 834 (3d Cir.) (court rejected claim by physician that he did not know accidents and injuries were faked), *cert. denied*, 436 U.S. 911 (1978).

364. 18 U.S.C. § 1341 (1982); *see, e.g.*, *United States v. Krowen*, 809 F.2d 144, 145 (1st Cir. 1987); *United States v. Jackson*, 761 F.2d 1541, 1542 (11th Cir. 1985); *United States v. Strong*, 702 F.2d 97, 98 (6th Cir. 1983); *United States v. Drury*, 687 F.2d 63, 63-64 (5th Cir. 1982), *cert. denied*, 461 U.S. 943 (1983); *United States v. Perkal*, 530 F.2d 604, 605 (4th Cir. 1976); *United States v. Reicin*, 497 F.2d 563, 564 (7th Cir.), *cert. denied*, 419 U.S. 996 (1974); *United States v. Medansky*, 486 F.2d 807, 808 (7th Cir. 1973), *cert. denied*, 415 U.S. 989 (1974); *United States v. Kaplan*, 470 F.2d 100, 101 (7th Cir. 1972), *cert. denied*, 410 U.S. 966 (1973); *United States v. Thomas*, 463 F.2d 1061, 1062 (7th Cir. 1972); *United States v. Sternback*, 402 F.2d 353, 353 (7th Cir. 1968), *cert. denied*, 393 U.S. 1082 (1969).

365. 18 U.S.C. § 371 (1982); *see, e.g.*, *United States v. Jackson*, 761 F.2d 1541, 1542 (11th Cir. 1985); *United States v. Strong*, 102 F.2d 97, 98 (6th Cir. 1983); *United States v. Drury*, 687 F.2d 63, 64 (5th Cir. 1982), *cert. denied*, 461 U.S. 943 (1983); *United States v. Kaplan*, 470 F.2d 100, 100-01 (7th Cir. 1972), *cert. denied*, 410 U.S. 966 (1973).

366. *See* *Glassman v. State*, 377 So. 2d 208, 209 (Fla. 1979) (grand larceny and conspiracy); *State v. Olkon*, 299 N.W.2d 89, 92 (Minn. 1980) (attempted theft and conspiracy to commit same), *cert. denied*, 449 U.S. 1132 (1981).

367. *People v. Benson*, 206 Cal. App. 2d 519, 520, 23 Cal. Rptr 908, 908 (1962) (conspiracy to present a false or fraudulent insurance claim and presenting a false or fraudulent insurance claim), *cert. denied*, 374 U.S. 806 (1963).

time period. All such frauds proceed in a similar manner: after a legitimate or staged automobile accident, false medical information is provided to generate false insurance claims. This theory is one of the easier theories to prove because of the straightforward nature of the fraud and the many participants in the scheme. The conspiracy charge and its advantages to a prosecutor generally will be available. Moreover, insider-witnesses are often available to describe the fraud and provide valuable insights into the scam's operation. Insiders also can describe the various defendants' knowledge of and participation in the fraud. To the extent these insiders may have engaged in criminal activity themselves their credibility will be diminished. Nevertheless, as long as a defendant's knowledge of the fraud can be shown, either through circumstantial evidence as referred to in *Perez* or through more direct evidence, this theory will be strong for the prosecution.

E. "Quackery": *Misrepresenting Credentials or Remedies*

Another theory for prosecuting fraud in the health care field focuses solely on the misrepresentations made by the health care provider to patients or potential patients. Unlike the other theories discussed thus far, this theory identifies the patient as the victim of the fraud. As one court explained:

[It is important to protect] people from the quacks who would deceive them into thinking they are receiving medical relief when, in reality, they are being deprived of their money without the remotest possibility of cure. This type of quackery also [harms] people who may be or are in dire need of competent aid by their either delaying or foregoing proper treatment. These ill people think they are being cured, when, in fact, they are receiving no real help.³⁶⁸

These misrepresentations are of two types: misrepresentations of medical credentials, and misrepresentations of the prophylactic or curative value of products or treatment.

*United States v. Vecchiarello*³⁶⁹ and *United States v. Maturo*³⁷⁰ exemplify the first type of misrepresentation. The defendants in these cases, one of whom was a disbarred attorney, were convicted on fraud charges for falsely representing themselves to be properly trained and licensed physicians.³⁷¹ In *United States v. Smith*³⁷² a physician falsely represented himself to be a specialist in nervous diseases. Affirming his fraud conviction, the court of appeals noted that defendant provided patients with false diagnoses of serious ailments to "induce them to part with their money for the defendant's benefit."³⁷³

368. *State v. Hoffman*, 558 P.2d 602, 605-06 (Utah 1976).

369. 536 F.2d 420 (D.C. Cir. 1976), *remanded and aff'd*, 569 F.2d 656 (D.C. Cir. 1977).

370. 536 F.2d 427 (D.C. Cir. 1976), *remanded and aff'd*, 569 F.2d 666 (D.C. Cir. 1977).

371. *United States v. Vecchiarello*, 569 F.2d 656, 656-57 (D.C. Cir. 1977). For other cases in which a lay person has held himself out to be a healing professional, see *United States v. De Welles*, 345 F.2d 387 (7th Cir.) (chiropractor), *cert. denied*, 382 U.S. 833 (1965); *United States v. Lott*, 630 F. Supp. 611 (E.D. Va.) (nurse), *aff'd*, 795 F.2d 82 (4th Cir. 1986); *People v. Varas*, 110 A.D.2d 646, 487 N.Y.S.2d 577 (1985) (physician); *Hoffman*, 558 P.2d at 603 (nurse).

372. 222 F. 165 (E.D. Pa. 1915).

373. *Id.* at 166.

The more prevalent method of fraud charged under this theory is the misrepresentation of the prophylactic or curative value of medicines, equipment, or treatment. These cases are a testament to the ingenuity and gullibility of human beings. One defendant was convicted for advertising and selling "oxypathors," a device that purportedly "begets in reality a supplementary breathing through the skins and membranes of the human body . . . ; increases the amount of oxygen consumed by the body . . . ; increas[es] vital combustion and the circulation . . . ; [and] causes the body to attract oxygen from the air."³⁷⁴ Another defendant was convicted on fraud charges for marketing "a wonder treatment that restores flagging vital forces [It] restore[s] lost and depleted vigor Men in their 60's, 70's, and 80's [have declared that it] has renewed their vigor, awakened their glands and made them young again."³⁷⁵ Several defendants were convicted for fraudulently representing that they had a treatment that would cure "piles, rupture, prostate, varicose veins and numerous other diseases and ailments."³⁷⁶ These same "physicians" detected cancer in their patients by "palpation, feeling of it and guessing whether the patient had it or not."³⁷⁷ Another defendant, convicted for misrepresenting that his clinics could cure cancer, diagnosed cancer using a machine called a "digitron," which was operated as follows:

The patient would hold onto a white square plate attached to the digitron with two wires. The operator would hold a pendulum in his right hand and swing it over the machine The digitron then purportedly diagnosed how much malignancy the patient had. . . . Sometime before the end of the treatment, the patient would be told that the digitron showed the malignancy level in his or her body to be zero.³⁷⁸

As part of this same course of treatment, some patients were told to rub their feet with castor oil and put on white cotton socks in order to draw out dead cancer cells.³⁷⁹

To convict a defendant under a theory of "quackery," three elements must be proved: (1) that representations as to the defendant's credentials or the prophylactic or curative qualities of a treatment were made; (2) that the representations were false; and (3) that the defendant knew the representations were false at the time they were made or acted with reckless indifference as to whether the representations were false.³⁸⁰

Proving the first element is not difficult. Although the reported cases generally do not discuss the manner in which misrepresentations of professional status

374. *Moses v. United States*, 221 F. 863, 866 (2d Cir.), *cert. denied*, 238 U.S. 629 (1915).

375. *Stunz v. United States*, 27 F.2d 575, 576 (8th Cir. 1928).

376. *Baker v. United States*, 115 F.2d 533, 537 (8th Cir. 1940), *cert. denied*, 312 U.S. 692 (1941).

377. *Id.* at 539.

378. *United States v. Keller*, 784 F.2d 1296, 1297 (8th Cir. 1986) (footnote omitted).

379. *Id.*; see also *United States v. Taller*, 394 F.2d 435, 436-37 (2d Cir.) ("calories don't count" weight control program), *cert. denied*, 393 U.S. 839 (1968); *United States v. Andreadis*, 366 F.2d 423, 427 (2d Cir. 1966) ("wonder drug for fat people"), *cert. denied*, 385 U.S. 1001 (1967).

380. See *West v. United States*, 68 F.2d 96, 96-97 (10th Cir. 1933); *United States v. Stunz*, 27 F.2d 575, 579 (8th Cir. 1928); *United States v. Moses*, 221 F. 863, 867 (2d Cir.), *cert. denied*, 238 U.S. 629 (1915).

or skills are made, apparently the mere fact that individuals falsely represent themselves to the public as healing professionals is sufficient to prove this element.³⁸¹ Proving that defendants misrepresented the prophylactic or curative quality of a treatment is easy when the misrepresentations are explicit and verifiable. In every reported case this was true: the misrepresentations were made in written literature or advertisements,³⁸² or were made orally to numerous people.³⁸³

Proving the remaining elements of the "quackery" theory, however, may be more difficult. As one court noted: "The so-called quack remedy of to-day may be hailed tomorrow as an absolute cure, and vice versa."³⁸⁴ Proof beyond a reasonable doubt that a remedy is a fraud is difficult if the evidence shows merely a conflict of medical opinion. *West v. United States*³⁸⁵ illustrates this. Finding the evidence of fraud to be insufficient, the United States Court of Appeals for the Tenth Circuit reversed the conviction of West, a pharmacist found by a jury to have committed mail fraud by falsely representing that a certain solution would cure syphilis and other blood impurities.³⁸⁶ The expert witnesses called by the Government testified that in their opinion the solution was not a cure for syphilis and was not currently recognized as a cure. These experts acknowledged, however, that this solution had been considered by the medical profession to be a cure for syphilis as recently as twenty-three years prior. In addition, medical publications and testimony by the codefendant-physician who used this solution on his patients established that the solution had some therapeutic value.³⁸⁷ Thus, while expert testimony is essential to prove this theory, such testimony should clearly and unequivocally demonstrate that the treatment at issue has no redeeming curative value. The more bizarre and unorthodox the alleged remedy, the easier it will be to show the falsity of the representations about the remedy.

Proving the third element of "quackery," that the defendant was aware of the falsity of the representations, is not difficult when defendants have misrepresented their professional credentials. When defendants are charged with misrepresenting the curative ability of a treatment or equipment, however, proving such knowledge can be more problematic. Similar to the second element, proving a defendant's knowledge that a cure is quackery is easier when the alleged treatment is bizarre. Testimony by employees or patients of a defendant about the defendant's tactics can help prove this knowledge of fraud. In *United States v. Andreadis*³⁸⁸ defendant operated a drug company that produced and mar-

381. *United States v. Vecchiarello*, 569 F.2d 656, 656-57 (D.C. Cir. 1977); *United States v. Hoffman*, 558 P.2d 602, 603 (Utah 1976).

382. *See, e.g., United States v. Baker*, 115 F.2d 533, 536-37 (8th Cir. 1940), *cert. denied*, 312 U.S. 692 (1941); *Stunz*, 27 F.2d at 577; *Moses*, 221 F. at 866.

383. *See, e.g., Baker*, 115 F.2d at 536; *People v. Varas*, 110 A.D.2d 646, 648, 487 N.Y.S.2d 577, 579 (1985).

384. *Stunz*, 27 F.2d at 578.

385. 68 F.2d 96 (10th Cir. 1933).

386. *Id.* at 97-98.

387. *Id.* at 97.

388. 366 F.2d 423 (2d Cir. 1966), *cert. denied*, 385 U.S. 1001 (1967).

keted what he alleged to be a "wonder drug for fat people."³⁸⁹ Individuals in defendant's television advertisements offered personal testimony of substantial weight loss while "eating the foods they normally ate and 'without dieting.'"³⁹⁰ These individuals testified at trial, however, that as the defendant well knew, they lost large amounts of weight by drastically reducing their caloric intake.³⁹¹ Insiders also can provide evidence of statements made by a defendant during the quackery scheme that are conclusive evidence of the defendant's knowledge.³⁹²

In most federal cases prosecuted under this theory defendants are charged with mail fraud,³⁹³ although prosecutors have also used charges of conspiracy,³⁹⁴ wire fraud,³⁹⁵ misbranding of controlled substances,³⁹⁶ and making false statements.³⁹⁷ State prosecutions have relied upon statutes prohibiting the practice of medicine without a license.³⁹⁸

In summary, the "quackery" theory, which is the only theory that consistently identifies the patient as the victim of a health care provider's fraud, has been used for two types of misrepresentations: misrepresentations of professional credentials and, misrepresentations of the prophylactic or curative ability of a course of treatment. To prevail on either use of this theory the prosecutor must prove that the defendant knowingly misrepresented facts. This is not difficult when the the defendant has misrepresented his professional credentials. It is more difficult when the alleged misrepresentation concerns the value of a treatment. The ambiguous nature of medicine and our resulting inability to determine categorically what is a proper practice of medicine makes it difficult to prove that a treatment does not have some curative ability. Bizarre remedies and representations, as well as testimony by employees and patients of a defendant indicating the defendant's knowledge that its representations were false, will help overcome these problems.

F. False Cost Reports

A sixth type of fraud committed by health care providers is the filing of false cost reports. Nursing homes, hospitals, and certain other health care providers who participate in Medicare or Medicaid are required to file annual cost

389. *Id.* at 427.

