



Office of the Deputy Attorney General  
United States Department of Justice

2950 Pennsylvania Ave. NW  
Washington, D. C. 20530

TO: Christopher Jennings  
Deputy Assistant to the President/  
Health Policy

FAX: 456-2878

FROM: Roslyn A. Mazer  
Associate Deputy Attorney General

VOICE: 202/514-1013  
FAX: 202/616-1239

Total Pages (excluding this cover): 6

**Additional Message:** Chris -- attached is the table of contents and Executive Summary of DOJ's FY 95 and 96 Health Care Fraud Report. Excerpt on developments in home health care fraud cases is attached. Full report is at the DOJ printer; copy is on its way to you by messenger.

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In 1993, the Attorney General made health care fraud one of her top priorities. This is the Department of Justice's second report on health care fraud. Covering the Department's activities in fiscal years 1995 and 1996, the report provides an overview of the Department's health care fraud enforcement program, highlighting the Department's numerous and significant successes.

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Effective health care fraud enforcement depends on innovative, aggressive and responsible action by law enforcement. The Department has launched several pilot health care fraud projects including efforts to explore electronic fraud detection, support state and local law enforcement and build alliances with public and private health insurance plans.

The Department's aggressive health care fraud enforcement record provides an effective foundation for the future. In 1996, the President signed the Health Insurance Portability and Accountability Act. This Act provides a framework, new tools and resources for the fight against health care fraud. The Department is working closely with the Department of Health and Human Services and the other federal, state and local law enforcement to combat this scourge against the integrity of our nation's health care system.



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# **HEALTH CARE FRAUD: CRISIS OF THE NINETIES**

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## **Health Care Fraud Is Committed by Every Type of Health Care Provider**

While most health care providers are honest and concerned first and foremost about their patients' welfare, unscrupulous persons and companies of every stripe willingly defraud our nation's health care programs. Health care fraud has been perpetrated by individual physicians as well as multi-state publicly traded companies, medical equipment dealers, ambulance companies, and laboratories as well as the hospitals, nursing homes, and home health care agencies they service. In addition, too many persons -- who provide no health care at all -- nevertheless prey upon the nation's health care programs with fraudulent scams.

## **Health Care Fraud Schemes Are Diverse**

Health care fraud schemes can be simple or complex. Unscrupulous health care providers target public as well private health insurance plans.

### **Billing Frauds**

The Department continues to bring criminal and civil charges against those providers who knowingly submit false bills to health care payors:

- ▶ billing for services or equipment not rendered
- ▶ billing for services or equipment not medically necessary;
- ▶ double billing for the same service or equipment;
- ▶ upcoding (e.g., billing for a service or equipment reimbursed at a higher rate than was provided);
- ▶ unbundling (e.g., billing separately for services or equipment included in a global rate).
- ▶ billing frauds in cost reports from hospitals or nursing homes, to obtain reimbursement when not permitted or at a higher rate of reimbursement than permitted.

### **Kickbacks**

Another too common fraudulent scheme is the payment and receipt of kickbacks in return for influencing the provision of health care. Kickbacks are pernicious because they corrupt medical providers' decision making, often replacing profit for patient welfare. Kickbacks can lead to grossly inappropriate medical care, including unnecessary hospitalization, surgery, tests, and equipment.

## **Other Schemes**

Other schemes include providing services by untrained personnel, failing to supervise unlicensed personnel, distributing unapproved devices or drugs, and creating phony health insurance companies or employee benefit plans, such as fraudulent Multiple Employer Welfare Arrangements.

## **Health Care Fraud Schemes Have Been Perpetrated Across the Country**

We have investigated health care fraud schemes in every part of the country from Maine to California, from Hawaii to Puerto Rico, from Washington State to Florida. Health care fraud is perpetrated in urban areas and rural regions.

## **The Consequences of Health Care Fraud Are Severe**

While no one has an exact figure, the General Accounting Office estimates that health care fraud, waste and abuse may account for as much as 10 per cent of all health care expenditures. As health care expenditures now exceed one trillion dollars each year, more than \$100 billion may be lost in fraud, waste and abuse annually.

Everyone pays the price for health care fraud: beneficiaries who pay more in premiums for medical services and equipment and in their copayments or contributions; businesses who are compelled to pay increasing amounts to provide health care to their employees; and taxpayers who pay more to cover health care expenditures in public health plans.

Health care fraud not only costs money, it also can place patients at risk of serious physical harm. The Department has prosecuted cases in which teenagers were unnecessarily hospitalized because of kickbacks paid to physicians and hospitals; senior citizens across the Midwest had medically unnecessary, poorly fitting knee, leg and back braces foisted upon them due to unscrupulous telemarketers; and other senior citizens underwent unnecessary cataract surgery because of an ophthalmologist's greed. In some instances, health care fraud can cause unnecessary deaths. In one case, patients died when a Fortune 500 company sold unapproved heart catheters to hospitals because it preferred immediate profits to waiting for Food and Drug Administration clearance.

The scope and variety of health care fraud and the seriousness of its consequences simply cannot be overestimated.

durable medical equipment, home health care and vascular tests totalling in excess of \$1.5-million. He admitted his involvement in a conspiracy involving the submission of approximately 416 fraudulent Medicare claims seeking a total of approximately \$255,000. On April 27, 1995, he was sentenced to 26 months in prison and ordered to pay restitution in the amount of \$441,262.

❖ A former vice president of a Mediq, Inc. subsidiary filed a qui tam action in the Middle District of Pennsylvania against Mediq, alleging illegal cross-billing of portable EKGs and portable X-rays. The subsidiary, ATS, Inc., billed services performed in one carrier's jurisdiction to the carrier in another jurisdiction where the reimbursement rate was higher. Ultimately, Mediq and ATS entered into a global settlement with the United States in which ATS and its president pleaded guilty to misprision of felony, and ATS agreed to pay a total of \$2.1 million.

### **Group Homes**

❖ Two corporate officials pleaded guilty in the Northern District of Ohio to embezzling approximately \$90,000 from the Ashtabula County Residential Services Corporation (ACRSC). The executive director and the executive assistant of ACRSC, a Medicaid-funded agency, operates three group homes for people with mental disabilities were ordered to pay full restitution and were sentenced to periods of home confinement.

### **Home Health Services**

❖ The Central District of California successfully prosecuted an administrator of a home health agency and his assistant on charges of mail fraud and conspiracy in 1995. The defendants submitted \$2.5 million in fraudulent billings to Medicare for services not rendered to patients. The case is scheduled for sentencing on February 24, 1997.

❖ In the first known prosecution of a major home health care provider in the history of the state of Georgia, in 1995, the US Attorneys Office Southern District of Georgia successfully prosecuted the owner and two other chief executives of Healthmaster, Inc., the largest home health care agency in Georgia, for defrauding the Medicare Program of millions of dollars. The defendants fraudulently billed Medicare for political contributions, "ghost employees" salaries, and lavish pleasure trips. The Healthmaster owner pleaded guilty to ten felony counts, charging conspiracy to defraud the United States and false statements, and was sentenced to serve 33 months in prison and fined \$2.5 million. She also was required to repay \$15 million to Medicare and \$1.5 million to Medicaid. Two other Healthmaster executives went to trial and were convicted on 114 counts and 72 counts respectively. One was sentenced to serve 151 months in prison, the other received a 97 month sentence.

