

A Primer on Health Care Fraud Prosecutions

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In our recent articles on the use of experts in white collar cases, we touched on health care fraud prosecutions as being particularly amenable to more aggressive use by defense lawyers of experts/investigators/case agents at trial. We now devote this article to an examination of the law on health care fraud and the statutory tools used by federal prosecutors to target doctors and providers of services.

Government Crackdown on Health Care Fraud

Knowledge of health care law constitutes more and more of a necessity for today's white collar practitioner. In the Clinton Department of Justice, health care fraud eclipses all other prosecutorial priorities save only for violent crime.¹ According to a recent article in the National Law Journal, the federal government has announced a policy of "zero tolerance" for health care fraud and has earmarked as much as \$900 million through the end of 2003 to combat it. The National Law Journal, *Health Law Boom*, May 17, 1999, at 10 (hereinafter, "*Health Law Boom*."). The reasons for this concentration of prosecutorial resources lie in the economic havoc health care fraud has wreaked in federally funded programs such as Medicare and Medicaid. Estimates of medical expenditures in the United States amount to roughly 15% of the gross national product and the cost of health care fraud to the taxpayer have risen to \$100 billion dollars a year.²

In recognition of the seriousness of this cost to the economy, the war on health care fraud and abuse is not limited to the federal government. The Attorneys General of as many as forty-four states have created specialized health care fraud units.³

¹ See Health Care Fraud is High Priority for Justice, Attorney General Claims, Medicare Rep. (BNA) at D-31 (June 14, 1996) (stating that, from 1993 to 1995, all 94 U.S. Attorneys coordinated civil and criminal teams for prosecuting health care fraud, and FBI nearly doubled its time spent on health care fraud).

² Health Care Reform in Nursing Homes, Part II: Hearings Before the Subcomm. On Human Resources of the House Comm. On Gov't Reform and Oversight, 105th Con. 12 (1997) (statement of Kathleen A. Buto, Deputy Dir., Health Care Financing Administration) (calculating that the United States now spends nearly 15% of Gross Domestic Product on health care); *Health Law Boom* at 11.

³ Gaming the Health Care System: Trends in Health Care Fraud: Hearing Before the Senate Special Comm. on Aging, 104th Cong., 1st Sess. 71 (1995) (statement of Thomas A. Temmermann, Director, Bureau of Medi-Cal Fraud).

Moreover, even at the federal level, powers of investigation and prosecution are not limited to the Department of Justice. The Office of the Inspector General (“OIG”) of the Department of Health and Human Services (“HHS”) has the authority to detect, prosecute, and punish fraudulent activities in Medicare and Medicaid programs, including authority to exclude providers from these programs. The Health Care Financing Administration (“HCFA”) also investigates fraud in federal programs. These entities have the power to issue investigative subpoenas to health care providers for records of billing practices.

High Profile Prosecutions and Civil Settlements.

The pervasiveness and cost to the economy of health care fraud have triggered a multilateral prosecutorial response. By policy, the Department of Justice uses civil and criminal teams to prosecute providers by deploying a “multi-agency, parallel proceedings approach, whereby fraud investigations are carried out by agents of both state and federal governments, and defendants are pursued and prosecuted in both civil and criminal proceedings.” S.G. Kleiner, E.A. Philp, J. Yokoyama, *Health Care Fraud*, 36 Am. Crim.L. Rev. 773, 804-05 (Summer 1999).

Producing what the National Law Journal recently described as “staggering” enforcement numbers, the federal government recovered almost \$1.7 billion through settlements of health care fraud cases in period from 1997 to 1998. *Health Law Boom, supra*, at 1, 10. Recent government coups include the SmithKline Beecham settlement for \$325 million and that of Health Care Service Corp. for \$144 million. Other, more modest settlements reported by the National Law Journal include the False Claims Act settlements by American Ambulance & Oxygen for \$1.45 million and by Meris Laboratories Inc. for \$5.2 million. *Id.*, at 10.