390. *Id.*

391. *Id.* at 427 n.6, 429 n.8.

392. See *supra* text accompanying notes 380-83.

393. 18 U.S.C. § 1341 (1982); see, e.g., *United States v. Maturo*, 536 F.2d 427, 427 (D.C. Cir. 1976); see also *Baker v. United States*, 115 F.2d 533, 536 (8th Cir.) (precursor to mail fraud statute), *cert. denied*, 312 U.S. 692 (1944).

394. 18 U.S.C. § 371 (1982); see, e.g., *United States v. Taller*, 394 F.2d 435, 437 (2d Cir.), *cert. denied*, 393 U.S. 839 (1968); *United States v. Andreadis*, 366 F.2d 423, 426 (2d Cir. 1966), *cert. denied*, 385 U.S. 1001 (1967).

395. 18 U.S.C. § 1343 (1982); see, e.g., *United States v. Keller*, 784 F.2d 1296, 1297 (5th Cir. 1986); *Andreadis*, 366 F.2d at 423.

396. 21 U.S.C. §§ 331(a), 333(b) (1982); see, e.g., *Andreadis*, 366 F.2d at 423.

397. 18 U.S.C. §§ 287, 1001 (1982); see, e.g., *United States v. Lott*, 630 F. Supp 611, 612 (E.D. Va. 1986).

398. *People v. Varas*, 110 A.D.2d 646, 487 N.Y.S.2d 577 (1985); *State v. Hoffman*, 558 P.2d 602, 603 (Utah 1976).

reports to obtain reimbursement for services rendered to Medicare or Medicaid patients.³⁹⁹ The amount due to the provider is based on a formula that incorporates the costs incurred by the provider in rendering patient care.⁴⁰⁰ The provider is instructed that it will be reimbursed only on the basis of costs related to patient care.⁴⁰¹ Providers have committed fraud in the cost reports in three ways: (1) by including expenses that are not related to patient care; (2) by inflating expenses that are related to patient care; and (3) by failing to disclose the related status of business entities with whom the provider is dealing.

*United States v. Smith*⁴⁰² exemplifies the first of the above cost report frauds. Defendant in *Smith* was President and Chairman of the Board of a non-profit hospital. As a Medicare provider the hospital was required to submit annual cost reports. Defendant included in the hospital's cost report expenses for remodeling his personal residence, and payments totalling \$67,000 to his nephew for services not rendered.⁴⁰³ The cost report described these expenses as "commercial" expenses,⁴⁰⁴ "general hospital expenses,"⁴⁰⁵ or expenses incurred for "patient care."⁴⁰⁶ In another case of this type, the President of a nursing home was convicted for including as nursing home patient expenses the marina services for his yacht and the repair costs for his residential swimming pool.⁴⁰⁷

*United States v. Collins*⁴⁰⁸ exemplifies the second type of cost report fraud, in which the provider inflates the patient care expenses. In *Collins* the owner and operator of a nursing home submitted a cost report in which various expenses, all related to patient care, were inflated by even amounts (such as \$5,000 or \$10,000) for each category of expenses.⁴⁰⁹ The fraud in the cost report was proven simply by comparing the expenses listed on the tax returns of the nursing home to the expenses listed on the cost report.⁴¹⁰ In most instances falsification of patient expenses will not be so blatant, and comparison to underlying docu-

399. 42 U.S.C. § 1395g (1982); 42 C.F.R. § 413.20(a), (b) (1987); 2 Medicare & Medicaid Guide (CCH) ¶¶ 7414, 7420 (Dec. 1985). When the cost reporting forms are not available the deadline for filing cost reports can be extended. See 4 Medicare & Medicaid Guide (CCH) ¶¶ 35,537, 35,562 (Aug. 1986); *id.* ¶ 35,068 (Jan. 1986); *id.* ¶ 34,403 (Dec. 1984).

400. A summary of the type of costs properly included is contained at 1 Medicare & Medicaid Guide (CCH) ¶ 5852 (Jan. 1986).

401. 42 C.F.R. § 413.9(c)(3) (1987); 1 Medicare & Medicaid Guide (CCH) ¶ 5852 (Jan. 1986).

402. 523 F.2d 771 (5th Cir. 1975), *cert. denied*, 429 U.S. 817 (1976).

403. *Id.* at 777-78.

404. *Id.* at 778.

405. *Id.* at 776.

406. *Id.* at 777 n.14.

407. *United States v. Simon*, 510 F. Supp. 232 (E.D. Pa. 1981); see also *United States v. Cella*, 568 F.2d 1266 (9th Cir. 1978) (hospital administrator and officers convicted for representing that political expenses and contributions to candidates for state office were hospital expenses related to patient care); *Commonwealth v. Minkin*, 14 Mass. App. 911, 436 N.E.2d 955 (nursing home administrators convicted for including as nursing home expenses \$26,000 for renovations to their family summer home and the salaries of nursing home employees who served as maids and babysitters in their private home), *cert. denied*, 386 Mass. 1104, 438 N.E.2d 75 (1982).

408. 596 F.2d 166 (6th Cir. 1979).

409. *Id.* at 168; see also *McKennie v. State*, 439 So. 2d 706 (Ala. Crim. App. 1982) (affirmed conviction of defendant for filing a falsified claim for payment), *rev'd on other grounds*, 439 So. 2d 713 (Ala. 1983).

410. *Collins*, 596 F.2d at 167-68.

mentation will be required to discover and prove the falsification. Resorting to these underlying documents complicates a plaintiff's case but also strengthens the proof of fraud. In *United States v. Jones*,⁴¹¹ for example, false "Plans of Treatment" and nurses' reports had been generated to support the false claims made to Medicare by a home nursing association. The evidence showed that defendants, the owners and operators of the association, directed the creation of these false documents.⁴¹² These instructions helped prove defendants' criminal intent and involvement.

*Commonwealth v. Cervený*⁴¹³ is another example of fraudulent inflation of expenses, but in a context other than a fraud designed to obtain immediate cost reimbursement. In addition to establishing the amount a provider is reimbursed at the end of a fiscal year, cost reports are used to derive the per patient per diem rate at which a provider receives subsequent interim payments. Some of the financial information requested on cost reports, therefore, is relevant only to the calculation of the per diem rate. Defendant Cervený and four corporations he owned falsified some of this financial information to secure a higher per diem rate. Under Cervený's direction each nursing home falsely increased its "cash on hand" when filing the annual cost reports for each nursing home. The effect of this falsification was to increase the stated equity of each nursing home, which in turn increased the per diem rate.⁴¹⁴

The third type of cost report fraud prosecuted using this theory is based on regulations that require providers to disclose on the cost report any related organization⁴¹⁵ with which the provider is doing business.⁴¹⁶ When a provider receives goods or services from an unrelated party, the provider is reimbursed for its "reasonable" costs.⁴¹⁷ In contrast, when the provider purchases goods or services from a related organization, it is reimbursed only for the cost of "comparable items" that could have been purchased elsewhere.⁴¹⁸ In *United States v. Alemany Rivera*⁴¹⁹ defendants were convicted in part for filing cost reports in which they failed to reveal that the hospital at which they were employed was purchasing equipment and furniture from an organization of which they were officers and employees.⁴²⁰ Because of this omission the hospital was reimbursed at a higher rate than allowed. Affirming the district court's conviction, the United States Court of Appeals for the First Circuit pointed out that the evidence must show that the parties were in fact related; otherwise there can be no

411. 587 F.2d 802 (5th Cir. 1979).

412. *Id.* at 804.

413. 373 Mass. 345, 367 N.E.2d 802 (1977).

414. *Id.* at 348-49, 367 N.E.2d at 805.

415. The term "related to the provider means that the provider to a significant extent is associated with or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies." 42 C.F.R. § 413.17(b)(1) (1987).

416. 1 Medicare & Medicaid Guide (CCH) ¶ 5677 (Apr. 1988).

417. 42 C.F.R. § 413.1(b) (1987); 2 Medicare & Medicaid Guide (CCH) ¶¶ 7223-24 (Sept. 30, 1986); *id.* ¶ 7225 (Jan. 21, 1988).

418. 1 Medicare & Medicaid Guide (CCH) ¶ 5679 (Apr. 1988).

419. 781 F.2d 229 (1st Cir. 1985), *cert. denied*, 475 U.S. 1086 (1986).

420. *Id.* at 231.

finding of criminal intent to deceive. In this instance the court found the evidence of relatedness, and the interlocking of officers and employees, to be "overwhelming."⁴²¹

*United States v. Huber*⁴²² presents an imaginative way to use the false cost report theory. Defendant, an owner and operator of a medical supply company, was charged with causing six hospitals to submit cost reports containing fraudulently inflated expenses.⁴²³ Without the hospitals' knowledge, defendant inflated the costs of the supplies he sold to the hospitals⁴²⁴ and charged for fabricated freight costs.⁴²⁵ Believing these to be legitimate charges, the hospitals listed them on their cost reports.⁴²⁶ At trial defendant offered a weak explanation: "his purpose, if any, was only to defraud the hospitals, not the government."⁴²⁷ The United States Court of Appeals for the Second Circuit affirmed the conviction as well as this use of the cost report theory of fraud.⁴²⁸

Cost report cases present problems for the prosecution. One problem is proving that the cost report actually included the improper expense. Generally, this is an accounting issue and the accountant preparing the cost report will need to testify as to how particular expenses are recorded in the expense provider's journal and carried forward to the cost report.⁴²⁹ If the books, records, or testimony needed to prove this fact are unavailable, it will not be possible to pursue this theory.

Another problem with this theory is proving that the defendant, who seldom personally records expenses in the corporate books or prepares the cost report, was familiar enough with the accounting procedure utilized to know that the improper expense was actually included as a proper expense in the cost report. In *United States v. Smith*⁴³⁰ the United States Court of Appeals for the Fifth Circuit was confronted with this knowledge issue and explained what evidence would suffice to prove it:

It is not necessary that [defendant] have known which line was incorrect when he approved the [cost report] forms, nor that he be able to properly fill out the forms himself. . . . It suffices that he understood the forms necessarily to include expenses which were not those of the hospital, and that a percentage of the amount claimed would be reimbursed erroneously to the hospital from [the United States Department of Health, Education and Welfare].⁴³¹

Defendant's knowledge can be shown circumstantially. For example,

421. *Id.* at 233.

422. 603 F.2d 387 (2d Cir. 1979), *cert. denied*, 445 U.S. 927 (1980).

423. *Id.* at 397.

424. *Id.* at 398.

425. *Id.* at 391.

426. *Id.* at 398.

427. *Id.*

428. *Id.* at 400.

429. *Cf.* *United States v. Cella*, 568 F.2d 1266, 1272 (9th Cir. 1977) (controller of hospital testified to accounting entries resulting from instructions given to him by defendant-officer of hospital).

430. 523 F.2d 771 (5th Cir. 1975), *cert. denied*, 429 U.S. 817 (1976).

431. *Id.* at 780.

knowledge has been proved with the following types of evidence: that the defendant knew the general method by which the Medicare reimbursement program worked;⁴³² that the defendant approved all checks for the improper expenses and these checks were taken to him for his approval with the respective invoices;⁴³³ that the defendant accepted delivery and endorsed many of the checks payable for improper expenses;⁴³⁴ that the defendant's exculpatory explanations for how these expenses were handled were contradicted by the facts;⁴³⁵ and that the defendant failed to supply his accountant with accurate information or instructions.⁴³⁶ Proving that supporting documentation has been falsified to help conceal the misrepresentation in the cost report may help demonstrate the defendant's knowledge of fraud. For this to be successful there must be credible evidence that the defendant directed or participated in the falsification. Finally, it should be noted that when employees of the defendant are used to provide evidence of the defendant's knowledge, the prosecution may encounter the credibility problems noted above with respect to insiders.⁴³⁷

Another problem presented by this theory is how to plead the offense properly. As with the other theories discussed in this Article, any number of criminal statutes may be used to charge this fraud. When prosecuted in the federal courts, defendants who have made fraudulent cost reports have been charged with making false statements,⁴³⁸ mail fraud,⁴³⁹ conspiracy,⁴⁴⁰ transporting in interstate commerce money obtained by fraud,⁴⁴¹ RICO,⁴⁴² theft of government property,⁴⁴³ tax evasion,⁴⁴⁴ and filing false tax returns and aiding and abetting in their preparation.⁴⁴⁵ States have charged defendants with attempted larceny by

432. See, e.g., *United States v. Huber*, 603 F.2d 387, 398 (2d Cir. 1979), *cert. denied*, 445 U.S. 927 (1980); *Smith*, 523 F.2d at 774; *Commonwealth v. Minkin*, 14 Mass. App. Ct. 911, 914, 436 N.E.2d 955, 958 (1982).

433. See, e.g., *Smith*, 523 F.2d at 775.

434. See *supra* text accompanying notes 409-12.

435. In *Smith*, for example, defendant claimed that the diaper service was a "fringe benefit." 523 F.2d at 777. He was, however, the only hospital employee receiving such a fringe benefit and the expense was not charged to the fringe benefit account but to the hospital's "commercial" account. *Id.* Furthermore, defendant claimed that the hospital funds he used for home improvement were a loan from the hospital to him. *Id.* at 775. The hospital's financial records, however, failed to reveal such a loan to defendant, although it did reflect when loans were made to other employees. *Id.*

436. *United States v. Cella*, 568 F.2d 1266, 1272 (9th Cir. 1977); *Minkin*, 14 Mass. App. Ct. at 913-14, 436 N.E.2d at 958.