❖ On February 4, 1996, a jury in Savannah, Georgia, convicted ABC Home Health Services, Inc. (ABC), the nation's largest privately-owned home health care provider, and its owners/operators of defrauding Medicare. From approximately 1990 until 1994, the defendants defrauded more than \$1 million by making false statements and claims for reimbursement from the Medicare

program. The case was prosecuted by the U.S. Attorney's office in Savannah (S.D. GA) and the Fraud Section, Criminal Division; the case was investigated by HHS OIG and the IRS, Criminal Investigation Division.

❖ Virtually every member of a company known as "Home Health of Louisiana" (HHL) was convicted in the Western District of Louisiana of a variety of fraudulent acts in connection with Medicare payments for home bound patients. The fraudulent acts included forged physicians' signatures authorizing home health services, claims for home health services that were never rendered, claims for services rendered to unqualified patients and the concealment of financial transactions between HHL and other companies created and owned by the primary defendant. The investigation and prosecution resulted in the seizure of equipment used by HHL, the conviction of six persons, and the end of HHL as an ongoing operation. The primary defendant was sentenced to 37 months incarceration and ordered to pay \$221,221.70 in restitution. The remaining five defendants were sentenced to between 3 and 18 months incarceration, supervised release and restitution ranging between \$62,272.53 and \$2,481.07.

### Home Infusion Therapy

❖ Throughout 1995, the United States Attorney's Office for the District of Connecticut accepted referrals from the Diversion Investigative Unit of the Drug Enforcement Administration (DEA) to bring civil penalty actions under the record keeping provisions of the Controlled Substances Act. These referrals resulted in the recovery of more than \$2.1 million in 1995. One of the largest of these recoveries was in United States v. Chartwell-Southern New England, a joint DEA and State of Connecticut, Department of Consumer Protection-Drug Control Division, investigation which revealed significant record keeping irregularities by Chartwell relating to its home infusion business. Chartwell, owned in part by Yale-New Haven Hospital, Stamford Hospital, Bridgeport Hospital, Charlotte-Hungerford Hospital, and Veterans Memorial Medical Center, agreed to pay the United States \$600,000. In addition, Chartwell agreed to furnish \$300,000 worth of medical supplies to Connecticut Hospice, Inc., in Branford; Bread and Roses Hospice in Georgetown; Hospice Care, Inc., in Stamford; and Saint Francis Hospital and Medical Center Home Health Agency in Hartford.

❖ Twelve individuals were convicted on a 35-count indictment charging conspiracy, mail fraud, false statements, money laundering, and structuring in connection with a nearly \$13 million Medicare fraud prosecuted by the Southern District of Florida. From April 1992 to October 1994, the defendants created 18 different companies for purposes of billing Medicare for Parenteral Nutritional therapy -- a milk supplement provided to people unable to digest most foods. Each company had a bank account and private mail-box, but none of the companies existed anywhere except on paper. The defendants qualified to participate in the Medicare PEN therapy program by submitting fraudulent applications to Medicare, listing the private mail-boxes as their "office locations". The defendants then billed Medicare using unlawfully-obtained Medicare patient numbers and physician identification numbers. On March 27, 1996, the court sentenced one defendant to 25 months imprisonment, and ordered him to pay restitution of \$392,954. Other defendants were placed on probation and ordered to pay restitution.



U.S. Department of Justice  
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August 4, 1997

TO: Christopher Jennings  
Deputy Assistant to the  
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FROM: Roslyn A. Mazer *RAM*  
Associate Deputy Attorney General

The attached report is presently being printed for official release. Developments in the area of home health services are referenced on pages 25-26.

It has been distributed to the regulars on the DOJ press corps over the last several weeks.

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# **NATIONAL HEALTH CARE FRAUD PROGRAM**

## **COORDINATION WITHIN THE DEPARTMENT OF JUSTICE**

The Department's health care fraud efforts are centered in the U.S. Attorneys' Offices, the Criminal Division and the Civil Division. Several persons provided invaluable leadership in health care fraud enforcement: Karen Morrissette, Deputy Chief, Fraud Section, Criminal Division; Joyce Branda, Deputy Director, Commercial Litigation, Civil Division; and Iden Martyn, Deputy Director, Executive Office for United States Attorneys (EOUSA).<sup>1</sup> These efforts are coordinated by Debra Cohn, Special Counsel to the Deputy Attorney General. Since 1994, the Attorney General's Advisory Council, comprised of U.S. Attorneys from across the country, has had a health care fraud subcommittee, presently chaired by Lynne Battaglia, U.S. Attorney for the District of Maryland. This subcommittee is responsible for supporting the health care fraud enforcement work of all 94 U.S. Attorneys, in every district in the nation.

### **U.S. Attorney's Offices**

Each U.S. Attorney has appointed a health care fraud coordinator. These prosecutors have some experience and/or interest in health care fraud enforcement. Many U.S. Attorneys named civil as well as criminal Assistant U.S. Attorneys as health care fraud coordinators. Each U.S. Attorney or FBI SAC also sponsors a local health care fraud working group to bring together federal and state law enforcement working in health care fraud enforcement.

### **Federal Bureau of Investigation**

Federal Bureau of Investigation (FBI) field offices continue to report dramatic increases in health care fraud as evidenced by the fact that the FBI's health care fraud caseload now exceeds 2000 active investigations.

The FBI actively supported the overall Department of Justice legislative initiative to obtain additional substantive, procedural and monetary tools and resources to combat health care fraud. Most of the FBI field offices were actively involved in task forces and working groups composed of representatives from several federal, state and local investigative and prosecutive agencies having joint or complementary jurisdiction in health care fraud matters. FBI Headquarters stressed the importance of joint investigations with the Department of Health and Human Services Office of Inspector General (HHS OIG). With recent U.S. Supreme Court decisions resolving several legal issues surrounding the use of civil and criminal forfeiture statutes and with new federal legislation authorizing forfeiture and use of the money laundering statute specifically in health care fraud cases, the FBI expects a significant increase in the utilization of this enforcement tool.

The FBI is committed to pursuing an effective blend of criminal, civil and administrative enforcement. FBI Headquarters is monitoring the growing number of *qui tam* civil fraud actions being filed by citizens alleging fraud in various health care programs. These complaints are reviewed for indications of national trends and geographically broad fraud schemes. The FBI has recently

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<sup>1</sup> In addition to these components, the Antitrust Division and Tax Division have been active on health care fraud or related matters.

altered its internal statistical accomplishment measurement process to include civil enforcement in health care fraud. To educate special agents about the complex Medicare program, which includes much of the civil and program exclusion remedies, HCFA and the FBI are jointly sponsoring regional conferences to train approximately 200 FBI and HHS OIG agents.