The National Law Journal also reported that in the years 1992 to 1998, criminal investigations of health care providers jumped from 343 to 1,866, while civil investigations shot from 270 to 3,471. *Health Law Boom, supra*, at 10. This dramatic prosecutorial focus has led to what the National Law Journal has reported as “[a]t least a doubling in size since 1993 of at least eight large-firm health care practices.” (Emphasis in original). *Id.* Much of this growth springs from the addition of white collar specialists who defend providers against charges of fraud. *Id.* at 11

The Statutory Framework

Federal and state prosecutors have at their disposal a wide variety of statutes under which they can prosecute health care fraud. Because most health care prosecutions have been brought by federal prosecutors, this article focuses on federal law. ⁴

⁴ For an excellent overview of state statutes, see Pamela H. Bucy, *Crimes by Health Care Providers*, 1996 U.Ill. L. Rev. 589 and Pamela H. Bucy, *Fraud by Frigate: White Collar Crime by Health Care Providers*, 67 N.C.L. Rev. 855 (1989).

While a variety of specialized health care fraud statutes exist, the offenses most commonly charged in health fraud prosecutions are under generic criminal statutes such as the mail fraud, false statements and false claims acts. We will rehearse the elements of each such statute as well as the health fraud-specific Medicare and Medicaid fraud statutes that target sophisticated kickback arrangements and which make it illegal for doctors to benefit from patient or service referrals.

I. Generic Federal Criminal Statutes

A. Mail/Wire Fraud

The mail fraud and wire fraud statutes are found in the federal criminal code at 18 U.S.C. §§ 1341 and 1343, respectively. The elements of mail fraud are (1) that the defendant devised a scheme or artifice to defraud or to obtain money or property by means of false or fraudulent pretenses and (2) that the defendant used the mails in furtherance of the scheme. Wire fraud shares the same first element as mail fraud but instead of use of the mails, the prosecution must prove interstate use of wire, radio or television communication.

As anyone who has ever defended a mail or wire fraud case knows, virtually any fraudulent conduct can constitute a “scheme or artifice to defraud” and the courts construe the mail and wire fraud statutes very broadly. Prosecutors do not need to show actual damage as a result of defendant’s conduct nor do they have to prove that the victim was actually defrauded. United States v. Hammond, 598 F.2d 1008 (5th Cir. 1979) (cited by Manual of Criminal Jury Instructions for the District Courts of the Ninth Circuit (1997 ed.) (Hereinafter, “Ninth Circuit Manual of Jury Instructions”) in commentary to Instruction 8.26.2, Mail Fraud -- Scheme to Defraud. Moreover, the “use mails in furtherance of the scheme” element of mail fraud is satisfied by any mailing that is “incident to an essential part of the scheme.” United States v. Hubbard, 96 F.3d 1223, 1228-29 (9th Cir. 1996). Indeed, the defendant need not even be aware of using or causing the mails to be used so long as use of the mails is reasonably foreseeable. Pereira v. United States 347 U.S. 1, 8-9 (1954). Further, the material mailed does not itself have to be false or deceptive. Ninth Circuit Jury Instructions, Instruction 8.26.1, Mail Fraud -- Scheme to Obtain Money or Property by False Promises. Finally, the mens rea requirement for mail and wire fraud is satisfied by showing that the defendant acted with the intent to defraud. Ninth Circuit Manual of Jury Instructions, Instruction 8.26.1, Mail Fraud -- Scheme to Obtain Money or Property by False Promises.

B. False Statements

The False Statements Act is codified in the federal criminal code at 18 U.S.C. § 1001. The act targets false representations of material fact, concealment of material facts and use of false writings made to the government either directly or through a third party in any matter within the jurisdiction of any department or agency of the United States. The elements of the offense of false statement are (1) that the defendant submitted a statement to a government agency; (2) the statement was false or concealed a fact; (2) the statement or concealment was

material and (4) the statement or concealment was made knowingly and wilfully.

As with mail and wire fraud, the courts interpret the False Statement Statute broadly. For instance, the Supreme Court in United States v. Rodgers, 466 U.S. 475, 479 (1984) construed the phrase “within the jurisdiction of any department or agency of the United States” to include most if not all of the authorized activities of federal agencies. Only in so doing, the Court reasoned, “would Congress’s purpose of protecting the government from fraud be served.” Id. at 480-82. Well before the Supreme Court decision in Rodgers, the Ninth Circuit had held that the submission of false statements to a private insurance company under contract to process Medicare claims is “within the jurisdiction of . . . [a]n agency of the United States.” United States v. Kraude, 467 F.2d 37 (9th Cir.), *cert. denied*, 409 U.S. 1076 (1972). More recently, in United States v. Rutgard, 116 F.3d 1270 (9th Cir. 1996), the Ninth Circuit held that patients’ records held in the office of an ophthalmologist were statements to a federal agency. The court, in an exhaustive opinion by Judge Noonan, stated:

[Section 1001] does not only criminalize false statements or representations to a federal agency. It criminalizes each ‘false entry’ made to conceal a material fact. There is no doubt that patient complaints and visual fields are material facts bearing on medical necessity. It is argued that doctors should not be made criminals for inaccurate notetaking. But the statute speaks to fraudulent notations. They are criminal only when, as here, they prevent review of payments made to a physician by the government.