437. See *supra* text accompanying notes 354-65.

438. 18 U.S.C. § 1001 (1982); see, e.g., *United States v. Alemany Rivera*, 781 F.2d 229, 231 (1st Cir. 1985), *cert. denied*, 475 U.S. 1086 (1986); *United States v. Huber*, 603 F.2d 387, 390 (2d Cir. 1979); *United States v. Jones*, 587 F.2d 802, 804 (5th Cir. 1979); *Cella*, 568 F.2d at 1277; *Smith*, 523 F.2d at 773; *United States v. Simon*, 510 F. Supp. 232, 233 (E.D. Pa. 1981); *United States v. Braunstein*, 474 F. Supp. 1, 3 (D.N.J. 1978).

439. 18 U.S.C. § 1341 (1982); see, e.g., *Huber*, 603 F.2d at 390; *United States v. Collins*, 596 F.2d 166, 167 (6th Cir. 1979); *Cella*, 568 F.2d at 1277; *Simon*, 510 F. Supp. at 233.

440. 18 U.S.C. § 371 (1982); see, e.g., *Huber*, 603 F.2d at 390; *Jones*, 587 F.2d at 804; *Cella*, 568 F.2d at 1277; *United States v. Nemes*, 555 F.2d 51, 52 (2d Cir. 1977); *Braunstein*, 474 F. Supp. at 3.

441. 18 U.S.C. § 2314 (1982); see, e.g., *Huber*, 603 F.2d at 390.

442. 18 U.S.C. §§ 1961-1968 (1982); see, e.g., *Huber*, 603 F.2d at 390.

443. 18 U.S.C. § 641 (1982); see, e.g., *Cella*, 568 F.2d at 1277.

444. 26 U.S.C. § 7201 (1982); see, e.g., *Cella*, 568 F.2d at 1277; *United States v. Smith*, 523 F.2d 771, 773 (5th Cir. 1975).

445. 26 U.S.C. § 7206(1)-(2) (1987); see, e.g., *Cella*, 568 F.2d at 1277; *Smith*, 523 F.2d at 773.

false pretense,⁴⁴⁶ Medicaid fraud,⁴⁴⁷ theft,⁴⁴⁸ conspiracy,⁴⁴⁹ and falsifying business records.⁴⁵⁰ Prosecution under any of these statutes may present problems of multiplicity and duplicity. Multiplicity is charging a single offense in several counts. Duplicity is joining in a single count two or more offenses.⁴⁵¹ A multiplicitous indictment may be dismissed because it subjects a defendant to double jeopardy.⁴⁵² A duplicitous indictment may be dismissed because of the danger that the jury would "find a defendant guilty on a count without having reached a unanimous verdict on the commission of a particular offense."⁴⁵³ Properly pleading the offense may be difficult in fraud cases in which one document contains multiple false statements;⁴⁵⁴ false cost reports are a prime example of this difficulty. The general rule is that as long as different facts are needed to prove each false statement, each false statement is a separate count.⁴⁵⁵ In most cost report cases one cost report for one fiscal year is one count.⁴⁵⁶

A special problem regarding related organizations that may occur in prosecutions of cost report fraud is assessing the value of the health care services. Even if the prosecutor is able to prove that the parties were related under the applicable definitions and that this information was not disclosed on the cost report, a jury is unlikely to convict the defendant unless the prosecutor also can prove that the provider received unallowable funds by failing to disclose the related status. The unallowable amount is the difference between "reasonable cost" and "cost of comparable items." Because of the ambiguous and emotional nature of health care services, it can be difficult to appraise "reasonable cost" as well as the "cost of comparable items." Unlike appraisals of real or personal property, an appraisal of the fair market value of a medical service is difficult to determine. The appraiser must assess a highly technical field in which there are few clear conclusions or certainties. The valuation necessarily will turn on a subjective determination of the value of health, the quality of the service, and the skill of the provider. When related party status is concealed, therefore, it is difficult to assess "reasonable cost" or "cost of comparable items" and thus show

446. See, e.g., *Commonwealth v. Cerveney*, 373 Mass. 345, 347, 367 N.E.2d 802, 804 (1977); *United States v. Minkin*, 14 Mass. App. Ct. 911, 911, 436 N.E.2d 955, 957 (1982); *People v. Notey*, 72 A.D.2d 279, 280, 423 N.Y.S.2d 947, 948 (1980).

447. See, e.g., *Greco v. State*, 307 Md. 470, 472, 515 A.2d 220, 221 (1986); *Minkin*, 14 Mass. App. Ct. at 911, 436 N.E.2d at 955.

448. *Greco*, 307 Md. at 472, 515 A.2d at 221.

449. *Notey*, 72 A.D.2d at 279, 423 N.Y.S.2d at 948.

450. *Id.*

451. *United States v. UCO Oil Co.*, 546 F.2d 833, 835 (9th Cir. 1976), *cert. denied*, 430 U.S. 966 (1977); 1 C. WRIGHT, *FEDERAL PRACTICE AND PROCEDURE* § 142 (1982).

452. *United States v. Conn*, 716 F.2d 550, 552 (9th Cir. 1983).

453. *UCO Oil Co.*, 546 F.2d at 835; see *United States v. Morse*, 785 F.2d 771, 774 (9th Cir.), *cert. denied*, 476 U.S. 1186 (1986); *United States v. Aguilar*, 756 F.2d 1418, 1422 (9th Cir. 1985).

454. 9 DEPARTMENT OF JUSTICE, U.S. ATTORNEY'S MANUAL § 9-40.170 (1985); *id.* §§ 9-42.220 to .221 (1984).

455. See, e.g., *Blockburger v. United States*, 284 U.S. 299, 304 (1932); *United States v. Schrenzel*, 462 F.2d 765, 771 (8th Cir.), *cert. denied*, 409 U.S. 984 (1972).

456. *United States v. Alemany Rivera*, 781 F.2d 229, 231 (1st Cir. 1985); *McKennie v. State*, 439 So. 2d 706, 707 (Ala. 1982); *Greco v. State*, 65 Md. App. 56, 57, 499 A.2d 209, 211 (1985), *aff'd*, 307 Md. 470, 515 A.2d 220 (1986).

some financial injury, which makes this third type of cost report fraud particularly difficult to prove.

In conclusion, the "false cost report" theory is appropriate when a provider files a cost report that contains false information. Three factual patterns of fraud routinely occur in cost reports: (1) falsely representing that personal expenses are expenses related to patient care; (2) exaggerating the amount of patient care expenses; and (3) failing to disclose the related party status of an entity with whom the provider is doing business. The pleading problems noted in use of this theory are insignificant compared to other problems such as following complex and voluminous accounting entries for which the evidence may not be available and proving the defendant's involvement in and knowledge of the fraud. Because of these latter two problems this theory is one of the most difficult to prove and historically has been used very little.⁴⁵⁷

G. *Illegal Remunerations*

Unlike the other theories of fraud that can be prosecuted under a variety of statutes, the theory of illegal remunerations can be prosecuted federally only pursuant to the specific statutory authority of 42 U.S.C. section 1320a-7b. This statute makes it an offense to

knowingly and willfully solicit[] or receive[] any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—(A) in return for referring an individual to a person for the furnishing . . . of any items or service . . . , or (B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item.⁴⁵⁸

Section 1320a-7b also makes it an offense to

knowingly and willfully offer[] or pay[] any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person—(A) to induce such person to refer any individual to a person for the furnishing . . . of an item or service . . . , or (B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item.⁴⁵⁹

The United States Court of Appeals for the Seventh Circuit described the harm that this statutory prohibition was designed to curtail: "[K]ickback schemes can freeze competing suppliers from the system, can mask the possibility of government price reductions, can misdirect program funds, and, when proportional, can erect strong temptations to order more drugs and supplies than needed."⁴⁶⁰

457. See *supra* Table 1 accompanying notes 214-22.

458. 42 U.S.C.A. § 1320a-7b(b)(1) (West Supp. 1988) (previously codified at 42 U.S.C. §§ 1395nn(b)(1), 1396h(b)(1) (1982)).

459. 42 U.S.C.A. § 1320a-7b(b)(2) (West Supp. 1988) (previously codified at 42 U.S.C. §§ 1395nn(b)(2), 1396(b)(2) (1982)).

460. *United States v. Ruttenberg*, 625 F.2d 173, 177 n.9 (7th Cir. 1980).

The types of payments that have been held to be illegal remunerations include fees paid to physicians by medical laboratories to induce referrals of patient specimens,⁴⁶¹ payments made to hospital or nursing home personnel by durable medical equipment companies to induce the purchase of equipment and supplies,⁴⁶² and payments in addition to the allowable Medicaid rate made by families of Medicaid patients to nursing home administrators to secure a place for the patient in the nursing home.⁴⁶³

The facts of the cases prosecuted under this theory are rarely in dispute. Investigated primarily by undercover officers, the transactions are often recorded by audio or video equipment.⁴⁶⁴ There is generally no question as to whether the payments were solicited or accepted by the provider or whether the referral was made. The difficulty with these cases is in determining whether the payment at issue was illegal.

The earliest reported cases utilizing this theory dealt with a question of statutory interpretation that was settled by the 1977 amendments to 42 U.S.C. §§ 1395nn(b) and 1396h(b), which are now codified at 42 U.S.C.A. section 1320a-7b(b). The controversy concerned whether the payments admittedly made to the providers were "kickbacks or bribes" within the meaning of the statute. The United States Courts of Appeals for the Second and Fifth Circuits narrowly construed the statutory language and reversed convictions on the ground that the payments were not "kickbacks or bribes" within the statutory prohibitions.⁴⁶⁵ The Sixth and Seventh Circuits rejected this narrow construction and affirmed convictions, finding that the payments were within the statutory prohibitions.⁴⁶⁶ In 1977 the statutory language was amended. Prior to the amendment these statutes prohibited, in pertinent part, soliciting, offering, or receiving any "*kickback or bribe* in connection with the furnishing of such items or services."⁴⁶⁷ After the 1977 amendment these statutes prohibited soliciting, offering, or receiving "*any remuneration* (including any kickback, bribe, or rebate) . . . in return for referring an individual to a person for the furnishing . . . of

461. *United States v. Lipkis*, 770 F.2d 1447, 1449 (9th Cir. 1985); *United States v. Tapert*, 625 F.2d 111, 115 (6th Cir.), *cert. denied*, 449 U.S. 1034 (1980); *United States v. Hancock*, 604 F.2d 999, 1001 (7th Cir.), *cert. denied*, 444 U.S. 991 (1979); *cf. United States v. Universal Trade & Indus.*, 695 F.2d 1151, 1152 (9th Cir. 1983) (clinical laboratory run by defendant held stock in second corporation and was paid a percentage of the corporation's gross revenues as an incentive for clinic to refer work to the corporation).

462. *United States v. Perlstein*, 632 F.2d 661, 662 (6th Cir. 1980), *cert. denied*, 449 U.S. 1084 (1981); *Ruttenberg*, 625 F.2d at 174; *United States v. Sadlier*, 649 F. Supp. 1560, 1561 (D. Mass. 1986).

463. *United States v. Zacher*, 586 F.2d 912, 913 (2d Cir. 1978).

464. *See, e.g., Universal Trade and Indus.*, 695 F.2d at 1152; *United States v. Stewart Clinical Laboratory, Inc.*, 652 F.2d 804, 805 (9th Cir. 1981); *United States v. Duz-Mor Diagnostic Laboratory, Inc.*, 650 F.2d 223, 225 (9th Cir. 1981).

465. *United States v. Porter*, 591 F.2d 1048 (5th Cir. 1979); *Zacher*, 586 F.2d at 917.

466. *Ruttenberg*, 625 F.2d at 176; *United States v. Tapert*, 625 F.2d 111, 121 (6th Cir.), *cert. denied*, 449 U.S. 1034 (1980); *United States v. Hancock*, 604 F.2d 999, 1002 (7th Cir. 1979); *see also United States v. Weingarden*, 468 F. Supp. 410 (E.D. Mich. 1979) (analyzing the statutory interpretation issue), *aff'd sub nom. United States v. Tapert*, 625 F.2d 111 (6th Cir.), *cert. denied*, 449 U.S. 1034 (1980).

467. 42 U.S.C. §§ 1395nn(b)(1), 1396h(b)(1) (1977) (emphasis added) (recodified as amended at 42 U.S.C.A. § 1320a-7b(b) (West Supp. 1988)).

any item or service.”⁴⁶⁸ Although this broader language effectively resolved some questions regarding the illegality of payments for referrals, it left unanswered other questions concerning the terms “remuneration,” “referral,” “individual,” and “service.”

Questions arise concerning the term *remuneration* because the physician making the referral may also supply services regarding the referral. If the remuneration is solely legitimate reimbursement for services provided, there is no offense. Thus, the issue becomes whether the remuneration is legitimate reimbursement for services rendered, or is an illegitimate kickback.⁴⁶⁹ *United States v. Lipkis*⁴⁷⁰ demonstrates this problem. In *Lipkis* a medical clinic received payments from a medical laboratory in the form of a percentage of the revenue generated by the business referred to the laboratory by the clinic. The clinic provided the laboratory with some services, “including collecting specimens, spinning down blood, supplying forms and stickers, and carrying insurance.”⁴⁷¹ Defendant argued that the remuneration received was reimbursement for these services and not remuneration for the referral.⁴⁷² The United States Court of Appeals for the Ninth Circuit disagreed. The court assessed the fair market value of the services provided by the clinic and found it to be “substantially less” than the referral payments. The court stated there was “no question that [the laboratory] was paying for the referrals as well as the described services.”⁴⁷³

This approach is consistent with that taken by the Third Circuit the same year in *United States v. Greber*.⁴⁷⁴ In *Greber* the payments at issue were also, in part, reimbursement for services rendered. Doctor Greber, president of the laboratory that made the payments, argued that absent proof that the “only purpose behind a fee was to improperly induce future services” there was no violation of the statute.⁴⁷⁵ The Third Circuit disagreed, stating that “if one purpose behind a fee was to improperly induce future referrals” the statute was violated.⁴⁷⁶ In *Greber* the Government was able to prove that one purpose of the payment was to induce referrals by presenting evidence that the payment exceeded the value of the actual service rendered.⁴⁷⁷

The prosecution’s problem with this approach is that it must prove the fair market value of the service rendered. As noted, appraising the value of medical services is difficult because of the unique character of health care. This appraisal problem may complicate the task of proving that the remuneration exceeds the fair market value of services provided and thus that these statutes have been violated.