## **COORDINATION BETWEEN JUSTICE DEPARTMENT AND OTHER LAW ENFORCEMENT AGENCIES**

Successful health care fraud enforcement cannot be achieved by the Department of Justice acting alone. We have relied heavily on the investigative and audit work of numerous federal and state law enforcement agencies committed to addressing health care fraud, each with different experience, expertise and program knowledge. This includes agencies which are dedicated to prevention, evaluation and investigation of fraud and abuse in particular health care plans: the Department of Health and Human Services Office of Inspector General (HHS OIG) (Medicare/Medicaid); the Medicaid Fraud Control Units (MFCUs) (Medicaid/patient abuse); Defense Criminal Investigative Service (DCIS) (Civilian Health and Medical Program of the Uniformed Services - CHAMPUS); the Office of Personnel Management Office of Inspector General (Federal Employees Health Benefits Plan (FEHBP)), the Railroad Retirement Board Office of Inspector General (Railroad Retirement), Veterans Administration OIG, and the Department of Labor, Office of Inspector General, Office of Labor Racketeering, Pension & Welfare Benefits Administration. Critical support also is provided by agencies with more general law enforcement mandates such as the U.S. Postal Service Inspection Service, the Drug Enforcement Agency, the Internal Revenue Service (IRS), the FDA, and the Federal Trade Commission (FTC).

All these entities share a common commitment to ending fragmented health care fraud enforcement, eliminating duplication and jointly targeting the most egregious providers. To that end, the Department has initiated several forums to facilitate coordination of our health care fraud enforcement efforts.

### **Executive Level Health Care Fraud Policy Group**

Since 1993, the Executive Level Health Care Fraud Policy Group has met monthly to coordinate issues relevant to health care fraud prevention, control, investigation and prosecution. The group's membership includes the HHS Inspector General, representatives from the Criminal Division, the Civil Division, the Attorney General's Advisory Committee (AGAC) Health Care Fraud Subcommittee, the FBI and the HCFA Senior Advisor on Program Integrity.

### **National Health Care Fraud Working Group**

The National Health Care Fraud Working Group, chaired by Karen Morrisette, Deputy Chief, Fraud Section, Criminal Division, meets quarterly. Nearly 100 prosecutors, investigators and representatives of federal -- and now state -- agencies attend. This group provides an invaluable forum for exchange of information on health care fraud schemes and investigative and prosecutorial techniques, problems and innovative solutions.

## **ENFORCEMENT ACCOMPLISHMENTS**

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The Department of Justice -- United States Attorneys' Offices and the litigating components of the Civil Division and the Criminal Division -- have aggressively confronted health care fraud. We have brought numerous criminal and civil charges resulting in criminal punishment, the recovery of millions of dollars, and the imposition of corporate integrity agreements to reduce future fraud. A sampling of the Department's enforcement accomplishments appears at the end of this report. Here we highlight a few notable cases and intensified enforcement initiatives.

### **SIGNIFICANT CASES**

#### **Fortune 500 Company Commits Fraud Against FDA**

◆ In August 1995, three former senior executives of C.R. Bard, Inc. were convicted in Boston of conspiring to defraud the Food Drug Administration (FDA) in connection with the sale and distribution of heart catheters unapproved for human use. The corporation earlier had pleaded guilty to a 391 count criminal information charging numerous federal crimes and paid \$61 million in criminal fines and a civil settlement. From 1987 through early 1990, Bard unlawfully sold and distributed heart catheters which FDA had not approved for human use. Much experimental testing in humans was -- without either patients' or doctors' knowledge -- for the purpose of "disaster checking" -- trying out as-yet unapproved catheters in humans to see if they would experience any unforeseen complications. The case was investigated by the FDA and prosecuted by the U.S. Attorney for the District of Massachusetts and FDA's Associate Chief Counsel for Medical Devices.

#### **Corporate Conviction for Paying Kickbacks To Induce Patient Referrals**

◆ Caremark Inc., a nationwide provider of health care services, entered into a global criminal, civil and administrative settlement with the Department of Justice, the Department of Health and Human Services (HHS) and the states. Caremark pleaded guilty to charges that it defrauded federal health care programs by making improper payments to induce doctors to refer patients to Caremark. Caremark agreed to pay a total of \$161 million in fines, restitution and damages and to implement a "corporate integrity plan" to ensure future compliance with health care laws and regulations. The Department also has brought criminal charges against employees and other individuals.

#### **Physician Found Guilty For Performing Unnecessary Cataract Surgery**

◆ In June 1995, a LaJolla, California ophthalmologist, was sentenced to 11 years, three months imprisonment and fined \$150,000 for fraud against government and private insurance plans. He also was ordered to make \$15.9 million in restitution. He had been convicted on 132 counts of fraud and money laundering after a five-month trial by the U.S. Attorney for the Southern District of California. Between 1988 and May 1992, this ophthalmologist received \$15.5 million from Medicare, primarily for cataract and eyelid surgeries that were not medically necessary or for which false billings were submitted.

## TARGETING PRACTICES BY INDUSTRY: CLINICAL LABORATORIES, INSURANCE COMPANIES AND HOSPITALS

### Clinical Laboratories: Concentrated Focus Yields Results

In 1993, the Department determined that many members of the independent clinical laboratory industry were billing Medicare for millions of unnecessary individual tests that were performed routinely and automatically together with an automated series of tests. The labs had misled physicians who purportedly "ordered" the tests to think that the tests would be performed for free. The prior year, National Health Laboratories, Inc. had reached a global resolution of criminal and civil charges paying over \$110 million.<sup>2</sup> The government launched a national project involving the Criminal Division, U.S. Attorneys, Civil Division attorneys, HHS OIG, HHS auditors and HCFA staff to examine many of the independent clinical laboratories. This effort was committed to (1) full criminal and civil investigations of the targeted laboratories; (2) centralized, focussed audit work with HCFA's cooperation; (3) coordination among Department of Justice, U.S. Attorneys' Offices, state Medicaid Fraud Control Units, investigative agencies, and federal benefits programs; and (4) flexibility in investigative approaches and venue issues. Law enforcement agencies such as FBI and DCIS joined the effort.

Highlights of Independent Laboratory Fraud matters resolved in FY 1995 and FY 1996 follow:

❖ Bioran Laboratories of Cambridge, Massachusetts (now owned by Corning Inc.), paid the United States \$6,675,000 to settle allegations that it routinely and automatically performed both an automated series of tests using a discrete analyzer machine, commonly known as a SMAC machine, as well as iron tests whenever a chemistry profile was ordered. Bioran was billing Medicare approximately \$27 every time an automated series was ordered, instead of the appropriate \$17.