Id. at 1287. Compounding the broad interpretation of the jurisdictional requirement, the Ninth Circuit and many others hold that there is no requirement that defendant have acted with the intention to influence a government agency, i.e., there is no mental state required with respect to the fact that a matter is within the jurisdiction of a federal agency. United States v. Green, 745 F.2d 1205, 1209-10 (9th Cir. 1984), *cert. denied*, 474 U.S. 925 (1985); United States v. Yermian, 468 U.S. 63, 73 & n.13 (1984). The Ninth Circuit Manual of Jury Instructions suggests that the initial determination of whether the matter is within the jurisdiction of a federal agency be made by the court as a matter of law. Commentary to Jury Instruction 8.20 -- False Statement to Government Agency. Further, while materiality must be proved by the government and is a matter for the jury (United States v. Gaudin, 515 U.S. 506 (1995)), actual reliance on the statement or concealment is not required. United States v. Talkington, 589 F.2d 415 (9th Cir. 1978). Finally, with respect to the mens rea for section 1001, the government is required to prove that the defendant acted wilfully, “that is deliberately and with knowledge that the statement was untrue.” Ninth Circuit Manual of Jury Instructions, Jury Instruction 8.20 -- False Statement to a Government Agency.

C. False Claims

Another generic federal fraud statute frequently invoked in health care fraud prosecutions is the statute criminalizing the submission of false claims to the government. The statute prohibiting the submission of “false, fictitious or fraudulent claims” is related to the False Statement statute and is found in the federal criminal code at 18 U.S.C. section 287. The

elements of a False Claims Act offense are (1) the defendant presented a claim to a department or agency of the United States; (2) the claim was “false, fictitious or fraudulent” and (3) the defendant presented the claim knowing it was false, fictitious or fraudulent. Prosecutors increasingly use this statute against providers who argue that complex billing regulations caused them to submit false claims. *See Health Care Fraud*, n. 27.

As with the mail/wire fraud and false statements statutes, the courts construe section 287 liberally. In *United States v. Jackson*, 845 F.2d 880, 882 (9th Cir.), *cert. denied*, 488 U.S. 857 (1988), the Ninth Circuit deemed section 287 to be a remedial statute and therefore susceptible to a broad reading of the word “claim.” This broad reading in *Jackson* led the Ninth Circuit to deem defendant’s submission of claims falsely denying receipt of checks to satisfy the “claim” requirement of the statute. In keeping with this liberal construction of the statute, as with false statements, presentation to an agency of the United States is shown even where the claim is not made directly to a federal agency. For example, the federal nexus is satisfied even where the claim is made to an intermediary such as a private insurance company under contract to administer Medicare or Medicaid. Under a theory of agency, courts have determined that the defendant in such a case caused the intermediary to submit the false claim to the federal government. *See, e.g., United States v. Catena*, 500 F.2d 1319, 1322 (3d Cir.), *cert. denied*, 419 U.S. 1047 (1974).

As with false statements, the government must prove materiality of the false claim to a jury. In addition, the government must prove that the defendant acted wilfully to violate the law. *United States v. Milton*, 602 F.2d 231, 233-34 & nn. 6, 9 (9th Cir. 1979).