468. *Id.* (Supp. II 1978) (emphasis added).

469. Clearly, the problem does not arise when a defendant admits that the remuneration is for the referral. *United States v. Tapert*, 625 F.2d 111 (6th Cir.), *cert. denied*, 449 U.S. 1034 (1980).

470. 770 F.2d 1447 (9th Cir. 1985).

471. *Id.* at 1449.

472. *Id.*

473. *Id.*

474. 760 F.2d 68 (3d Cir.), *cert. denied*, 474 U.S. 988 (1985).

475. *Id.* at 71.

476. *Id.* at 69.

477. *Id.* at 70.

The second term in section 1320a-7b(b) that makes prosecution difficult is *referral*. By prohibiting remunerations for referrals this statute is both too broad and too narrow. It is too broad because, taken literally, the statute prohibits legitimate activity. Hospitals have always given indirect remunerations for referrals by providing its physicians who have admitting privileges "perks" such as free office space, discounts for hospital care rendered to the physician's family, and the "cheap labor" of residents available at teaching hospitals who can substantially reduce the admitting physician's workload.⁴⁷⁸ In addition, taken literally, the ban on payments for referrals penalizes the behavior encouraged by cost containment measures. The HMO demonstrates this. HMOs (as do many group practices) have guidelines regarding referrals by its care providers. Many of these guidelines seek to reduce unnecessary medical services. The provider must comply with these guidelines as a condition of employment. Because the provider is paid by the group practice, the provider's salary remunerates the provider when his referral decision comports with these guidelines. Although one would expect prosecutors to use judgment and reason in deciding which remunerations for referrals cross the line of legality, it is not fair or appropriate for a criminal statute to provide such little guidance to providers or prosecutors.

Overbreadth is not the only problem with a prohibition that focuses solely on payments for "referrals." Such a prohibition is also too narrow to cover abuses that may occur because of the incentive of Prospective Payment Systems (PPS) to underprovide necessary services. In fact, Congress recognized the inappropriately narrow scope of this statutory prohibition and extended it in 1986 to cover payments that serve as "an inducement to reduce or limit services" to Medicare patients.⁴⁷⁹ This latest amendment, however, is still too narrow. It provides only civil sanctions, not criminal. Criminal penalties should be available for the egregious instances when payments are given or accepted for intentionally limiting or reducing necessary services so as to maximize reimbursement. More importantly, this amendment by its terms does not prohibit payments that induce abuses other than limiting or reducing services, such as improper hospital admitting or transferring practices.⁴⁸⁰

The second problem with the 1986 amendment is that it is also too broad. By failing to utilize sufficiently precise language it proscribes practices that PPS

478. See generally Comment, *The Medicare-Medicaid Anti-Fraud and Abuse Amendments: Their Impact on the Present Health Care System*, 36 EMORY L.J. 691, 727-28 (1987) (referring to some of the "perks" hospitals have traditionally given physicians).

479. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9313(c)(1)(E), 100 Stat. 2003 (1986) (codified as amended at 42 U.S.C. § 1320a-7b(b)(1) (Supp. IV 1986)).

480. See *infra* text accompanying notes 569-75. For authorities addressing the potential for abuse presented by Hospital Physician Incentive Plans, see UNITED STATES GENERAL ACCOUNTING OFFICE, REPORT TO THE CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS HOUSE OF REPRESENTATIVES, H.R. DOC. NO. 86-103, 99TH CONG., 2D SESS. 3, MEDICARE—PHYSICIAN INCENTIVE PAYMENTS BY HOSPITALS COULD LEAD TO ABUSE (1986); Note, *Abusing the Patient: Medicare Fraud and Abuse in Hospital-Physician Incentive Plans*, 20 U. MICH. J.L. REF. 279 (1986). In the above Note the author states that hospital physician incentive plans violate 42 U.S.C. § 1395nn (now codified at 42 U.S.C.A. § 1320a-7b(b)(1) (West Supp. 1988)). Note, *supra*, at 287. To the extent these plans induce the "referral" of patients, this conclusion is correct. This view, however, is incorrect to the extent these plans encourage a particular medical treatment of patients.

appropriately encourages. PPS encourages reducing and limiting unnecessary services. The 1986 amendment fails to distinguish between necessary and unnecessary services, and by its terms prohibits payments that induce limiting and reducing unnecessary services.⁴⁸¹ Such a prohibition is inappropriate and, surely, unintended.

The third aspect of section 1320a-7b(b) that makes prosecution difficult results from an unfortunate opinion by the United States Court of Appeals for the Ninth Circuit. In *United States v. Stewart Clinical Laboratory, Inc.*⁴⁸² the Ninth Circuit made a distinction between the referral of an "individual" and the referral of a "service." Remuneration of the former is prohibited under one section in the statute.⁴⁸³ Remuneration for the latter is prohibited under another section.⁴⁸⁴ In *Stewart* the Ninth Circuit reversed convictions of medical laboratory owners and operators because the court found a "fatal variance" between the indictment and the proof at trial.⁴⁸⁵ There was no question that the defendants offered remuneration as an inducement to a physician to refer laboratory business to them.⁴⁸⁶ According to the Ninth Circuit, the problem was that the indictment charged an offense under 42 U.S.C. section 1396h(b)(2)(A),⁴⁸⁷ which proscribed paying a remuneration to induce any person to refer an individual,⁴⁸⁸ while the referral of the blood and urine specimens was a referral of "service," which should have been charged under section 1396h(b)(2)(B).⁴⁸⁹

If followed by other circuits, this decision could have serious consequences because many of the remuneration cases concern medical laboratories⁴⁹⁰ and because in the medical laboratory context characterization of a referral as an "individual" or a "service" will be difficult. For example, is it a referral of an

481. For an excellent discussion of the types of regulations that would help resolve this problem, see Hyman & Williamson, *Fraud and Abuse: Regulatory Alternatives in a "Competitive" Health Care Era*, 19 Loy. U. Chi. L.J. 1133, 1185-95 (1988).

482. 652 F.2d 804 (9th Cir. 1981).

483. 42 U.S.C.A. § 1320a-7b(b)(1)(A) (West Supp. 1988) (formerly 42 U.S.C. §§ 1395nn(b)(2)(A), 1396h(b)(2)(A) (Supp. IV 1981)).

484. 42 U.S.C.A. § 1320a-7b(b)(1)(B) (West Supp. 1988) (formerly 42 U.S.C. §§ 1395nn(b)(2)(B), 1396h(b)(2)(B) (Supp. IV 1981)).

485. *Stewart*, 652 F.2d at 807.

486. *Id.* at 805.

487. Now codified as amended at 42 U.S.C.A. § 1320a-7b(b)(2)(A) (West Supp. 1980).

488. *Stewart*, 652 F.2d at 806.

489. *Id.* at 806-07. Section 1396h(b)(2)(B) is now codified at 42 U.S.C.A. § 1320a-7b(b)(2)(B) (West Supp. 1988).

490. See *Kickbacks in Clinical Laboratories: Hearing Before the Subcomm. on Oversight and Investigations of the House Comm. on Energy and Commerce*, 97th Cong., 2nd Sess. 5 (1982) (testimony of Charles P. Monroe, Assistant Director, Criminal Investigative Division, FBI). Assistant Director Monroe stated:

Convicted laboratory owners, who have cooperated with the Government, advise that they had no desire to get business by paying kickbacks. They claim they made the payments only because they felt they were economically forced to do so. Several convicted lab owners report that the kickback payment was quite essential in obtaining physician's accounts. If no kickback was paid, the doctor would take his business elsewhere.

Id.; see also *Medicare & Medicaid Fraud: Hearing Before Senate Comm. on Finance*, *supra* note 7, at 7 (statement of Oliver B. Revell, Assistant Director, Chief of Criminal Investigative Division, FBI) ("It became immediately apparent [to FBI agents conducting an undercover investigation] that kickbacks and rebates were a way of life. Virtually every provider of ancillary services . . . made offers of rebates and kickbacks . . .").

individual or a service when a patient physically visits a laboratory for a blood test rather than visiting a physician who takes a blood sample and sends it to a laboratory? Is it significant how much of a patient goes to the laboratory (meaning a bodily fluid specimen versus an amputated limb)? Does it matter if the laboratory is a psychiatric/psychological laboratory instead of a pathology laboratory? The almost infinite variety of medical laboratory services and methods will always create uncertainty as to whether a referral is of a patient or of a service.

The Ninth Circuit may have realized the futility of a highly technical review of indictments charging this offense. Two years after *Stewart* it was confronted with the converse of the *Stewart* facts. In *United States v. Universal Trade and Industries, Inc.*⁴⁹¹ defendants, a medical laboratory and its administrator, were convicted for paying remuneration for referrals of tests to the laboratory. The indictment charged that the remunerations at issue were for "services."⁴⁹² Defendants argued that there was a fatal variance between the proof and the indictment because, according to the defendants, referrals were of "individuals."⁴⁹³ The Ninth Circuit did not explicitly overrule *Stewart* but declined to rule on this issue. Instead the court stated that the only significant fact was the remuneration for referral of laboratory tests; it did not matter whether the tests were of an individual or a service.⁴⁹⁴ As the Ninth Circuit also noted, however, if such a variance exists, it can be cured by descriptions of the offense in the indictment, by pretrial discovery given by the prosecutor to defendant, and by the testimony and documents produced at trial.⁴⁹⁵

Defendants in federal remuneration cases have been prosecuted almost exclusively under federal Medicare and Medicaid statutes that prohibit remunerations for referrals.⁴⁹⁶ Defendants in state remuneration cases have been prosecuted under statutes prohibiting bribery.⁴⁹⁷

In summary, the theory of fraud by illegal remunerations is created statutorily. Its advantage for the prosecution is that it usually is not difficult to prove what conduct occurred. There will be little credible dispute as to whether payments and referrals occurred. Cases prosecuted under this theory are especially appropriate for undercover investigations because the provider customarily is

491. 695 F.2d 1151 (9th Cir. 1983).

492. *Id.* at 1153.

493. *Id.* at 1152.

494. *Id.* at 1153-54.

495. *Id.*

496. 42 U.S.C.A. § 1320a-7b(b) (West Supp. 1988) (previously 42 U.S.C. §§ 1395nn, 1396h (1982)); see, e.g., *United States v. Universal Trade and Indus.*, 695 F.2d 1151, 1152 (9th Cir. 1983); *United States v. Stewart Clinical Laboratory, Inc.*, 652 F.2d 804, 805 (9th Cir. 1981); *United States v. Duz-Mor Diagnostic Laboratory, Inc.*, 650 F.2d 223, 225 (9th Cir. 1981); *State v. Perlstein*, 632 F.2d 661, 662 (6th Cir. 1980), *cert. denied*, 449 U.S. 1084 (1981); *United States v. Ruttenberg*, 625 F.2d 173, 174 (7th Cir.); *United States v. Tapert*, 625 F.2d 111, 113 (6th Cir.), *cert. denied*, 449 U.S. 1034 (1980); *United States v. Hancock*, 604 F.2d 999, 1000 (7th Cir.), *cert. denied*, 444 U.S. 991 (1979); *United States v. Porter*, 591 F.2d 1048, 1050 (5th Cir. 1979); *United States v. Sadlier*, 649 F. Supp. 1560, 1561 (D. Mass. 1966); see also *Sadlier*, 649 F. Supp. at 1561 (prosecuting under 18 U.S.C. § 666, proscribing theft or bribery concerning programs receiving federal funds).

497. See *People v. Warden*, 141 A.D.2d 193, 529 N.Y.S.2d 230 (1988); *People v. Lerner*, 90 Misc. 2d 513, 394 N.Y.S.2d 514 (N.Y. Sup. Ct. 1977).

contacted by businesspersons he does not know. Thus, it is not difficult or time-consuming for an undercover officer to establish sufficient rapport with the provider so that the provider feels comfortable enough to initiate illegal activity. Rather, the difficulty presented by the remuneration cases lies in determining whether the conduct at issue was criminal.

The statute itself creates this difficulty. The term *remunerations* is overly broad, prohibiting legitimate and illegitimate payments. The term *referrals* is also overly broad, literally prohibiting financial arrangements traditionally employed among providers as well as new financial behavior encouraged by Prospective Payment Systems (PPS). The term *referrals* is also too narrow. It fails to encompass all abuses that are encouraged by PPS. Although Congress has attempted to close this gap with civil sanctions, the behavior prohibited in the new legislation still fails to encompass all abuses encouraged by PPS. The third deficiency in the statute, the distinction between *individual* and *service*, is minor in comparison to these other problems and results more from one questionable court opinion than from the statute itself. Nevertheless, when pleading an offense under these statutes, prosecutors should take care to plead the proper offense and to provide the defendant with discovery sufficient to render nonprejudicial any error later found in pleading.