❖ Corning Clinical Laboratories Inc., formerly known as MetPath Inc., paid the Government \$11 million to settle allegations that it charged various Government programs for both a Complete Blood Count ordered by the doctor, as well as additional indices not ordered by the doctors and not medically necessary. The affected agencies included Medicare, the Railroad Retirement Medicare program, CHAMPUS, FEHBP, and the California and Georgia Medicaid programs. The settlement resolves a qui tam suit.

❖ Allied Clinical Laboratories paid a \$4.9 million civil settlement to resolve allegations that it inserted false diagnosis codes into the Medicare billings for certain laboratory tests submitted by certain Allied billing offices, enabling it to bill for "limited coverage" blood tests even when the physician had not provided the requisite diagnosis indicating that the test was medically necessary and therefore reimbursable by Medicare. HHS OIG secured a corporate integrity agreement.

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<sup>2</sup> In December 1992, National Health Laboratories, Inc. (NHL) pled guilty in federal court in San Diego to submitting false claims to the government and paid a \$1 million fine. The President of NHL also pled guilty to two felony counts, served a prison sentence and paid a \$500,000 fine. NHL also agreed to pay \$100 million in a federal civil settlement. NHL also reached agreements with 33 state Medicaid Fraud Control Units and paid \$10.4 million to those states.

## Medicare Contractor Cases: Fraud By Insurance Companies

The Civil Division and the U.S. Attorneys are handling a group of cases involving the Medicare carriers and fiscal intermediaries, i.e., the contractors which HCFA pays to review and process the claims for reimbursement submitted by physicians, hospitals and other health care providers. Generally, these cases concern misrepresentations in the context of HCFA's Contractor Performance Evaluation Program (CPEP). Several of these cases have been settled in the past three years, including:

- ❖ Blue Cross Blue Shield of Michigan agreed to pay \$27 million to settle allegations that it backdated and altered audit reports submitted to HCFA to obtain favorable CPEP ratings. HCFA terminated its contractual relationship with the company.
- ❖ Blue Cross and Blue Shield of Florida agreed to pay \$10 million to settle allegations that it paid claims without performing required audits and edits in order to report to HCFA reductions in the contractor's claims backlog.
- ❖ Blue Cross and Blue Shield of Massachusetts agreed to pay \$2.75 million, to settle allegations that it destroyed claims and manipulated samples of claims submitted for audit by HCFA to obtain favorable CPEP ratings. It also entered into a program compliance agreement with HHS OIG.
- ❖ On May 1, 1996, Blue Shield of California, the Medicare Part B carrier for Northern California, was convicted of three felonies on guilty pleas to two counts under 18 U.S.C. § 1516 (obstruction of a government audit) and one count under 18 U.S.C. § 371 (conspiracy) arising out of allegations that the carrier falsified Medicare records, submitted rigged samples of Medicare claims to HCFA for auditing, and misrepresented performance under the carrier's contract with HCFA.

## Teaching Hospitals

On December 12, 1995, the United States Attorney for the Eastern District of Pennsylvania signed an agreement with University of Pennsylvania Health System (UPHS) to settle civil claims alleging fraudulent billing of the Medicare program. UPHS paid the government \$30 million and implemented a compliance program which requires a corporate reorganization, five years of outside audits, and mandatory education programs. The Government alleged that "attending physicians" billed Medicare Part B for services in fact rendered by Graduate Medical Education residents (whose salaries are already reimbursed through Medicare Part A) and also upcoded services to obtain higher levels of reimbursement.

The HHS OIG has instituted a nationwide audit program called PATH to address similar past mischarging by attending physicians and physician practice groups at other institutions. As a result of the first PATH audit, the United States Attorney's Office for the Eastern District of Pennsylvania secured a \$12 million settlement with the Thomas Jefferson University in Philadelphia. Thomas Jefferson University also entered into a compliance agreement with HHS OIG.

## **Inpatient-Outpatient Hospital Fraud**

HHS OIG worked with the Department to combat a widespread practice by many hospitals of double billing Medicare for outpatient services in connection with inpatient admissions. Many hospitals were billing Medicare separately for non-physician outpatient services required in connection with inpatient admissions although Medicare was already paying for those services under the Diagnosis Related Group for inpatient services. Between 1987 and 1992, HHS OIG Office of Audit, Region III, conducted an audit and brought the data to the attention of the United States Attorney for the Middle District of Pennsylvania. This launched a project by HHS OIG and U.S. Attorneys, led by the Middle District of Pennsylvania, to target hospitals nationwide which committed this fraudulent billing practices. Each hospital action results in collection of fraudulent payments, interest and damages and (2) a compliance agreement and training requirements for hospital billing personnel. As of December 1996, approximately \$33 million has been recovered.

## STATISTICAL ENFORCEMENT ACCOMPLISHMENTS

### Increased FBI Health Care Fraud Investigations

Year	Number of Cases
FY 96	2,200
FY 95	1,878
FY 94	1,500
FY 93	1,051
FY 92	657
FY 91	365

### Increased Criminal Health Care Fraud Prosecutions<sup>3</sup>

#### Criminal Matters

Year	# of Matters	# of Defendants
FY 96	1,346	2,151
FY 95	1,247	2,047
FY 94	711	1,150
FY 93	621	1,031
FY 92	343	578

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<sup>3</sup> Excluding cases involving Multiple Employer Welfare Arrangements.

### Criminal Prosecutions Filed<sup>4</sup>

Year	# of Cases	# of Defendants
FY 96	246	450
FY 95	229	381
FY 94	146	241
FY 93	105	157
FY 92	83	116

### Convictions<sup>5</sup>

Year	# of cases	# of defendants
FY 96	177	307
FY 95	158	255
FY 94	102	140
FY 93	73	96
FY 92	59	90

### Increased Civil Prosecutions<sup>6</sup>

The False Claims Act (FCA or Act), 31 U.S.C. 3729 et seq., establishes civil penalties for a variety of forms of fraud against the United States and authorizes the Attorney General to file civil actions to enforce the Act. Many health care fraud cases are brought under this Act.

The FCA prohibits any person from "knowingly" presenting "a false or fraudulent claim or payment or approval" to the federal government. 31 U.S.C. 3729(a)(1). The Act also prohibits a

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<sup>4</sup> FBI also has tracked criminal prosecutions but due to different definitions and practices in tracking health care fraud cases, the results are different.

<sup>5</sup> Includes guilty pleas and guilty verdicts.

<sup>6</sup> Handled and prosecuted in U.S. Attorneys' Offices and in the Civil Division. These numbers are estimates; variations may be due to statistical counting of cases handled jointly by the Civil Division and a U.S. Attorney's Office.

variety of related deceptive practices involving government funds and property. Any person who violates the FCA "is liable to the United States government for a civil penalty of not less than \$5,000 and not more than \$10,000, plus 3 times the amount of damages which the Government sustains," for each violation of the Act. 31 U.S.C. 3729(a).