Prosecutions under section 287 present unusual hazards in terms of the damage that can be caused by the institution of parallel proceedings. The policy of the Department of Justice is to file both criminal and civil actions against health care defendants. In the criminal cases, the DOJ pursues defendants under section 287 rather than section 1001 where possible in order to earn preclusive effect for the criminal conviction in subsequent civil enforcement actions under the False Claims Act (31 U.S.C. §§ 3729-3812). The civil enforcement actions authorized under the False Claims Act allow for private enforcement by a qui tam plaintiff. The private qui tam suit is initiated by the filing of a complaint under seal setting forth the allegations of fraud committed against the government. *Id.*, § 3730(b)(2). The government conducts an investigation into the allegations while the complaint is under seal and may intervene in the action lifting the seal and assuming responsibility for the prosecution of the action. *Id.*, § 3720(b)(3) & (b)(4). If the government declines to intervene, the private plaintiff may still proceed with the action. *Id.*, § 3720(b)(4)(B). If the government prevails on the merits, it is awarded treble damages plus a \$5,000 to \$10,000 penalty for each false claim submitted. *Id.*, §§3729(a) & 3730(d)(1). *See, generally*, R. Salcido, *Mixing Oil and Water: The Government’s Mistaken use of the Medicare Anti-Kickback Statute in False Claims Act Prosecutions*, 6 *Annals Health L.* 105 (1997) for a discussion of the legitimacy of the Department of Justice’s practice of prosecuting qui tam suits under the False Claims Act which allege violations of the Medicare/Medicaid Anti-Kickback Act.

D. Money Laundering

Health care providers who commit fraud and use the proceeds to conduct certain financial transactions may be charged under the money laundering statutes codified at 18 U.S.C. §§ 1956 and 1957. For a detailed discussion of these statutes, potential defenses and defense strategies, see our previous FORUM article in volume 26, number one.⁵

II. Specialized Health Care Fraud Criminal Statutes

A. Medicare and Medicaid Fraud -- Submitting False Claims

42 U.S.C. § 1320a-7b(a)(1) codifies the federal health care false claims statute. It targets false statements in any application for any benefit or payment under the [Medicare] programs or a State health care program. The elements of the offense are (1) making or causing to be made a statement or representation of material fact in an application for payment under the Medicare, Medicaid or other state health care program (2) the statement or representation was false (3) the defendant acted knowingly and wilfully.

United States v. Rutgard, *supra*, 116 F.3d 1270 offers a good example of the use of an expert to solidify a defense of medical necessity to a charge of medicare fraud. In Rutgard, a prominent San Diego ophthalmologist appealed his conviction on numerous counts of mail fraud on, and false claims to, Medicare, of mail fraud on other insurers and money laundering involving transactions in money derived from these frauds. Dr. Rutgard was accused of billing Medicare for procedures that were not medically necessary in violation of 42 U.S.C. § 1395y(a)(1)(A). Both the defense and prosecution called experts to testify on the question of medical necessity of the procedures. The experts contradicted each other's opinions. Ninth Circuit held that

[w]ith two expert ophthalmologists, neither of whom had seen the patient, disagreeing as to whether the performance of cataract surgery on an eye . . . is ever medically necessary and with [a government witness] testifying that [the patient's] chart met Medicare standards, no reasonable juror could conclude beyond a reasonable doubt that Rutgard knew the surgery on [the patient] was medically unnecessary; the evidence is insufficient to establish fraud.

Id. at 1283.

B. Medicare and Medicaid -- Anti-Kickback Provisions

42 U.S.C. § 1320a-7b(b)(1) and (2) and § 1395nn codifies the federal health care anti-

⁵ Mary McNamara and Edward W. Swanson, *Money Laundering: How Prosecutors Clean Up Under 18 U.S.C. Sections 1956 and 1957*, FORUM Vol. 26, No. 1, page 61.

kickback laws. These laws criminalize payments by providers to one another for patient referrals and also criminalize self-dealing in referrals. In addition to criminal prosecution and civil fines, violation of these laws subjects the violator to exclusion from Medicare, Medicaid and other state health care programs.

(i) 1320a-7b(b)

A violation of § 1320a-7b(b)(1) is established where (1) the defendant knowingly and wilfully (2) *solicits or receives* remuneration of any kind, either directly or indirectly (3) in return for program-related business. 42 U.S.C. § 1320a-7b(b)(1). A violation of § 1320a-7b(b)(2) is established where (1) the defendant knowingly and wilfully (2) *offers or pays* remuneration of any kind, directly or indirectly (3) to induce the receipt of program-related business. 42 U.S.C. § 1320a-7b(b)(2).