Because of the problems in the illegal remunerations statute, it fails to put providers and law enforcement officials on notice as to what behavior is prohibited. These statutory gaps also typify what occurs when criminal and civil statutes fail to keep pace with the type of fraud committed. Problems in the statute have had an effect on prosecution of illegal remunerations. Although illegal remunerations are widely acknowledged to be a pervasive problem, especially with medical laboratories,⁴⁹⁸ this theory of prosecution is one of the least used (used in only 5.6% of the reported prosecutions)⁴⁹⁹ and convictions obtained under it have had a relatively high rate of reversal (twenty-three percent of convictions obtained under this theory have been reversed).⁵⁰⁰ Because of the problems noted, this theory of prosecution should be used only when the remuneration is clearly for the referral and when the referral is not of a type traditionally employed or encouraged by private or governmental reimbursement systems.

H. *Providing Unnecessary Or Substandard Health Services.*

"Professional incompetency or malpractice is not . . . a criminal offense."⁵⁰¹ Providing unnecessary or substandard health services becomes fraudulent, however, when as a prerequisite to reimbursement, a provider knowingly misrepresents that services rendered were necessary or competently provided.⁵⁰² Of all

498. See *supra* note 490.

499. See *supra* Table 1 accompanying notes 214-22.

500. *United States v. Stewart Clinical Laboratory, Inc.*, 652 F.2d 804, 807 (9th Cir. 1981); *United States v. Porter*, 591 F.2d 1048, 1058 (5th Cir. 1979); *United States v. Zacher*, 586 F.2d 912, 917 (2d Cir. 1978).

501. *United States v. Talbott*, 460 F. Supp. 253, 263 (S.D. Ohio), *aff'd*, 590 F.2d 192 (6th Cir. 1978).

502. See, e.g., *United States v. Campbell*, 845 F.2d 1374, 1383 (6th Cir.), *cert. denied*, 109 S. Ct.

the theories, this is the most difficult to prove and has been used the least, because, more than any of the other theories of fraud, it directly confronts the ambiguities inherent in medical decisionmaking. Because this theory is widely applicable, however, and because it allows patients to be identified as the victims of a provider's fraud, it is potentially the most powerful theory the prosecution can use.

1. The Historical Use of This Theory

The reported cases reveal two situations in which this theory has been used: (1) to prove that misrepresentations as to the necessity of services were made; and (2) to prove that misrepresentations as to the competency of services were made. Proving the latter in a criminal case is the more difficult approach. *United States v. Talbott*,⁵⁰³ one of the first reported cases to use this theory, is also one of the few that explicitly used this second approach and found defendants guilty of fraud for falsely representing that they provided competent health services. Doctors Talbott and Taylor, both dentists, shared a practice in which ninety-five percent of their patients were covered by Medicaid. After a bench trial, the court found defendants guilty on mail fraud charges for providing substandard care, such as administering root canals "without proper diagnostic X-rays,"⁵⁰⁴ failing to treat "obvious cavities," and failing to extract teeth that needed extraction.⁵⁰⁵ The court also found that defendants had misrepresented the necessity of the services rendered. Specifically, they represented that teeth restorations and endodontic treatment were necessary when the teeth actually had deteriorated to such an extent that patients could not benefit from the treatment.⁵⁰⁶ The court based its finding of guilt on both types of fraud. Defendants provided services that were "either medically unnecessary or, if necessary, performed in such an unprofessional manner, with utter disregard for the patient's well-being, as to be harmful and detrimental to continued good health."⁵⁰⁷

Because of the difficulty of proving beyond a reasonable doubt that services have been provided incompetently, this approach will be difficult to use in criminal prosecutions. The fact that only one reported case has used this approach, a case in which misrepresentations of competency were only part of the fraud found, attests to this difficulty. If attempted, therefore, this approach should be used only in conjunction with proof that the provider committed other forms of fraud as well.

With the exception of the *Talbott* case, cases prosecuted under this theory have alleged that a provider committed fraud by representing that services ren-

490 (1988); *United States v. Mahar*, 801 F.2d 1477, 1481 (6th Cir. 1986); *United States v. Zipstein*, 601 F.2d 281, 284 (7th Cir. 1979), *cert. denied*, 444 U.S. 1031 (1980); *People v. Rehman*, 253 Cal. App. 2d 119, 120, 61 Cal. Rptr. 65, 67-69, *cert. denied*, 390 U.S. 947 (1967); *In re Wayne County Prosecutor*, 121 Mich. App. 798, 799, 329 N.W.2d 510, 512 (1982).

503. 460 F. Supp. 253 (S.D. Ohio), *aff'd*, 590 F.2d 192 (6th Cir. 1978).

504. *Id.* at 263.

505. *Id.* at 263-64.

506. *Id.* at 264.

507. *Id.* at 256.

dered were necessary when they were not. An analysis of these cases indicates that this variety of fraud consists of three elements, each of which must be proved beyond a reasonable doubt: (1) that the provider, or someone at its direction, knowingly represented that the services billed were necessary; (2) that the services were not necessary; and (3) that the provider knew the representations of necessity were false.

Few problems will arise in proving the first element, that a representation of necessity was made. Most claim forms utilized by third-party payers require the provider to "certify that the services [billed] . . . were medically indicated and necessary for the health of the patient."⁵⁰⁸ Because of the explicit and unambiguous nature of this representation of necessity on the claim form and the long-standing nature of this requirement, it will not be difficult to prove that the provider knowingly represented that the services were necessary. Thus, providers will rarely assert that they erroneously or mistakenly represented that services provided were necessary. By comparison, providers charged with fraud under the third theory discussed in this Article, which dealt with misrepresentations as to the compensable nature of services,⁵⁰⁹ often will claim that because the regulations at issue are ambiguous, inconsistent, and changing, they did not know exactly what representations were included in their claim forms.

The second element of this theory, proof that the services rendered were not necessary, presents the biggest hurdle. The imprecise and subjective nature of medicine makes it difficult to determine what is "necessary" treatment. As one court opined in reversing the conviction of a physician charged under this theory, "such a subjective term [as 'necessary services'] would not be compatible with the need for precision in criminal statutes."⁵¹⁰ A plaintiff should not use this theory, therefore, unless the necessity of the services at issue is not subject to a credible difference of opinion. The factual scenarios in the reported cases are illustrative of the type of cases appropriate for this theory: unnecessary administration of "Argon Laser Trabeculoplasty," which places small burns on the "trabecular meshwork which is the 'drain' in the eye";⁵¹¹ an obstetrician who would "rub and massage, in a sexual manner, the vaginal and anal areas, the breasts and the buttocks of patients" as "medically indicated and necessary examinations";⁵¹² dental patients who received up to nine root canals each on "badly

508. "Health Insurance Claim Form," Form HCFA-1500-C2 (1-84), Form OWCP-1500, Form CHAMPUS-501, Form RRB-1500. The Medicare program and most Medicaid programs use the above forms. Some states use additional forms that also contain a representation that services performed were necessary. See, e.g., *Alabama*: "Alacaid—Medical Transportation Claim Form," MCD-17 (Rev. 1/87) EDS-13s; "Alacaid—Medicaid Dental Claim Form," MCD-5 (10/77) 380-202; *California*: "Medi-Cal Outpatient Claim," 15-1 7/80; "Hospital Inpatient Claim," 16-1C 12/82; "Patient Request for Long Term Care" 25-1 6/80; *Maine*: "Medicaid Recipient Benefits Assigned to State of Maine by Law," BMS-006 (8-84); *New Hampshire*: "New Hampshire Medical Assistance Program—Dental," 279-001 (11-86); *North Carolina*: "Request for Payment—North Carolina Medical Assistance Program—Ambulance Service Claim," HNCA-OI, 372-108; *Washington*: "Electronic Billing Agreement."

509. See *supra* text accompanying notes 290-321.

510. *In re Wayne County Prosecutor*, 121 Mich. App. 798, 801, 329 N.W.2d 510, 511 (1982).

511. *United States v. Campbell*, 845 F.2d 1374, 1376 (6th Cir.), cert. denied, 109 S. Ct. 259 (1988).

512. *United States v. Casey*, No. 88-48 (E.D. Mo. Mar. 1, 1988).

broken down . . . non-restorable" teeth;⁵¹³ patients who received unnecessary x-rays, blood tests,⁵¹⁴ cardiac electrocardiography,⁵¹⁵ or surgery;⁵¹⁶ and patients who were drug addicts and were required to submit to extensive, intrusive, and often dangerous medical tests, which generated income for the physician, if they wanted the physician-defendant to prescribe their drug of choice.⁵¹⁷ The pattern detected from these cases is that the more painful, dangerous, or violative the service in question is to the patient, the greater the likelihood of finding a lack of necessity and the better suited the case is to this theory of fraud.

The third element of this theory, the defendant's knowledge that the services were not necessary and thus that the representation of necessity was false, can also be difficult to prove. Like the second element, defendant's knowledge will be easier to prove when the procedure at issue is intrusive and obviously unnecessary. Insider testimony from employees or colleagues of the provider, which reveals the provider's statements and *modus operandi*, will also help prove this knowledge. For example, employees and patients of one Medicaid clinic testified as to the *modus operandi* of the clinic.⁵¹⁸ On a typical day 100 patients visited the clinic.⁵¹⁹ Although the same tests were to be performed on each patient, some patients avoided the tests by paying not to have them done since all they wanted was a prescription for controlled substances.⁵²⁰ Performance of the medical exam lasted a few seconds, and nonphysicians determined which drug would be prescribed.⁵²¹ In another case in which the owners of medical clinics were convicted, employees testified about the "Garfield Shuffle," Garfield being the name of defendants' chain of clinics.⁵²² "Patients were sent to one or more doctors for unscheduled examinations which bore no relation to the patient's specific complaint Likewise, laboratory tests, such as x-rays and blood analyses, as well as prescription drugs, were ordered for patients regard-

513. *United States v. Talbott*, 460 F. Supp. 253, 261, 264 (S.D. Ohio), *aff'd*, 590 F.2d 192 (6th Cir. 1978).

514. *United States v. Ziperstein*, 601 F.2d 281, 285 (7th Cir. 1979), *cert. denied*, 444 U.S. 1031 (1980).

515. *See United States v. Greber*, 760 F.2d 68 (3d Cir.), *cert. denied*, 474 U.S. 998 (1985). The reported opinion in *Greber* mentions, but does not discuss, the conviction for providing unnecessary services. However, Government's Sentencing Memorandum, *Greber* (No. 83-00414) (filed Sept. 12, 1984), summarizes the evidence introduced under this theory.

516. *See People v. Rehman*, 253 Cal. App. 2d 119, 61 Cal. Rptr. 65 (1967), *cert. denied*, 390 U.S. 947 (1968). In *Rehman* one patient received a "D & C and cervical biopsy . . . a uterine suspension, an appendectomy, [and] an adhesiotomy by way of an exploratory laparotomy," none of which was "necessary or indicated." *Id.* at 127, 61 Cal. Rptr. at 71. Another patient, age 10, almost received an emergency appendectomy when he had only an impacted bowel. *Id.* at 131, 61 Cal. Rptr. at 73.

517. *United States v. Mahar*, 801 F.2d 1477, 1484 (6th Cir. 1986); *see also United States v. Sblendorio*, 830 F.2d 1382, 1384-85 (7th Cir. 1987) (drug addicts required to submit to blood, breath, and other tests before being given a prescription for codeine-based cough syrup), *cert. denied*, 108 S. Ct. 1034 (1988).

518. *Mahar*, 801 F.2d at 1482-83.

519. *Id.* at 1483.

520. *Id.*

521. *Id.*

522. *United States v. Ziperstein*, 601 F.2d 281, 285 (7th Cir. 1979), *cert. denied*, 444 U.S. 1031 (1980).

less of medical necessity."⁵²³

Federal cases using this theory are prosecuted as mail fraud⁵²⁴ or conspiracy.⁵²⁵ State cases using this theory are prosecuted as Medicaid fraud⁵²⁶ or acts injurious to the public health.⁵²⁷

2. The Potential Advantage of This Theory for the Prosecution

This theory has a potential advantage over all other theories because it alleges that the patient as well as the third-party payer is a victim of the provider's fraud. In the "services not rendered," "misrepresenting the nature of services provided," "improper remuneration," "false cost report," and "auto accident scam" theories, the insurer is identified as the victim of the fraud. With the "Rx by fraud" theory, used in cases in which a provider facilitates the consumption of controlled substances by falsely representing that a prescription is for a legitimate medical purpose, any insurer that pays for the prescription is the financial victim and, as with all illegal drug dealing, the general public is also a victim. Drug addicts who are patients of such a provider arguably are also victims. Generally, however, the addicts, unlike the patients who receive unnecessary services, are knowing and enthusiastic participants in the fraud. Thus, there is little strategic advantage to proving that such patients are victims of the provider's fraudulent prescriptive practices. The "quackery" theory has always identified the patient as the victim of the fraud but the applicability of this theory is limited, by definition, to outlandish procedures, treatments, or providers. In contrast, the applicability of the unnecessary services theory is quite broad; almost any medical procedure or service may be unnecessary in any given situation.

Identifying the patient as a victim of a provider's fraud has a tremendous tactical advantage for the criminal or civil plaintiff. As noted above, when the victim of a fraud is a businessperson, insurance corporation, conglomerate, or governmental entity, as is the case in most white collar crimes, the victim does not generate much sympathy.⁵²⁸ Indeed, in prosecutions of health care providers the insurance company or governmental agency identified as the victim often is detested by people who have had negative experiences with complex regulations or health insurance bureaucrats. By contrast, patients who have received inadequate, incompetent, or unnecessary medical services are genuinely sympathetic victims.

Courts are reluctant to admit evidence of harm suffered by patients when

523. *Id.* at 285.