**Civil Health Care Fraud Matters Pending**

<b>Year</b>	<b># of Matters</b>
FY 96	2,488
FY 95	1,406
FY 94	819
FY 93	500
FY 92	270

**Civil Health Care Fraud Cases Filed**

<b>Year</b>	<b># of Cases</b>
FY 96	90
FY 95	60
FY 94	75
FY 93	29
FY 92	28

In fiscal year 1996 the Civil Division received more than three times as many health care fraud cases as in fiscal year 1993.

**Judgments/Settlements**

<b>Year</b>	<b># of Civil Judgments</b>
FY 96	30
FY 95	81
FY 94	60
FY 93	46
FY 92	25

## Monetary Recoveries<sup>7</sup>

The Civil Division has documented significant financial recoveries in health care fraud cases in FY 1995 and FY 1996:

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Health Care Non-Qui Tam	=	\$138,553,002
Health Care Qui Tam	=	\$135,516,897
<b>Total Health Care Fraud</b>	<b>=</b>	<b>\$274,069,899</b>

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In fiscal years 1995 and 1996, health care fraud recoveries constituted approximately 33 percent of the \$831,860,818 in total fraud recoveries secured by the Civil Division, working in conjunction with the United States Attorneys Offices across the country. This number does not include recoveries in cases handled exclusively by U.S. Attorneys or monetary recoveries in criminal cases.

According to the FBI, monetary recoveries, including restitution, fines and civil settlements in FBI cases totaled \$139.5 million in FY 1993, 767.7 million in FY 1994, \$177.3 million in FY 1995, and \$223.5 million in FY 1996. This is only part of the monetary recoveries; it does not include forfeitures or monetary recoveries in criminal or civil cases investigated by agencies other than FBI.

### Dramatic Increase in Health Care Fraud Qui Tam Suits

Under certain circumstances, the False Claims Act authorizes private parties (known as relators) to file civil actions to enforce the Act. These suits are known as qui tam actions, 31 U.S.C. 3730(b)(1), while some informally refer to them as whistleblower cases.

Increasingly, qui tam cases are a major factor in health care fraud enforcement work. Indeed, the number of qui tam suits filed involving allegations of health care fraud increased dramatically so that in fiscal year 1996 they constitute over one half of the total qui tam caseload:

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#### FISCAL YEAR 1992

Total cases filed	119
Cases filed involving health care fraud allegations	14

#### FISCAL YEAR 1996

Total Cases Filed	361
Cases filed involving health care fraud allegations	200

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<sup>7</sup> Health care fraud recoveries are down from FY 1994, because the majority of recoveries that year resulted from one case, National Medical Enterprises.

Since the 1986 amendments, the United States has recovered about \$1.3 billion in qui tam cases. Approximately one-quarter of this was recovered in health care fraud qui tam cases.

The influence of qui tam cases in health care area cannot be overstated. Qui tam cases are filed against every type of health care fraud provider: hospitals, physicians, durable medical equipment suppliers, clinics, ambulance companies, clinical laboratories, universities, billing services, therapists, home health care providers, nursing homes, fiscal intermediaries. Qui tam cases are filed by every actor in health care industry: employees, doctors, nurses, competitors, researchers, and subcontractors. Qui tam relators can bring meritorious as well as frivolous cases. The government may decline to intervene or may intervene and also develop significant criminal charges.

**Recent health care fraud qui tam cases have included wide-ranging allegations:**

❖ **VA Drug Procurement Fraud.** The Chicago U.S. Attorney's Office and the Civil Division secured a \$7.5 million settlement with Modern Wholesale Drug Midwest, Inc. (Rugby), a generic drug distribution company, to settle allegations that Rugby overcharged the VA for generic drugs by failing to inform the Government about discounts given to other customers.

❖ **PPO Fraud.** A corporate official was convicted and sentenced to 24 years imprisonment and he and his corporation, Integrated Network Systems, Inc., Washington state's largest preferred provider organization (PPO), agreed to pay approximately \$2.5 million to settle a qui tam action. after admitting to skimming \$1.4 million from health insurance companies. They negotiated discounts with medical center hospitals and agreed to pass on the discounted prices to various rural medical service bureaus which agreed to pay the discounted prices to defendants, who, in turn, were to pay those sums to the hospitals. Defendants cheated by quoting and collecting boosted prices from medical service bureaus and paying the lesser discounted sums to the hospitals. One of the victim medical service bureaus administered FEHBP claims under contract with the U.S. Office of Personnel Management.

❖ **Medical Equipment Fraud.** The U.S. Attorney's Office in the Western District of Wisconsin, and the Civil Division obtained a \$2.1 million settlement against Curative Technologies, d/b/a Ultramed to settle allegations that it billed Medicare for expensive lymphedema pumps that it had not provided.

❖ A former vice president of ATS, a Mediq, Inc. subsidiary, filed a qui tam action in the Middle District of Pennsylvania against Mediq, alleging that the subsidiary billed for portable EKGs and X-rays performed in one carrier's jurisdiction to the carrier in another jurisdiction where the reimbursement rate was higher. Ultimately, Mediq and ATS entered into a global settlement in which ATS and its president pleaded guilty to misprision of felony, and ATS agreed to pay a total of \$2.1 million.

❖ **Fraud by Physicians:** The U.S. Attorney for the Eastern District of New York settled a qui tam against a Brooklyn doctor, alleging that she collected \$550,000 from the Social Security Administration for performing complete physical examinations on 10,000 people seeking Social Security disability benefits from 1990-94, when only cursory reviews had been performed, if at all. She then submitted false medical reports to make it appear as though an examination had taken place. The qui tam action was filed by five persons who were denied benefits based on the doctor's reports. Since filing the action, the relators have obtained benefits and, in addition, have received \$113,700 as their share in the proceeds of the action.

## **INVESTIGATIVE AND PROSECUTORIAL RESOURCES**

### **EXISTING RESOURCES ALLOCATED TO HEALTH CARE FRAUD**

The number of Department of Justice prosecutors working criminal and civil health care fraud matters continues to grow, although few prosecutors are dedicated exclusively to health care fraud cases. In U.S. Attorneys' Offices, in Fiscal Year 1996, the equivalent of 81 prosecutorial work years were devoted to health care fraud, up from 35 in Fiscal Year 1993, and 54 in Fiscal Year 1994. Civil resources similarly increased to 39 work years up from 22 work years in Fiscal Year 1993 and 27 in Fiscal Year 1994. These resources are supported by personnel in the Department's litigating components, the Criminal and Civil Divisions. Indeed, in Fiscal Year 1996, more than sixty percent of the Civil Division's Commercial Litigation Branch, the attorneys who do civil fraud cases, worked on health care fraud cases.

The FBI has allocated significantly more resources to health care fraud since Fiscal Year 1992.

#### **Federal Bureau of Investigations Resources Devoted to Investigating Health Care Fraud**

<b>Year</b>	<b>Agent Work Years</b>
1996	256.0
1995	260.5
1994	225.0
1993	146.9
1992	111.8
1991	62.5

### **PILOT HEALTH CARE FRAUD PROJECTS**

No matter how many investigatory and prosecutorial resources the Department targets to health care fraud, the complexity and number of health care fraud schemes demand that we use our resources efficiently and innovatively. To that end, the Department has explored various pilot health care fraud projects to enhance the effective use of its resources.