The anti-kickback statute has been amended several times since its original passage in 1972, each time to further its reach and bolster its penalties. Originally a misdemeanor offense, Congress amended the statute in 1977 to upgrade health care-related kickbacks to felony status and to broaden the scope of criminal activity from kickbacks, bribes or rebates to include “any remuneration.”⁶ Before the 1980 amendments, the statute provided for strict liability. *Crimes by Health Care Providers*, at 610. In 1980, however, Congress amended the statute to require proof that violators act knowingly and wilfully before liability could attach.⁷ By further amendment in 1987, Congress added an additional penalty and authorized the exclusion from the Medicare or Medicaid program of individuals or entities found by the Secretary to have committed an act proscribed by § 1320a-7b(b).⁸ The 1987 amendments also narrowed the scope of the statute by authorizing the Secretary to issue regulations defining a safe harbor for innocuous conduct customarily engaged in or needed in the medical field which, by its literal terms, the statute would otherwise render illegal. Under safe harbor regulations released by the Secretary,⁹ certain investment interests are protected so long as full compliance with the safe harbor provision is made. 42 C.F.R. pt. 1001. If, for example, the investment is in a large corporation, and it is in an equity security, it must be registered with the S.E.C. If the investment is made by one who can generate business for the entity, it must be obtained via arms length terms equally available to the trading public. Several other conditions must also be satisfied

⁶ Social Security Amendments of 1972, Pub. L. No. 92-603, § 242(b), (c), 86 Stat. 1419.

⁷ Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 917, 94 Stat. 2599, 2625.

⁸ The Medicare and Medicaid Patient and Program Protection Act, Pub. L. No. 100-93, 101 Stat. 680 (1987).

⁹ Fraud and Abuse OIG Safe Harbor Anti-Kickback Provisions, 59 Fed. Reg. 3088 (1989).

such as that payment to the investor in return for the investment must be directly proportional to the amount of the investor's capital investment. 42 C.F.R. § 1001.952(a)(1) (1997).

The Safe Harbor provisions also protect leases between physicians and health care facilities which do not incorporate price breaks based on referrals between the two. To be shielded under this provision, the lease must be in writing, specify the precise premises or equipment covered, specify the rents for items leased over periodic intervals, must be for at least one year and the rent must be consistent with fair market value. 42 C.F.R. § 1001.952(b)-(c) (1997). In addition, safe harbor provisions shield the sale of a practice, certain referral services (carried on by professional societies and consumer groups so long as fees are not adjusted based on referral volume), the activities of group purchasing organizations under certain circumstances and other practices beneficial to the public. *See Health Care Fraud* at 798-801 for a detailed overview of these and other safe harbor provisions. Only full compliance with the detailed provisions of the particular safe harbor provision will confer protection, but failure to satisfy all conditions is not in itself an offense. *Id.*, at 794-95 (and authorities cited therein.)

The Ninth Circuit has handed down a very important decision interpreting section 1320a-7b(b). *Hanlester Network v. Shalala*, 51 F.3d 1390 (9th Cir 1995) was the first case in the Medicare Anti-kickback act was applied to physician self-referral joint ventures and to remuneration arrangements other than kickbacks, bribes or rebates. 51 F.3d at 1396. In *Hanlester*, a civil case involving an appeal from a decision of an Administrative Law Judge who had ordered a medical partnership excluded from Medicare and Medicaid, the Ninth Circuit elevated the mens rea element to the highest possible standard by interpreting the word "wilfully" to require knowledge by defendant that his conduct is illegal. *Id.* at 1400. In doing so, the Ninth Circuit, alone of all the other Circuits, followed the Supreme Court's construction of "wilfully" in the anti-structuring provisions of 31 U.S.C. § 5324 in its decision in *Ratzlaf v. United States*, 510 U.S. 135, 137 (1994).¹⁰

The case presents an excellent example of how a stringent mens rea requirement defeats criminal intent in complex white collar cases. *Hanlester* involved a master laboratory service contract between Hanlester Network ("Hanlester"), a medical partnership with Smithkline BioScience Laboratories ("SKBL") to provide management services to several joint venture laboratories in which Hanlester had an ownership interest. Hanlester then issued private placement memoranda offering limited partnership shares in the joint venture laboratories. SKBL entered into management agreements with these joint ventures which required the joint ventures to pay SKBL for its services. In accordance with these agreements, 85 to 90% of tests physicians ordered from the Hanlester labs were performed at SKBL facilities. 51 F.3d at 1395-96. The court held that a Hanlester agent violated the provisions of the Medicare-Medicaid

¹⁰ *See* T. D. Love, *Toward a Fair and Practical Definition of "Wilfully" in the Medicare/Medicaid Anti-Kickback Statute*, 50 Vand. L. Rev. 1029 (1997) for a discussion of *Hanlester* and the author's view that the Ninth Circuit went too far in requiring specific intent to violate the law to support a violation of the Anti-Kickback law.