524. 18 U.S.C. § 1341 (1982); *see, e.g.*, *United States v. Campbell*, 845 F.2d 1374, 1382-83 (6th Cir.), *cert. denied*, 109 S. Ct. 259 (1988); *Mahar*, 801 F.2d at 1489-90; *United States v. Greber*, 760 F.2d 68, 70 (3d Cir.), *cert. denied*, 474 U.S. 988 (1985); *Zipperstein*, 601 F.2d at 295-96; *United States v. Furman*, 507 F. Supp. 848, 849 (D. Md.), *rev'd*, 672 F.2d 914 (4th Cir. 1981) (mem.); *United States v. Talbott*, 460 F. Supp. 253, 255 (S.D. Ohio), *aff'd*, 590 F.2d 192 (6th Cir. 1978).

525. 18 U.S.C. § 371 (1982); *see, e.g.*, *Zipperstein*, 601 F.2d at 284; *Talbott*, 460 F. Supp. at 266.

526. *In re Wayne County Prosecutor*, 121 Mich. App. 798, 799, 329 N.W.2d 510, 510 (1982).

527. *People v. Rehman*, 253 Cal. App. 2d 119, 119, 61 Cal. Rptr. 65, 65 (1967), *cert. denied*, 390 U.S. 947 (1968).

528. *See supra* text accompanying notes 201-02.

they are not identified as victims of the fraud. In *People v. Alizadeh*⁵²⁹ a New York appellate court reversed the conviction of an obstetrician, stating that it disapproved of the Government's cross-examination of defendant.⁵³⁰ The court believed the prosecutor had improperly inquired into the operations of the obstetrician's "clinic conditions and practices that constituted a danger to the health of those who came to the clinic."⁵³¹ The court found this line of questioning irrelevant to the issues in the case which, as defined by the Government's theories of prosecution, were whether defendant billed for services not provided and misrepresented the nature of services which had been provided.⁵³² Had the prosecution also alleged a theory of fraud that identified the patients of Dr. Alizadeh as victims of his fraud, the powerful evidence of the poor quality of care he provided would have been relevant and should have been admissible.

*United States v. Campbell*⁵³³ also revealed courts' reluctance to admit evidence of injuries patients sustain when patients are not included as victims in the indictment. Although the United States Court of Appeals for the Sixth Circuit held that the testimony of two patients not included as victims in the indictment was properly admissible under Federal Rule of Evidence 404(b),⁵³⁴ it was a two-to-one decision over a vigorous dissent by Judge Martin. The dissent had no problem with the admission of evidence showing that patients were victims of the provider's fraud when the patients were explicitly included in the indictment. However, other courts may agree with Judge Martin's opinion that "the trial court erred when it admitted into evidence the testimony of two former patients of the defendant . . . who were not listed in the indictment as defrauded by the defendant."⁵³⁵ The majority's determination that this testimony was properly admissible turned on the fact that the prosecution used the "unnecessary services" theory.⁵³⁶ The majority found the testimony of the two patients relevant to the "issue of whether the defendant had knowingly engaged in a scheme to defraud his patients and their insurers by charging for unnecessary treatments."⁵³⁷ Had the government not chosen to use the unnecessary services theory, it is doubtful whether evidence proving these two patients were victims of the fraud would have been admitted.

Because the theories of prosecution historically utilized have failed to identify the patient as a victim, few cases have been reported in which the evidence admitted at trial revealed the harm suffered by patients because of a provider's fraud. Congressional investigations of health care fraud, however, have been unencumbered by legal theories that direct the focus of the investigation away from the issue of care given to patients. Congressional hearings demonstrate

529. 87 A.D.2d 418, 452 N.Y.S.2d 425 (1982).

530. *Id.* at 432, 452 N.Y.S.2d at 433.

531. *Id.*

532. *Id.* at 432, 452 N.Y.S.2d at 434.

533. 845 F.2d 1374 (6th Cir.), *cert. denied*, 109 S. Ct. 259 (1988).

534. *Id.* at 1380.

535. *Id.* at 1383 (Martin, J., dissenting).

536. *Id.* at 1380-81.

537. *Id.* at 1381.

that providers defrauding third-party payers also often are delivering poor medical care to patients by the same course of conduct. The evidence in these hearings is powerful. As one congressional staff member stated after serving undercover as a Medicaid patient, "[P]atients were just being used. The patients—or more to the point, their medicaid numbers—were just the necessary raw material for the production of profits."⁵³⁸ One physician who served in a Medicaid clinic testified, "I think the quality of care is appalling. It is the worst medical care that I have ever seen in all of my experience working anywhere."⁵³⁹ Senator John Heinz, who chaired many of the congressional hearings, attested to findings of "poor care and inadequate treatment from serious undiagnosed illnesses to extensive patient abuse in nursing homes and boarding facilities," in addition to findings of fraud in medical insurance programs.⁵⁴⁰

A few examples are illustrative. One Chicago reporter testified about his experience when he went undercover as a janitor in a Chicago hospital. He explained that he "found that nurses were doing the job of doctors. Nurses aides were doing the job of registered nurses. And I, as a janitor, would do the job of orderly, aide, and nurse."⁵⁴¹ This reporter told of one physician who "specialized in mass tonsillectomies," saw more than 100 patients per day, and billed Medicaid \$124,000 per year.⁵⁴² This physician "herded [his patients] into his office 'like cattle[,] . . . lined them up, and [peered into] their throats . . . for a second or two' " before deciding the surgery was necessary.⁵⁴³ Entire families, sometimes with five or six children, were given tonsillectomies after two-minute examinations.⁵⁴⁴ "A mother of six was told that all of her children must have their tonsils out, and when she protested, the doctor told her she didn't love her family if she didn't have their tonsils out."⁵⁴⁵ The reporter told of one instance when two sisters were operated on consecutively for both tonsils and hernias.

The first child, 8 years old, had been left in the recovery room with an untrained aide while the surgery crew operated on the second child. State law . . . requires that a registered nurse be in the recovery room . . . , and the vital signs must be monitored after surgery to insure that the patient does not aspirate blood. The aide was unable to awaken the child and she had to interrupt surgery to get help to force air down the child's throat. Then the child was returned to her bed, the next operation concluded on the 6-year-old sister, and I, the janitor, was left to

538. *Medicare and Medicaid Frauds: Hearing Before the Senate Comm. on Aging, Pt. 5, supra* note 7, at 544 (statement of Patricia G. Oriol, Chief Clerk, Senate Comm. on Aging).

539. *Medicare and Medicaid Frauds: Hearing Before the Senate Comm. on Aging, Pt. 6, supra* note 9, at 687 (statement of Nancy Kurke, M.D.).

540. *Oversight, supra* note 7, at 19.

541. *Medicare and Medicaid Frauds: Joint Hearing Before the Senate Comm. on Aging, Pt. 1, supra* note 12, at 68 (statement of William Gaines of the *Chicago Tribune*).

542. *Medicare and Medicaid Frauds: Joint Hearing Before the Senate Comm. on Aging, Pt. 1, supra* note 12, at 69 (statement of William Gaines of the *Chicago Tribune*).

543. *Medicare and Medicaid Frauds: Joint Hearing Before the Senate Comm. on Aging, Pt. 1, supra* note 12, at 68 (statement of William Gaines of the *Chicago Tribune*).

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545. *Medicare and Medicaid Frauds: Joint Hearing Before the Senate Comm. on Aging, Pt. 1, supra* note 12, at 68 (statement of William Gaines of the *Chicago Tribune*).

watch the child in the recovery room.⁵⁴⁶

Senator Frank E. Moss, along with congressional staff members,⁵⁴⁷ served undercover as a Medicaid patient to observe Medicaid fraud firsthand. He found that providers who were defrauding Medicaid by billing for unnecessary services were also providing poor medical care by rendering the unnecessary services. Senator Moss and the other investigators, all healthy when they visited the medicaid clinics, were given at each clinic blood and urine tests, x-rays, and examinations by several types of providers, such as internists, ophthalmologists, and chiropractors.⁵⁴⁸ At one clinic Senator Moss received a thirty-needle allergy test before even seeing the doctor, extensive blood and lab work, and was given a handful of prescriptions to fill. He was told to return the next day for more tests.⁵⁴⁹

Misdiagnoses were common at the clinics. One congressional staff member was told by the Medicaid ophthalmologist that she had symptoms of glaucoma and needed a glaucoma test. This investigator refused the glaucoma test and, upon examination by her own ophthalmologist, learned that she had no symptoms of glaucoma.⁵⁵⁰ Another investigator was given a prescription for eye-glasses although he had twenty-twenty vision.⁵⁵¹ At another clinic an investigator filled a urine specimen bottle with green soap and water. The nurse found the specimen to be normal then "emptied the contents into the sink and then merely ran water over the bottle, rinsing it out only once with water, before returning it to the shelf with the rest of the 'clean' bottles, ready to be used again on some other unsuspecting patient."⁵⁵²

One doctor who served in a Medicaid clinic gave an example of the poor medical care she saw: "[The clinic has] one size of blood pressure cuff and, unfortunately, that is good for taking blood pressure only on a normal sized arm Many, many of our patients are obese and if you use a normal size cuff on an obese arm you get what is called factitious hypertension."⁵⁵³ This physician saw patients who had been diagnosed as hypertensive by the other physician at

546. *Medicare and Medicaid Frauds: Joint Hearing Before the Senate Comm. on Aging, Pt. 1, supra* note 12, at 69 (statement of William Gaines of the *Chicago Tribune*).

547. *Medicare and Medicaid Frauds: Hearing Before the Senate Comm. on Aging, Pt. 5, supra* note 7, at 521, 543, 556 (statements by Sen. Frank E. Moss; Patricia G. Oriol, Chief Clerk, Senate Comm. on Aging; James A. Roberts, Jr., Temporary Investigator, Senate Comm. on Aging).

548. *Medicare and Medicaid Frauds: Hearing Before the Senate Comm. on Aging, Pt. 5, supra* note 7, at 521-22 (statements by Sen. Frank E. Moss; Patricia G. Oriol, Chief Clerk, Senate Comm. on Aging; James A. Roberts, Jr., Temporary Investigator, Senate Comm. on Aging).

549. *Medicare and Medicaid Frauds: Hearing Before the Senate Comm. on Aging, Pt. 5, supra* note 7, at 522 (statement by Sen. Frank E. Moss).

550. *Medicare and Medicaid Frauds: Hearing Before the Senate Comm. on Aging, Pt. 5, supra* note 7, at 559-60 (statement by James A. Roberts, Jr., Temporary Investigator, Senate Comm. on Aging).

551. *Medicare and Medicaid Frauds: Hearing Before the Senate Comm. on Aging, Pt. 5, supra* note 7, at 547 (statement of Darrell R. McDew, Temporary Investigator, Senate Comm. on Aging).

552. *Medicare and Medicaid Frauds: Hearing Before the Senate Comm. on Aging, Pt. 5, supra* note 7, at 565 (statement of James A. Roberts, Jr., Temporary Investigator, Senate Comm. on Aging).

553. *Medicare and Medicaid Frauds: Hearing Before the Senate Comm. on Aging, Pt. 6, supra* note 9, at 689.

this clinic. However, "90 percent of [these patients] were not hypertensive."⁵⁵⁴ There was no doubt that these patients suffered from the erroneous diagnosis. The physician explained, "They were taking very potent antihypertensive medications and some of them were symptomatic [because of these medications] to the point of loss of balance, dizziness, and weakness. They were being treated for a condition they didn't have simply because we didn't have a proper blood pressure cuff."⁵⁵⁵ This physician gave another example of the poor medical care rendered in some Medicaid clinics:

One was a patient of 50 [years of age] who came in, who had been seen by 6 other physicians [in the Medicaid clinic]. He asked for medication for pain in his face. I asked him why he had a pain in his face and he was very surprised.

"You know, none of the other doctors asked me that."

What he had was the largest growth that I have ever seen—about the size of an egg—that was literally choking him. I looked through the chart and I said, "You know, I really don't understand this. Is it really true that no one has looked in your mouth?"

He said, "Yes, that's right, they never looked in my mouth They gave me medication but they never looked in my mouth."⁵⁵⁶

Explaining why none of the Medicaid clinic physicians looked in the patient's mouth, the physician said, "No one cared to know. It was not worth the trouble to take the time to look in his mouth because you don't get paid for that, it is a waste of time. Anything you do that you can't put down on an invoice is a waste of time."⁵⁵⁷

These few anecdotes illustrate the important point that the fraudulent provider victimizes not only the insurer that pays for the unnecessary or wholly inadequate services, but also the patient who endures the unnecessary, painful, or dangerous procedures or who fails to receive necessary medical treatment because of the provider's incompetence.

As noted, the major challenge in the prosecution of a white collar crime is to choose a theory of prosecution that maximizes the chances for admission of powerful evidence. Because the legal theories historically used to prosecute health care providers have failed to identify the patients as fraud victims, the powerful evidence that a provider delivered poor medical care has seldom been used to its maximum advantage. A prosecutor able to identify a patient as a victim of the fraud will present a more complete picture of the scope of the provider's fraud and thus will have a stronger case.

554. *Medicare and Medicaid Frauds: Hearing Before the Senate Comm. on Aging, Pt. 6, supra* note 9, at 689.

555. *Medicare and Medicaid Frauds: Hearing Before the Senate Comm. on Aging, Pt. 6, supra* note 9, at 689.

556. *Medicare and Medicaid Frauds: Hearing Before the Senate Comm. on Aging, Pt. 6, supra* note 9, at 694.

557. *Medicare and Medicaid Frauds: Hearing Before the Senate Comm. on Aging, Pt. 6, supra* note 9, at 694.