The Department allocated an additional \$1.6 million from its Assets Forfeiture Fund for pilot programs in U.S. Attorneys' offices to sustain the Department's efforts against health care fraud. Approximately 25 pilot projects were funded in districts across the country: from San Diego to Boston; from Washington State to Washington D.C.; from Colorado to Tennessee. Each was designed by the United States Attorney's Office to foster creative approaches to health care fraud.

Priorities were given to fraud in projects which focussed on government health care programs, fraud affecting patient harm and/or fraud involving nursing homes or home health care. In addition, pilot projects were sought which provided outreach to the public and which explored novel uses and approaches to electronic fraud detection. Some examples of pilot health care fraud projects follow:

- ▶ **Health Care Fraud Task Forces.** Projects have facilitated bringing together federal and state investigators and prosecutors to focus on health care fraud.
- ▶ **Electronic Code Fraud Project.** Project brings together experienced health care fraud prosecutors and computer crime and other technology experts to develop resources to assist in electronic health care fraud investigation, detection and civil or criminal prosecution using adapted medical utilization screening software. Development of guidance on identifying suitable cases and fraudulent schemes for electronic fraud assistance, available software and applicable procedures.
- ▶ **Public Education and Outreach.** Numerous U.S. Attorneys have sponsored conferences and educational seminars on health care fraud in numerous locations including Maryland, Tennessee, and state of Washington. These conferences have brought together federal, state and local law enforcement, health plan administrators, health care providers and consumers to discuss emerging health care fraud schemes as well as health care fraud prevention, detection, investigation and prosecution.

## **BUREAU OF JUSTICE ASSISTANCE**

The Department also launched a health care fraud pilot project for state Attorneys General. In Fiscal Year 1995, the Office of Justice Program's Bureau of Justice Assistance (BJA) initiated a project to reinforce the capability of State Attorneys General and local prosecutors to investigate and prosecute health care fraud, including consumer fraud and fraud against insurance companies and health maintenance organizations. The project was designed to foster health care fraud work other than that already performed by state Medicaid Fraud Control Units. BJA provided the National Association of Attorneys General Offices with \$250,000 to provide technical assistance to health care fraud units in state Attorneys General. In addition, three Attorneys General -- Maryland, Wisconsin and Minnesota -- received demonstration funding of \$200,000 each in Fiscal Year 1995 for eighteen months.

## **INNOVATIONS TO IMPROVE USE OF AVAILABLE RESOURCES**

We have been engaged in various efforts to coordinate our civil and criminal enforcement with the various administrative remedies available to the Department of Health and Human Services. For example, in late 1994, the Department approved a Memorandum of Understanding (MOU) to permit HCFA to initiate civil monetary penalty administrative proceedings against nursing homes for violations of health and safety regulations. The MOU, negotiated with the Civil and Criminal Divisions and approved by AGAC, permits the agency to initiate administrative proceedings against nursing homes found in violation of the regulations after consultation and coordination with the appropriate U.S. Attorney. The MOU accommodates HCFA's interest in obtaining speedy compliance and the interest of law enforcement in ensuring that a case that may be appropriate for criminal or civil prosecution is not compromised by precipitous administrative action.

## **COLLABORATION WITH PUBLIC & PRIVATE HEALTH INSURANCE PLANS**

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Recognizing that law enforcement alone cannot eliminate the health care fraud problem, the Department of Justice (both federal prosecutors and investigators) works closely with public and private health insurance plans to enhance fraud prevention, detection, and control.

At the national level, the FBI maintains liaison with various private insurance companies and organizations who have committed resources to fight health care fraud. Specifically, the FBI has worked with the National Health Care Anti Fraud Association (NHCAA) and the National Insurance Crime Bureau (NICB). Each field office develops and maintains contacts in the private insurance industry in that particular region. Furthermore, the FBI sponsors an annual conference for various insurance executives together with FBI management to discuss health care fraud issues.

Numerous U.S. Attorneys' offices, including Connecticut, Los Angeles, Atlanta and Milwaukee, have sponsored regional meetings or conferences aimed at encouraging more referrals from private insurers.

We also worked with insurers to improve electronic fraud data analysis.

- ▶ HCFA's Bureau of Data Management and Strategy has designed a relational database (TORTIS) that identifies fraud indicators in claims of two industries: 1) home health care; and 2) skilled nursing facilities. This database will be an invaluable tool for targeting future investigative activity, and for evidentiary purposes in ongoing health care fraud investigations.
- ▶ The Department has supported the development of several private and public databases of fraud allegations, including HCFA's Fraud Investigation Database (FID), a comprehensive nationwide system devoted to Medicare fraud and abuse data accumulation, NHCAA's Provider Indexing Network System (PINS), and NICB's on-line database.

## **FUTURE OF HEALTH CARE FRAUD ENFORCEMENT**

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### **Health Care Fraud Legislation**

In August of 1996, the President signed the "Health Insurance Portability and Accountability Act of 1996" (HIPAA) which contains many provisions to strengthen health care fraud and abuse control. Building on the existing enforcement efforts of the Department of Justice and the Department of Health and Human Services (HHS), HIPAA requires the Attorney General and the HHS Secretary to establish a "Fraud and Abuse Control Program" to promote the coordination of federal, state and local law enforcement; investigations, evaluations, inspections and audits; specific guidance to providers; and data sharing. HIPAA's provisions recognizes the leadership in health care fraud enforcement already forged through the relationship between the Department of Justice -- its criminal and civil prosecutors and the FBI -- and the HHS OIG auditors, evaluators, and investigators.

HIPAA provides additional criminal, civil and administrative tools to combat health care fraud. New or revised provisions include:

- ▶ Creates new criminal offense for health care fraud, theft or embezzlement in connection with health care offense, false statements relating to health care offense, and obstruction of criminal investigations of health care offenses;
- ▶ Adds a Federal health care offense to the money laundering statute;
- ▶ Extends injunctive relief relating to health care offenses (includes freezing of assets);
- ▶ Authorizes investigative demand procedures;
- ▶ Establishes forfeitures for Federal health care offenses;
- ▶ Expands anti-kickback statute to cover all Federal health care programs, not just Medicare and State health care programs; and
- ▶ Strengthens exclusions for health care convictions.

HIPAA secures resources to investigate and prosecute health care fraud matters. In particular, HIPAA provides up to \$104 million in fiscal year 1997 for health care enforcement activities as determined by the Departments of Justice and Health and Human Services. This amount increases by fifteen percent each year through 2003 and would be capped at the amount for 2003 thereafter. In addition, \$47 million is appropriated in fiscal year 1997 for enforcement activities of the Federal Bureau of Investigation, increasing gradually to \$114 million in 2003 and each fiscal year thereafter.

Other provisions require the Department of Health and Human Services to issue written advisory opinions with respect to whether certain arrangements violate the criminal anti-kickback statute and to establish a health care fraud and abuse data collection program.