anti-kickback statute by representing to prospective limited partners in the joint venture laboratories controlled by Hanlester that their ability to buy shares would depend on the volume of referrals of work to the laboratories. The court held that such a representation constituted an offer of payment to induce referrals of program-related business in violation of § 13201-7b(b)(2). 51 F.3d at 1399-1400. On a theory of vicarious liability, the court held Hanlester, although not its individual partners, responsible for the actions of the agent, who was not herself a party. *Id.* at 1400. The court specifically held, however, that “[t]he fact that a large number of referrals resulted in the potential for a high return on investment, or that the practical effect of low referral rates was failure for the labs, is insufficient to prove that appellants offered or paid remuneration to induce referrals.” *Id.* at 1399. As for the charge that, by virtue of its management agreement with SKBL, Hanlester violated § 13201-7b(b)(1), soliciting or receiving remuneration “in return for” referrals, the court held that there was no evidence to support the theory that the joint ventures functioned as shams to funnel payments to Hanlester in return for referrals of business to SKBL. The court noted that “the management services agreement between SKBL and appellants reflects a relatively common practice in the clinical laboratory field” and that the Inspector General “did not prove that any of the appellants intentionally solicited or received remuneration from SKBL in return for referrals. *Id.* at 1401.

While Hanlester narrowed the reach of the Anti-Kickback Act by requiring the government to prove that the defendant had knowledge of the illegality of the kickback conduct, it also broadened the statute to hold that for a violation of either § 1320a-7b(b)(2), an offer to pay remuneration to induce program-related business, or § 1320a-7b(b)(1) receipt of remuneration in return for program-related business, there is no requirement that the government demonstrate an agreement to refer the business. Hanlester, 51 F.3d at 1396. The Hanlester court also upheld § 1320a-7b(b) against a claim of constitutional vagueness. *Id.* at 1398.

(ii) § 1395nn -- Stark Amendments

The Ethics in Patient Referrals Act, found at 42 U.S.C. § 1395nn(a), prohibits a physician from making a referral to an entity that delivers designated health services, including inpatient and outpatient hospital services, which would be billed to Medicare if the physician or a family member holds a financial interest in the entity. This Act, known as the Stark Amendment,¹¹ was passed in 1989 and took effect in 1992. It made illegal the previously legal practice of physician self-referral. The Stark Amendment also prohibits clinical laboratories from billing any person for services performed as a result of a prohibited referral. 42 U.S.C. § 1395(a)(1)(B).

In 1993, in a second Stark Amendment (“Stark II”),¹² Congress broadened the scope of

¹¹ Omnibus Reconciliation Act of 1989, Pub. L. No. 101-239, § 6204, 103 Stat. 2106, 2236 (1989)

¹² Omnibus Reconciliation Act of 1993, Pub. L. No. 103-66, tit. XIII, § 13562, 107 Stat. 312, 596-605 (1993).

the prohibited self-referral activity to include several additional categories of medical providers in addition to clinical laboratories. Stark II also augmented the penalties for violation of these self-referral provisions from misdemeanor to felony status, but provided several safe harbors. 42 U.S.C. § 1395nn(a)(1) and nn(b).

The complexity of the various federal statutes and the criminalization of erstwhile normal business practices virtually guarantees increased violation of the law by well-intentioned health care providers. As Professor Bucy notes in her article,

[w]ith the kickback statute, the safe harbor regulations, and Stark I and II, voluminous and complex regulations apply to virtually every business arrangement involving health care providers. Because of the dire consequences that may befall providers who violate these provisions -- criminal liability, criminal and civil fines and penalties, exclusion from participating in Medicare or Medicaid, and potential loss of professional license -- health care providers and those who enter into business arrangements with providers should take care to ensure that their practices comply with these laws.

Crimes by Health Care Providers, at 619.

C. The Health Insurance Portability and Accountability Act of 1996

In 1996 Congress enacted the Health Insurance Portability and Accountability Act (“HIPAA”), codified at 42 U.S.C. § 1320a-7(c). In an effort to consolidate federal power in combating health care fraud and abuse, HIPAA enlarged federal criminal jurisdiction to cover all federal health care programs, making it illegal to “knowingly and wilfully” defraud any health care benefit program or to obtain, by means of false representations, any money or property of a health care benefit program. 18 U.S.C. § 1347. In addition, HIPAA criminalized the making of false statements “in any matter involving a health care benefit program.” 18 U.S.C. 1035. It also specifically outlawed the offense of obstruction of an investigation of a federal health care offense. 18 U.S.C. § 1518.