3. How to Allege and Prove that the Patient is a Victim of a Provider's Fraud

People v. Rehman,⁵⁵⁸ the first reported case using this theory, demonstrates the most straightforward way to prosecute providers who render unnecessary or substandard services. This prosecution did not utilize a fraud theory at all. Instead, Dr. Rehman, an osteopathic physician, was prosecuted for violation of a California penal statute that made it an offense "[t]o commit any act injurious to the public health."⁵⁵⁹ The acts for which Dr. Rehman was convicted included performing and attempting to perform unnecessary surgery,⁵⁶⁰ falsifying birth certificates,⁵⁶¹ and allowing unskilled personnel, including a gas station attendant,⁵⁶² to administer anaesthesia, suture patients after surgery, and deliver babies.⁵⁶³

The broad language of the California statute made all acts of unnecessary and substandard medical practice admissible. Although there is no comparable federal statute and few comparable state statutes,⁵⁶⁴ existing statutory authority and theories of fraud already approved by the courts enable prosecutors to identify and prove that patients are victims of a provider's fraud. Applying the existing mail fraud statute to the "unnecessary services" theory is an excellent vehicle for doing so. By including "and its patients" in the portion of the mail fraud charge that identifies the victims of the provider's fraud, and by including the misrepresentations of necessity made by the provider to the patients in the portion of the charge that specifies the misrepresentations made, an indictment will sufficiently incorporate patients as victims of the fraud.⁵⁶⁵

Including patients as victims of the provider's fraud should not increase the previously discussed problems encountered in using this theory. At first blush, one may be concerned about the nature of the representation made by the provider to the patient. When representations are vague, implicit, or uncorroborated oral statements, proof of fraud becomes difficult. Questions will arise as to the nature of the representation and whether the hearing party misunderstood

558. 253 Cal. App. 2d 119, 61 Cal. Rptr. 65 (1967), *cert. denied*, 390 U.S. 947 (1968).

559. *Id.* at 122, 61 Cal. Rptr. at 68.

560. *Id.* at 127-28, 61 Cal. Rptr. at 71-72.

561. *Id.* at 122 n.1, 61 Cal. Rptr. at 68 n.1.

562. *Id.* at 131, 61 Cal. Rptr. at 73.

563. *Id.* at 122 n.1, 61 Cal. Rptr. at 67-68 n.1.

564. See OKLA. STAT. ANN. tit. 21, § 421 (West 1983) (conspiracy statute making it unlawful for two or more persons to "commit any act injurious to the public health").

565. The indictment in *United States v. Campbell*, 845 F.2d 1374 (6th Cir.), *cert. denied*, 109 S. Ct. 259 (1988) charged:

[T]he defendants . . . unlawfully, willfully, and knowingly devised and intended to devise a scheme and artifice to defraud . . . their patients, the Department of Health and Human Services, a department of the United States, Nationwide, the State of Ohio and others, for obtaining money and property by means of false and fraudulent pretenses, representations, and promises.

Campbell, No. CR 1 86-0126, indictment at 3 (S.D. Ohio Nov. 20, 1986). The indictment further alleged that defendants made the following misrepresentations, among others: "The defendant . . . did falsely represent to . . . his patients that they had glaucoma; . . . that a surgical procedure called argon laser trabeculoplasty would benefit a medical condition with respect to their eyes; . . . [and] that he had performed argon laser trabeculoplasty surgery on them . . ." *Id.*

the conversation. As noted, when the victim is the insurer, there is no question that the provider explicitly represented that the services rendered were necessary because the misrepresentation is stated on the claim form that the provider must sign.⁵⁶⁶ Similarly, proving the misrepresentation of necessity should not be difficult when the patient is included as victim. The patient often signs the claim form sent to the third-party payer and thereby reviews the assertion of necessity contained therein. Moreover, the patient often will sign consent forms that contain representations that the services are necessary.⁵⁶⁷

It also is helpful to focus on the provider's fiduciary relationship to a patient. Courts have consistently held that a provider (especially a physician) has a duty to disclose to patients all "information essential to give knowledgeable consent to medical treatment."⁵⁶⁸ Clearly, that treatment is not necessary is "essential" information. It is well established that a defendant who conceals information she has a duty to disclose is guilty of fraud.⁵⁶⁹ Thus, a provider who fails to tell a patient that a procedure is unnecessary is as guilty of fraud as a provider who explicitly represents on a claim or consent form that a certain treatment or medical procedure is needed.

Often the "unnecessary services" theory is used in conjunction with other, more easily provable theories of fraud.⁵⁷⁰ By combining this theory with other theories, a plaintiff can capitalize on the strategic advantage of this theory, which makes human pain and suffering relevant, while also capitalizing on the reliability of the other fraud theories. In addition, it is not necessary for the defendant to be charged under this theory for it to be of use to the prosecution in a criminal case. For example, in *United States v. Balasco*,⁵⁷¹ in which defendant-physician was convicted for accepting kickbacks, the court during sentencing expressly considered facts not introduced at trial that showed the practice of poor medicine but no criminal offense. According to the court, detailed information in the presentencing report indicated that "Balasco has performed nu-

566. See *supra* note 508.

567. Common phrases in consent forms include: "The procedure(s) necessary to treat my condition (has, have) been explained to me by my said doctor . . .," DCH Regional Medical Center Form 9810872; and "Your physician has advised you of your need to have this type of examination," DCH Regional Medical Center Form 9871870(A). Other consent forms will address the reason and necessity for the specific tests in question; for example, "In order to evaluate how well your heart, lungs and blood vessels perform during exercise, your doctor has ordered a cardiac stress test . . ."

568. See *Nelson v. Gaunt*, 125 Cal. App. 3d 623, 634, 178 Cal. Rptr. 167, 172 (1981) (and cases cited therein); *accord* *Willard v. Hagemeister*, 121 Cal. App. 3d 406, 418, 175 Cal. Rptr. 365, 372-73 (1981).

569. *United States v. Bronston*, 658 F.2d 920, 926, (2d Cir. 1981), *cert. denied*, 456 U.S. 915 (1982); *United States v. Bohonus*, 628 F.2d 1167, 1171-72 (9th Cir.), *cert. denied*, 447 U.S. 928 (1980); *United States v. George*, 477 F.2d 508, 512-13 (7th Cir.), *cert. denied*, 414 U.S. 827 (1973). Both *Bronston* and *Bohonus* were overruled on other grounds by *McNally v. United States*, 107 S. Ct. 2875 (1987). See *Inger v. Enzor*, 841 F.2d 450 (2d Cir. 1988).

570. See, e.g., *United States v. Campbell*, 845 F.2d 1374, 1381 (6th Cir.) (services not rendered and unnecessary services), *cert. denied*, 109 S. Ct. 259 (1988); *United States v. Sblendorio*, 830 F.2d 1382, 1385 (7th Cir. 1987) (drug offenses and unnecessary services rendered); *United States v. Mahar*, 801 F.2d 1477, 1490 (6th Cir. 1986) (drug offenses and unnecessary services); *United States v. Greber*, 760 F.2d 68, 70 (3d Cir.) (kickback, services not provided, unnecessary services), *cert. denied*, 474 U.S. 988 (1985).

571. No. 85-059 P (D.R.I. Apr. 4, 1986) (unpublished opinion), *aff'd*, 831 F.2d 280 (1st Cir. 1987).

merous pacemaker implantations on elderly patients whose medical conditions did not justify the surgical procedure.'"⁵⁷² A sentencing court's consideration of such information is appropriate because a trial court has authority during sentencing to consider facts outside those introduced at trial.⁵⁷³ This important possible use of identifying patients as victims should not be overlooked.

4. Conclusion

The "unnecessary services" theory historically has been used in two ways to allege fraud: (1) fraud occurs when a provider collects reimbursement by intentionally making claims that services were competently provided when they were not; and (2) fraud occurs when a provider collects reimbursement by intentionally making claims that services provided were necessary when they were not. Because it is so difficult to prove the first type of fraud under this theory, such an approach is not suitable by itself in criminal prosecutions. The reported cases reveal that this approach has been used only once and in this case other theories of fraud were also alleged and proved.

The second approach to this theory, that fraud occurs when a provider falsely represents that services rendered were necessary, also is difficult to prove. The first component of proof, that the provider knowingly represented that services were necessary, is not difficult to establish because the representation is usually made in writing in a claim or consent form and because the necessity requirement, unlike other reimbursement criteria, is clear, unambiguous, and consistently imposed by all third-party payers. The second component, that the services rendered were not necessary, is by far the most difficult element to prove using this theory. Therefore, this theory should only be used when the services provided were blatantly and uncontrovertedly unnecessary. Proof of the third component, that the provider was aware of the unnecessary nature of the services rendered and thus of the falsity of the representation of necessity, is facilitated when the nonnecessity is blatant and well recognized. Proof of the provider's knowledge can also be shown through employees, colleagues, or patients of the provider who testify as to the provider's *modus operandi* or inculpatory statements.

This theory has a potential advantage over the other theories historically used to prosecute health care providers because it allows pleading and proving that the patient is a victim of a provider's fraud. Strategically, such evidence is advantageous to the prosecution, and factually it presents a more accurate portrayal of the scope and harm of the provider's fraud. Although prosecutions using this theory have not always identified the patient as well as the insurer as a victim of this fraud,⁵⁷⁴ few modifications in this theory, as already approved by

572. Transcript of Sentencing at 30, *Balasco*, No. 85-059 (Apr. 4, 1986) (sentencing order).

573. See, e.g., *United States v. Tucker*, 404 U.S. 443, 446 (1972); *Williams v. Oklahoma*, 358 U.S. 576, 584 (1959); *Williams v. New York*, 337 U.S. 241, 252 (1949); 18 U.S.C. § 3577 (1982) ("[n]o limitation" will be placed on sentencing information). The information must, of course, be accurate. *United States v. Lemon*, 723 F.2d 922, 934 (D.C. Cir. 1983).

574. For example, the indictments charging Shannon N. Mahar, see *United States v. Mahar*, No. 84 CR 20438, indictment at 25-26 (E.D. Mich. Aug. 10, 1984), and Richard G. Casey, see *United*

numerous courts, are needed to do so.

Finally, it must be noted that although this theory can be a powerful tool for the prosecution, it may be of historical interest only. If the third-party fee-for-service reimbursement mechanism is completely phased out, there will be no structural incentive to provide unnecessary services. The structural incentive of the major new reimbursement mechanism, Prospective Payment Systems, is to underprovide services. It remains to be seen whether this theory will be applicable in actions alleging fraudulent reimbursement obtained by falsely reporting that necessary services were provided.

I. *Conclusion*

Analysis of reported prosecutions of health care providers indicates that in the last seventy-nine years, twenty-nine different prosecuting sovereignties have used fifty different statutory authorities to convict twenty types of health care providers. Only eight theories of fraud have been used in these prosecutions. These theories are: (1) "Rx by fraud;" (2) "services not provided;" (3) "auto accident scams;" (4) "misrepresenting the nature of services provided;" (5) "quackery;" (6) "submitting false cost reports;" (7) "illegal remunerations;" and (8) "unnecessary services." Of these, the first five are potentially the easiest to prove while the last three are potentially the most difficult.

Five types of evidence have been used to prove these theories. Undercover investigations have been used successfully in the "Rx by fraud" and "auto accident scam" cases. Medical expert testimony is needed to prove the "Rx by fraud," "services not provided," "misrepresenting the nature of services provided," "quackery," and "unnecessary services" theories. Accounting expert testimony may be needed to prove the "false cost report theory" and expert testimony on reimbursement procedures may be needed to prove the "misrepresenting the nature of services provided" theory. Patients have regularly been helpful witnesses in all but the "Rx by fraud," "false cost report," and "illegal remuneration" theories, although documentary and testimonial corroboration of these patient-witnesses is almost always necessary. Credible insiders can be valuable witnesses in proving any of the theories. Documentation, including claim forms, reimbursement regulations, and patient charts, will be a part of proving any of the theories.

Of the eight theories of fraud utilized, only the "quackery" theory has consistently identified the patient as the victim of a provider's fraud. Because this theory is limited to instances of quackery, it is not widely applicable. Although the "unnecessary services" theory has been used only sporadically to identify the patient as a victim of the provider's fraud, it can easily be modified to identify

States v. Casey, No. 88-48 CR(4), indictment at 3 (E.D. Mo. Mar. 11, 1988), do not include the patients as victims of the fraud. However, the indictment charging Doyle E. Campbell, *see* United States v. Campbell, No. CR 1 86-0126, indictment at 3 (S.D. Ohio Nov. 20, 1986), includes patients as victims of the fraud. The indictment of A. Alvin Greber, *see* United States v. Greber, No. 83-00414, indictment at 6 (E.D. Pa.), charges that Greber devised "a scheme and artifice to defraud and to obtain money from [Pennsylvania Blue Shield], the United States, and others."

patients as victims on a more consistent basis. Such a modified theory, which would be applicable to many factual situations, should be used whenever possible.

IV. FUTURE PROSECUTIONS OF HEALTH CARE PROVIDERS

The way you pay people influences the way they cheat. Health care providers are no exception. As noted in Part I, one reimbursement mechanism, third-party fee-for-service, has dominated most of twentieth-century medicine. It is likely that Prospective Payment Systems (PPS), introduced within the last decade, will dominate the remainder of the twentieth century and beyond. Both of these reimbursement mechanisms affect the types of fraud discussed in Part III.

The fraud encouraged by third-party, fee-for-service reimbursement results from the incentive in this mechanism to overutilize medical services. Thus, this mechanism encourages billing for services not rendered⁵⁷⁵ and providing unnecessary procedures.⁵⁷⁶ Moreover, because it rewards providers who perform a high volume of services, fee-for-service encourages remuneration for referrals. By compensating providers on the basis of their reported costs, fee-for-service encourages submission of false cost data.