## **Managed Care And Fraud Working Group**

To further ensure that the government's health care fraud enforcement program is prepared to address health care fraud in the future, the Department of Justice is confronting the growth of managed care and the attendant fraud and abuse. The number of Americans who receive their health care through various forms of managed care increases daily. We recognize that perpetrators often will reshape their schemes to fit any form of reimbursement -- fee-for-service, managed care, or managed competition. The Department of Justice established a Managed Care and Fraud Working Group. This Group has examined the operation of managed care plans (public and private), program vulnerabilities, fraudulent schemes unique to managed care, and issues of prevention and prosecution.

The Working Group's members represent a cross-section of the Department of Justice community -- criminal, civil, tax and antitrust lawyers, and the FBI -- and federal investigative agencies (such as HHS OIG, DCIS, and IRS), and administrators from federal agencies overseeing public health plans such as HCFA's Office of Managed Care, CHAMPUS, and FEHBP and Labor Department. Representatives of state Medicaid Fraud Control Units (MFCUs) have been active participants from the inception. The Working Group has met with representatives of managed care plans, regulators, providers, and consumers.

In May of 1995, the Criminal Division and the Managed Care and Fraud Working Group co-sponsored a one-day managed care and fraud conference for federal health care administrators, investigators and prosecutors.

## **SELECTED CASES**

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### **Ambulance Services**

❖ The Southern District of Alabama successfully prosecuted the principals of a Mobile, Alabama, ambulance company for defrauding Medicare out of approximately \$650,000 over a three year period beginning in 1992. The CEO of Southwest Alabama Ambulance Company and a bookkeeper were convicted in September 1995 of filing false claims and mail fraud following a two-week trial. Although many of the beneficiaries transported by Southwest Alabama Ambulance walked to an ambulance and rode in the front seat, the defendants filed claims falsely stating that the beneficiaries were bedridden or could only be transported by stretcher. The defendants also submitted claims for ambulance transportation when beneficiaries were transported by private vehicles. On February 15, 1996, the court sentenced the CEO to 30 months imprisonment and the bookkeeper was sentenced to 12 months imprisonment.

❖ The United States Attorney's Office for the Western District of Virginia brought criminal and civil charges against a family-owned ambulance service and the individual owners which submitted fraudulent claims to Medicare and Medicaid. The defendants transported patients from nursing homes to doctors' offices or dentists' offices, but would bill as if the patients were transported to the hospital. The defendants also inflated the mileage for the trips. The court sentenced two owners to 12 months imprisonment each, imposed fines exceeding \$20,000, imposed civil penalties of \$100,000 and forfeited ambulances valued at \$106,000.

### **Billing Firms**

❖ On December 21, 1995, in the Eastern District of Virginia, two individuals were convicted of conspiring to commit wire fraud and money laundering, one of which was convicted of bank fraud and perjury. The defendants operated Medical Payment Services, Inc. of Virginia (Medpay), a Richmond company which financed the accounts receivable of doctors and health care providers in Virginia and North Carolina. During the operation of Medpay, defendants defrauded Healthline, an affiliate of Blue Cross/Blue Shield (BCBS) of Maryland, of approximately \$3.2 million by secretly diverting the loans from Healthline to themselves and their private businesses. On July 3, 1996, both defendants were sentenced to more than seven years' imprisonment and ordered to pay fines and restitution totalling more than \$3 million.

### **Clinics**

❖ A psychiatrist and his brother-in-law, an optometrist, were both convicted in the Central District of California of billing fraud relating to the operation of a clinic that provided basic medical testing. The optometrist referred his patients to the medical clinic for testing, which included routine blood tests, tympanograms, allergy tests, electrocardiograms and carotid artery ultrasound studies. These referrals were made without regard to whether the patient had his or her own primary care doctor or had any medical complaints at all. An employee of either the

optometry practice or the clinic would draw blood from the patients and also perform a variety of medical tests as instructed by the optometrist. In many cases, the employees were not trained to administer these tests, nor were they trained to interpret the results of such tests. Moreover, in most instances, the patients were never informed of the results of the tests performed at the clinic. The psychiatrist allowed the optometrist to use his Medicare provider number to bill Medicare and private insurers. The claim forms falsely certified that medical examinations and tests were actually performed and were medically necessary, even though no medical examinations were ever performed and no medical doctor ever determined that any of the tests were necessary. A total of approximately \$1 million was fraudulently billed to Medicare alone. The optometrist was sentenced on July 15, 1996 to 5 months imprisonment followed by 5 months probation and \$150,000 in restitution. The psychiatrist received a sentence of 15 months imprisonment and was ordered to pay \$86,000 in restitution.

❖ On January 6, 1995, twelve defendants including the owner and operator of Florida Medical and Diagnostic Center, Inc. and related companies were convicted in the Southern District of Florida in a wide-ranging scheme to defraud the Medicare and Medicaid programs of over \$3 million. Florida Medical paid kickbacks to numerous persons who recruited elderly and poor persons to come to the clinic. The recruiters were paid between \$30 and \$150 for each patient they brought to the clinic who agreed to take a battery of diagnostic tests and whose tests could be billed to Medicare and Medicaid. The recruiters received an additional sum of up to \$150 if they could convince the patient to accept a piece of durable medical equipment, such as nebulizers and oxygen concentrators, for which the clinic could obtain reimbursement. On March 24, 1995, the clinic's owner and operator was sentenced to 41 months incarceration and ordered to pay \$1,038,617 restitution.

❖ On October 12, 1995, a businessman pleaded guilty in the Southern District of Florida to engineering a fraud on Medicare in excess of \$120 million. From June, 1992, through July, 1995, he orchestrated a scheme that consisted of creating forty-four companies, which operated as medical clinics, billing and transportation companies, and billing Medicare for medical services and testing that never occurred or were not medically necessary. He obtained Medicare patients by paying recruiters to bring them to his clinics and by purchasing Medicare patient numbers from an individual who worked for a legitimate healthcare provider. The defendant recruited doctors to approve his fraudulent claims by paying them kickbacks and also used doctors' identification numbers without their authority. The defendant doctors to approve his fraudulent claims by paying them kickbacks and also used doctors' identification numbers without their authority. He received a sentence of 108 months imprisonment followed by 3 years of supervised release and was also ordered to pay \$32 million in restitution.

❖ The United States Attorney's Office for the Middle District of Florida brought charges against the owners and operators and physician employees of six acupuncture clinics relating to fraudulent billing of Medicare totaling over \$1.8 million from December 1989 through October 1993. The acupuncture clinics were located in central Florida and hired physicians to illegally circumvent the Medicare rules prohibiting reimbursement for acupuncture and acupuncture

related medical services. The defendants fraudulently back-dated medical and billing records to conceal that they were operating acupuncture clinics and that the medical services rendered were all in conjunction with acupuncture treatments. One owner/operator was convicted after trial and sentenced to 31 months imprisonment and ordered to pay close to \$1 million in restitution. One of the physician employees defendants plead guilty and was sentenced to probation and pay more than \$100,000 in restitution. Another defendant-owner is a fugitive.