In addition to this expansion of criminal jurisdiction, HIPAA introduced several new and potentially devastating civil penalties, including asset forfeiture, injunctive relief and the requirement that settlements of health care fraud charges include a requirement that the offender adopt a government supervised corporate integrity program. *Health Care Fraud, supra*, at 791 and citations therein.

On the other hand, several authors suggest that implementation of provider compliance programs may help to reduce or eliminate the specter of criminal prosecution. See Jerome T. Levy, *Use of Compliance Programs; Offers Benefits to Providers*, N.Y.L.J. August 3, 1998, at 7; see also, *Health Care Fraud, supra*, at 792. For discussion of safe harbor provisions, see section Medicare and Medicaid -- Anti-Kickback Provisions, 1320a-7b(b).

Collateral Consequences of a Criminal Conviction of a Physician

In addition to the usual adverse consequences of a criminal conviction such as incarceration, fines, damage to reputation and supervision, conviction of a physician usually carries a professional death sentence. California Business and Professions Code § 2234 provides that “[t]he Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct.” Business and Professions Code § 2236(a) defines unprofessional conduct to include “[t]he conviction of any offense substantially related to the qualifications, functions, or duties of a physician and surgeon.” The California courts have liberally construed the phrase “substantially related” to refer to conduct far removed from the actual work of healing patients. There is no doubt that a conviction for medicare fraud constitutes grounds for professional discipline on the basis that it involves moral turpitude. Matanky v. Board of Medical Examiners, 79 Cal. App. 3d 293 (1978) (conviction for submitting false medicare claims for services that were not rendered); see also, Carey v. Board of Medical Examiners, 66 Cal. App. 3d 538 (1977) (conviction under 18 U.S.C. § 1001 for false statements to federal agency deemed crime of moral turpitude warranting suspension of physician from practice). Nor does the conviction have to be for a felony. A recent decision of the California Court of Appeal, First Appellate District held that a misdemeanor conviction for soliciting subornation of perjury was “substantially related to the qualifications, functions or duties of a physician or surgeon” within the meaning of § 2236(a) and thus constituted proper grounds for revocation of a physician’s license. Krain v. Medical Board, 71 Cal. App. 4th 1416 (1999), modified on denial of rehearing.

By law, the prosecuting agency is *required* to notify the Division of Medical Quality of the *mere pendency* of a felony or misdemeanor prosecution against a licensee and provide details of the offenses charged. Cal. Bus. & Prof. Code § 2236 (b). Moreover, the prosecutor must notify the clerk of court in which the prosecution is pending that the defendant is a licensee and the clerk in turn must “record prominently in the file that the defendant holds a license as a physician and surgeon.” Id.

If the licensee is convicted, the clerk of court shall within 48 hours transmit a certified copy of the record of conviction to the board. Cal. Bus. & Prof. Code § 2236(c). The statute provides that

[t]he division may inquire into the circumstances surrounding the commission of a crime in order to fix the degree of discipline or to determine if the conviction is of an offense substantially related to the qualifications, functions, or duties of a physician and surgeon.

Id.

In addition to these calamitous consequences to the physician’s license, as set forth in section II.B(i) *supra*, the Medicare and Medicaid Anti-Kickback statute set forth at 42 U.S.C. § 1320a-7b(b) provides for the exclusion of offending providers from federal programs.

The Value of an Early Presentation to the Prosecutor

Because of the complexity of billing regulations and safe harbor provisions, the difficulty

of determining the medical necessity of given procedures and the potential for billing error to have occurred through honest mistakes by billing clerks rather than through the deliberate conduct of the professionals authorizing the procedures, the successful defense of a health care fraud case demands that the practitioner possess a sophisticated grasp of the facts which includes learning the client's business. This is particularly important in the post-HIPAA world of increased federal funding for health fraud prosecutions and what the National Law Journal has reported as "*the increased hiring of former DOJ or HHS lawyers who are experienced litigators*." Many of them understand the complexities of Medicare reimbursement, billing and conflict-of-interest laws that outlaw certain business relationships in the health care industry." *Health Care Boom, supra*, (emphasis in original) at 10.