PPS both encourages and discourages fraud. PPS and some of the other new approaches to reimbursing providers will have some salutary effect in deterring fraudulent behavior. Larger copayments and deductibles will encourage patients to examine more carefully the representations made by providers to third-party payers. Closer scrutiny by patients should help discourage the commission of fraud and improve its detection. More importantly, to the extent prospective reimbursement penalizes overutilization of services, PPS should discourage the types of frauds motivated by the reward inherent in fee-for-service for high utilization of services.⁵⁷⁷ Thus, PPS will discourage three types of fraud historically prosecuted: billing for services not rendered, automobile accident scams, and providing unnecessary services while falsely representing that the services were necessary. Together these types of fraud represent thirty-one percent of the reported prosecutions.⁵⁷⁸

Despite these potential positive effects of PPS on fraudulent behavior, it also supplies the incentive to engage in at least three types of fraudulent behavior. First, some providers will fail to provide necessary services while representing that all necessary services have been provided. This type of fraud is the converse of the "unnecessary services" theory.⁵⁷⁹ It is generally acknowledged that PPS provides economic incentives to underprovide services.⁵⁸⁰ Recogniz-

575. See *Oversight*, *supra* note 7, at 115.

576. See, e.g., Fein, *Social & Economic Attitudes Shaping American Health Policy*, 58 MILBANK MEMORIAL FUND Q. 349, 363, 376 (1980); Bovbjerg, *supra* note 23, at 969-70.

577. See *supra* text accompanying notes 575-76.

578. See *supra* Table 1 accompanying notes 214-22.

579. See *supra* text accompanying notes 501-73.

580. *Healthcare Anti-Fraud Bills: Hearings Before the Subcomm. on Health of the Senate Comm. on Finance*, 99th Cong., 1st Sess. 61-62 (1985) (statement of Michael Zimmerman, Associate Director, Human Resources Division); Jost, *supra* note 29, at 590.

ing this incentive, a number of checks and balances have been incorporated into PPS to deter this behavior.⁵⁸¹ Although it is hotly debated whether these checks and balances will be sufficient,⁵⁸² the point is that the unscrupulous provider will have an incentive to underprovide services and, in order to circumvent the checks and balances, will commit fraud by falsifying or concealing information.

The second kind of fraud is encouraged by one of the most visible prospective payment systems, the DRGs. DRGs provide incentives for misrepresenting the condition of a patient so as to maximize reimbursement. Because DRGs (as well as any similar system that reimburses based upon the diagnosis of a patient) reimburse a provider more for one type of diagnosis than for another, DRGs may encourage false reporting of diagnoses. This would range from blatant fabrication of a diagnosis to the less obvious "DRG Creep," which is assigning to a patient a diagnosis for which there is a greater reimbursement than a more appropriate, but less lucrative, diagnosis. In addition, because DRGs reimburse a hospital based solely upon the patient's "principal diagnosis,"⁵⁸³ providers will have an incentive to represent falsely, as the principal diagnosis, what is really a more lucrative, secondary diagnosis. Concealing the existence of multiple diagnoses will facilitate misrepresentations of the principal diagnosis. The principal diagnosis rule may also encourage "unbundling." In the context of DRGs, unbundling refers to treating a patient with two independent diseases through multiple hospital admissions, each with a different diagnosis, when one admission with multiple diagnoses would suffice.⁵⁸⁴ Because DRGs exempt some types of admissions (such as psychiatric and alcohol/drug unit),⁵⁸⁵ improper transfers of patients within a hospital to these DRG exempt wards will be encouraged to manipulate reimbursement favorably. False statements and concealment may be necessary to prevent detection of these improper transfers. DRGs currently apply only to hospitals. The above medical decisions regarding diagnosis, date of discharge, readmission, and transfer are made by physicians who are not bound by DRGs. Herein lies the danger of hospital incentive plans⁵⁸⁶ that transfer the economic incentives of DRGs to physicians. This danger emphasizes the impor-

581. Peer Review Organizations, created in 1982, evaluate providers to determine if quality care, including provision of all necessary services, has been rendered. 42 U.S.C.A. §§ 1320c to 1320c-3 (West Supp. 1988); see also 42 C.F.R. § 466.70(c) (1987) (setting the scope of review for PROs). The Omnibus Budget Reconciliation Act of 1987 authorized civil penalties for certain providers that fail "substantially to provide medically necessary items and services . . . if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual." Pub. L. No. 100-203, § 4015, 101 Stat. 1330-61 (codified at 42 U.S.C.A. § 1395mm(g)(6) (West Supp. 1988)). This last provision, though commendable, is too narrow to cover all potential failures to provide necessary services. It does not apply to many providers, and it allows only for civil sanctions regardless of the intent of the provider.

582. See Jost, *supra* note 29, at 526 n.5 (listing legislation passed to help ensure that quality care is provided under Proposed Payment Systems); *id.* at 528-29 (explaining why none of these procedures are adequate). But see Roper, *supra* note 174, at 184 (severely criticizing a Senate Committee report stating that Medicare patients were receiving poorer quality of care under DRGs, and discussing the legislation and procedures implemented to monitor quality of care under DRGs).

583. 42 C.F.R. § 412.60(c)(1), (2) (1987).

584. W. ROE & J. GONG, THE POTENTIAL IMPACT OF PROSPECTIVE PAYMENT ON THE QUALITY OF CARE 34-35 (1986).

585. 42 C.F.R. § 412.25(a) (1987).

586. See *supra* note 480.

tance of clearly distinguishing between legal and illegal behavior in any statutory prohibitions of remunerations between providers. Before turning to the third type of fraudulent behavior encouraged by PPS, it must be stressed that a provider does not commit fraud simply by choosing a more lucrative diagnosis over another, admitting a patient to a hospital more than once, or transferring a patient within a hospital. Rather, the provider commits fraud when she supplies false information or conceals material information to effectuate the economic aims of these acts.

The third type of fraud encouraged by the structure of PPS, the submission of false cost reports, is also encouraged by third-party fee-for-service reimbursement. To pay hospitals pursuant to DRG reimbursement, the Health Care Financing Administration of the Department of Health and Human Services sets an appropriate amount of reimbursement for each DRG based upon information supplied by hospitals as to the costs of treating patients.⁵⁸⁷ The types of falsifications that may occur in these cost reports will include some of the same types of falsifications committed under third-party fee-for-service, such as including personal expenses as expenses of patient care, and inflating legitimate expenses. However, the structure of DRGs will make more profitable new types of falsification, such as falsely reporting the number of days patients spend in the hospital and including as DRG expenses other hospital expenses that are inapplicable to DRG computations (such as capital expenditures, direct medical education expenses, and costs of kidney acquisitions).⁵⁸⁸

The above discussion demonstrates that as reimbursement mechanisms within the health care industry change, the types of fraud committed also will change. Whereas third-party fee-for-service, by rewarding overutilization, encourages the "services not provided," "illegal remunerations," "false cost report," and "unnecessary service" types of fraud, PPS, by rewarding underutilization, discourages "services not provided," "auto accident scams," and "unnecessary services." PPS also will encourage new forms of the theories of fraud discussed in Part III. The converse of the unnecessary services fraud will occur under PPS when the unscrupulous provider fails to provide necessary services and falsifies or conceals information to facilitate this failure. Misrepresentations will occur, but instead will focus on those which affect DRG reimbursement. Remunerations designed to maximize reimbursement will continue between providers. The legality of these remunerations remains to be seen. Submission of false cost reports will also continue under PPS, but the information falsified will change to better manipulate new reimbursement criteria. Two of the theories of fraud historically used will likely be unaffected by changes in reimbursement: the appetite for drugs will ensure that the "Rx by fraud" theory remains viable, and naive and desperate patients will keep the "quackery" theory alive. In short, although the specific types of fraud may change, structural incentives for fraud will continue to exist.

In addition to the new structural incentives for fraud provided by PPS,

587. 42 C.F.R. §§ 412.60-.63 (1987).

588. *Id.* § 412.2(d).

recent socioeconomic changes will also encourage fraudulent behavior. The growing commercialization of health care is one such change.⁵⁸⁹ Sociological studies have shown that as a profession becomes more commercialized and socialized to the behavior of profit-seeking, fraud increases.⁵⁹⁰ An additional socioeconomic change that will affect fraudulent behavior is the increase in the number of health care providers,⁵⁹¹ coupled with the current efforts to decrease, or at least stabilize, national health care expenditures. This change means there will be fewer dollars to be split among an increasing number of providers. As providers seek to maintain what they perceive as appropriate target incomes, the unscrupulous provider is more likely to succumb to fraud.⁵⁹²

These bleak projections of the future structural and socioeconomic incentives for fraudulent behavior by health care providers suggest four points. First, fraudulent behavior by health care providers will continue, if not increase. Second, criminal fraud by health care providers will probably be harder to prove. Two of the frauds encouraged by PPS, concealing the failure to provide necessary services and manipulating DRG reimbursement by falsifying patient medical information, require a showing that grossly improper medical treatment was knowingly administered. Proof of such facts beyond a reasonable doubt is very difficult. The other two offenses likely to occur under PPS, remunerations between providers and submission of false cost reports, also present major difficulties for the prosecution. The long-standing custom of providers giving direct and indirect remuneration to other providers and the problems of constructing statutes prohibiting remuneration raise serious questions as to the legality of any given remuneration. The evidentiary problems discussed above in proving inten-

589. See *supra* text accompanying notes 115-16.

590. See Quinney, *Occupational Structure and Criminal Behavior: Prescription Violation by Retail Pharmacists*, 11 SOCIAL PROBS. 179 (1963). Quinney conducted a study in which he divided pharmacists into those who had a "business orientation" toward their jobs and those who had a "professional orientation" toward their jobs. He then studied the prescription violations (usually misdemeanor offenses in the respective jurisdictions studied) by the pharmacists. Quinney found that 75% of the pharmacists who had a business orientation committed prescription violations while none of the pharmacists with a professional orientation committed prescription violations. *Id.* at 183 (Table 1).

Another sociologist, J.E. Conklin, has identified six market conditions conducive to business crimes: (1) seller concentration; (2) buyer concentration; (3) product differentiation ("in distinguishing its product from competing products in the consumer's mind, a company may engage in fraudulent or deceptive advertising to create false distinctions"); (4) entry barriers; (5) price elasticity of demand (when an increase in price will result in little reduction in demand); and (6) a slow growth rate of demand. J. CONKLIN, *supra* note 122, at 51-52.

All of these conditions exist in the health field, at least to some extent. Because of licensing requirements, entry barriers have existed in health care since the early twentieth century. As third-party payers began to dominate payment, buyer concentration developed. Consequently, the demand for health care services has increased consistently even though the price for these services has risen steadily. As public policy makers attempt to slow the growth of health care expenditures, competition between providers initially should increase. This competition will likely induce many individual health care providers to merge into health care conglomerates, resulting in seller concentration. Finally, advertisements on radio, television, and billboards readily demonstrate the attempts by health care providers to sell and differentiate their services.

591. See *supra* text accompanying note 105.

592. Brown, *supra* note 96, at 162 ("target incomes" are "those incomes [physicians] believe they have a right to achieve as a consequence of years spent in acquiring expertise").

tional submission of a false cost report⁵⁹³ will be exacerbated by the tremendous volume of new regulations governing cost reporting under PPS.

Third, given the difficulty in proving criminal fraud, civil remedies will become even more important enforcement weapons. Aggressive civil actions, expulsion from Medicare and Medicaid, and revocation of professional licenses should accompany any criminal action. If criminal action is inappropriate or ineffective, these sanctions can be extremely effective substitutes.

Fourth, the patient will continue to be a victim of the unscrupulous provider's efforts to fraudulently maximize reimbursement. The examples in this Article demonstrate that patients have been victims of fraud in the third-party fee-for-service reimbursement system, and will continue to be victims in a prospective reimbursement system that rewards under-utilization of medical services.

V. CONCLUSION

It is not fair or accurate to suggest that all health care providers will defraud third-party payers or patients. Some attempts to take advantage of reimbursement mechanisms are not fraudulent but are aggressive, creative, and legal business tactics in an increasingly competitive industry. Other activity that appears fraudulent is not; such as genuine error committed in a good faith attempt to comply with complex regulations. If neither of these situations applies, however, the fraudulent health care provider should be pursued tenaciously and relentlessly in the criminal, civil, and administrative forums. This will require an appreciation of the socioeconomic developments in health care and the difficulties of proving this fraud. The selection of an optimal theory of the case is imperative for overcoming these difficulties. Although the optimal theory was articulated in one of the first reported prosecutions of a health care provider,⁵⁹⁴ it has been ignored too often since. This theory, which focuses on the patient as a victim of the fraudulent provider, allows proof of a sad truth: the health care provider, by virtue of expertise and status, is able to commit fraud by frightening the ill and trusting patient into parting with money, or more. It is likely that as PPS or other reimbursement mechanisms develop, some changes will be needed in this theory to make it directly applicable to frauds committed under the new reimbursement schemes. There is little chance, however, that this theory will lose its vitality. To the unscrupulous provider, the patient will always be "the raw material for profits."⁵⁹⁵

593. See *supra* text accompanying notes 430-37.

594. *United States v. Smith*, 222 F. 165, 167 (E.D. Pa. 1915).

595. *Medicare and Medicaid Frauds: Hearing Before the Senate Comm. on Aging, Pt. 5, supra* note 7, at 544 (statement of Patricia G. Oriol, Chief Clerk, Senate Comm. on Aging).