A thorough understanding of the vicissitudes of a given medical practice may be crucial in minimizing or even eliminating the client's criminal exposure. For instance, if the particular medical procedure constitutes a relatively minor fraction of the client's profit margin, there is more force to the argument that the client has little motivation to overbill. Similarly, if the diagnosis for which the procedure is prescribed is the product of diagnostic criteria which are more, rather than less objective, there is a corresponding likelihood that the procedure is appropriate, rather than a vehicle for illegitimate profit-taking. Further, the legitimacy of the procedure recommended may be greatly affected by the nature of the patient population. A low income, elderly patient population may have far more incidence of diabetes and weight problems (requiring more laboratory work and medication) than a younger, more affluent population. The very factual complexity of these cases demands that the practitioner know the business at issue. To that end, practitioners should make on site visits to the client's offices, interview all key employees, determine who trained personnel on billing procedures, has access to billing records and for what purpose (i.e., which personnel generate the records, approve them and send them out).

Given the range of possible charges at the prosecutor's disposal, the sheer complexity of billing regulations, the expense and risk of a trial, one of the key decisions that practitioners face in defending a doctor or other provider is whether to make a pre-indictment or, if the case of a pending case, a pre-trial presentation to the prosecutor in an effort to secure a non-criminal disposition. This decision is freighted with consequence: Failure to secure a dismissal leaves the defense exposed and the prosecutor well informed as to the defense at trial. Failure to make the presentation deprives the client of a chance to avoid the risk, expense and stress of trial. The importance of this decision places a premium on exhaustive investigation. Generally speaking, given the potentially devastating consequences of conviction to the provider in terms not only of loss of liberty, but, in the case of physicians, loss of license and for all providers, exclusion from health care programs, the stronger the case for reasonable doubt, the stronger the incentive to make a presentation to the Assistant United States Attorney. Experienced prosecutors will be able to size up which cases are worth taking to trial and will not be afraid to dismiss cases which do not belong on their desks. Both of the authors have made successful presentations to Assistant United States Attorneys in the Northern and Eastern Districts of California which resulted in the forestalling of an indictment and the dismissal of charges already filed against individual doctors.

If the offense is not yet discovered, the practitioner must consider the merits of making a voluntary disclosure to the Department of Health and Human Services. The Office of Inspector General of HHS has implemented a voluntary disclosure program which allows a provider to confess to violation of health care laws before agency action occurs. The rationale for such a course is to invite a less severe sanction than would be visited on the provider had it gambled and waited for the conduct to be discovered. There is no guarantee of lenient treatment, however, and the National Law Journal recently reported what a Jones, Day, Reavis and Pogue lawyer cites as a “vivid” example of government overzealousness on foot of voluntary disclosure. According to the lawyer, after a 100 bed hospital notified the government that it had received \$20,000 in Medicare overpayments and returned the money, the government initiated a False Claims Act investigation and issued a sweeping subpoena. *Health Care Boom, supra*, at 11.

Practitioners should nonetheless be mindful that the successful prosecution of a health care fraud case requires prosecutors to have a sophisticated grasp of the reimbursement principles at play, obliges them to marshal witnesses, consult with medical experts, determine the number and type of counts to charge in the indictment and coordinate with the OIG before plea bargaining. By the time the case is indicted, the extent of prosecutorial investment is high and that fact alone suggests that where an offense is more likely than not to come to light, it behooves the defense lawyer to recommend voluntary disclosure in an effort to obtain the most favorable disposition possible for his or her client.

Conclusion

Health care prosecutions often present a dangerous twinning of civil and criminal prosecutions with all the attendant procedural difficulties of managing parallel proceedings. Coupled with the intricacies of the billing regulations at play in many cases, the broad judicial interpretation accorded the applicable charging statutes and the disastrous personal and professional consequences of a criminal conviction for the physician client, health fraud cases constitute a challenging practice area for even the most experienced white collar practitioner. Given the high prosecutorial priority accorded such prosecutions and the vigorous efforts of Congress to criminalize an ever greater number of billing practices, more and more white collar practitioners will find themselves representing health care providers in the coming years. While health care fraud cases are often complex on their facts, the elevated mens rea requirements of at least some of the applicable criminal statutes provide opportunities to the creative practitioner to craft viable defenses, or better yet, present a compelling case for dismissal of the charges.