❖ After a five and one-half month trial, a physician was convicted in the Southern District of Illinois of mail fraud stemming from a scheme to defraud insurance companies and patients. He built a ten-million dollar medical diagnostic clinic in Alton, Illinois, by providing medical testing to residents of cities in the surrounding areas. Unable to recruit physicians and sufficient physician referrals, the defendant resorted to extensive unnecessary medical testing, entering false symptoms in the patients' records and billing Medicare and/or private insurance companies falsely certifying that all billings were reasonable and necessary. Dr. He was sentenced to two years in prison as well as fines and restitution.

#### **Defective Pricing and Buy America Act Violations: Drugs and Supplies**

❖ Working with the Office of the Inspector General of the VA, the Department has recovered millions of dollars in connection with defective pricing and Buy America Act violations by companies supplying drug and medical supplies to the Government.

❖ The Civil Division recovered \$10 million from United States Surgical Corporation (US Surgical) to settle allegations that US Surgical failed to disclose required pricing data in negotiations for a VA contract for surgical instruments and supplies.

❖ The U.S. Attorney's Office in Chicago and the Civil Division secured a \$7.5 million settlement with Modern Wholesale Drug Midwest, Inc. (Rugby), a generic drug distribution company, to settle allegations in a qui tam case that Rugby overcharged the VA for generic drugs. The Government alleged that Rugby failed to inform the Government about discounts given to other customers.

❖ The Government recovered \$5 million from Medline Industries, Inc. to settle allegations that the company wrongly certified that foreign sourced items were, in fact, manufactured in compliance with the Buy America Act.

#### **Durable Medical Equipment Suppliers**

❖ On February 2, 1995, a Little Rock businessman entered a Rule 20 guilty plea in the Western District of Pennsylvania to charges of mail fraud filed in the Eastern District of Arkansas and resulting from a scheme to defraud Medicare through durable medical equipment sales. Agents from the FBI and the HHS OIG determined that his companies, Staco Marketing, Inc., Staco Marketing and Supply, Inc., and Southwest Medical, Inc., systematically billed Medicare for

useless and medically unnecessary items sold to nursing home residents in Arkansas and Michigan as oral hygiene "kits". These noncompensable "kits" were billed to Medicare through the inclusion in the kits of saline solution and lubricating jelly, both of which are compensable, but not necessary for oral care. This matter was consolidated with similar charges in the Western District of Pennsylvania where the defendant made restitution of \$1.9 million on charges filed in that District. The Pennsylvania court sentenced him to home detention, five years probation and fined him \$5,000. He and his partner agreed to pay \$656,000 in settlement of civil charges.

❖ Three defendants pleaded guilty in the Southern District of Florida to fraudulent billings submitted to Medicare through a company called "Get Well Medical Care." Get Well submitted false claims for the rental of oxygen concentrators and medication, which allegedly had been prescribed for Medicare patients by a physician. Two of the defendants also purchased copies of Medicare cards from a confidential informant who was acting as a Medicare patient recruiter. The Medicare cards were actually bogus cards for non-existent patients. C.F. Medical continued billing on the bogus Medicare cards originally obtained by Get Well and on Medicare patient lists obtained from Elso and other recruiters. None of the patients for whom equipment rental and medications were billed were ever examined by a licensed physician. One defendant, was sentenced to three months imprisonment and was ordered to pay \$98,747.40 in restitution. The second defendant was sentenced to probation for a term of four years and was ordered to pay \$39,999.99 in restitution. The third defendant also received a sentence of three months imprisonment and was ordered to pay \$42,327.60 in restitution.

❖ In United States v. Express Medical DME, Inc., litigated in the Southern District of Florida, a twenty-one year old individual received over \$2 million in Medicare and Medicaid payments over several months for either medically unnecessary or non-provided medical equipment, primarily oxygen and nebulizers, for Adult Congregate Living Facility (ACLF) residents. The owners of ACLF received kickbacks for providing the beneficiaries' names and HIC numbers, and physicians received kickbacks for signing the certificates of medical necessity without examining the beneficiaries. Nearly all of the funds have been recovered by restraint/consent judgment and consent asset forfeiture.

❖ On May 3, 1995, an individual pleaded guilty in the District of Massachusetts to conspiring to defraud the United States through the submission of as much as \$20 million in false Medicare claims. The defendant, an employee at a Knoxville, Tennessee durable medical equipment supplier, Providers, Inc., engaged in numerous fraudulent practices. The most notable of the practices was a point-of-sale scheme that involved setting up dummy offices in several states, including Massachusetts, for the purpose of billing Medicare at higher rates for durable medical equipment than those applicable in Tennessee, where the company had, in fact, sold or provided the equipment.

❖ On February 14, 1995, the District Court in the Eastern District of Michigan entered a default judgment against Life Line Home Health Care Co. (Life Line), and its four principal owners in the amount of \$714,978.86, plus interest. The default judgment stemmed from the defendants' failure

to pay the government according to the terms of a global settlement reached by the U.S. Attorney's Office for the Eastern District of Michigan, the Department of Justice, and Life Line. The settlement resolved both civil and criminal liability for Life Line's submission of false Medicare claims. The corporation sold durable medical equipment to Medicare beneficiaries who were solicited by telephone, but the corporation did not collect the 20-percent co-pay from the beneficiaries. The corporation agreed to plead to two counts of mail fraud and the corporation and individual defendants had agreed to pay the United States \$626,000 over a two year and three month period in full satisfaction of their liability to the program.

❖ In August 1995, principals of a durable medical equipment company pleaded guilty in the Eastern District of Oklahoma to multiple counts of conspiracy and submitting false claims to Medicaid. The defendants billed Medicaid for oxygen equipment not provided, or in some instances double and triple billed for the equipment that was provided. One cooperating defendant received probation and the other was sentenced to five months' imprisonment. Additionally, one defendant entered into a civil settlement in which he agreed to pay \$40,000 to the United States over and above any restitution, and to sell the company. The company agreed to pay a \$10,000 civil penalty. As a result of this prosecution, the Oklahoma Medicaid Program has revised its billing procedures to eliminate the payment of multiple billings.

❖ In May 1995, a one-week trial in the Eastern District of Pennsylvania culminated in the conviction of the CEO of a durable medical equipment telemarketing company responsible for \$2.3 million in fraudulent Medicare over-billings. The Chief Executive Officer of United States Health Products and its five subsidiary companies was convicted, of mail fraud, false claims, money laundering and structuring charges. His office manager pleaded guilty to six counts of mail fraud and false claims in April 1995. Cocivera was sentenced to 78 months imprisonment. She was placed on five years probation, with the first eight months to be served in home detention.

❖ On September 8, 1995, Support Products, Inc., a Houston company, was ordered to pay restitution of \$450,000 upon its plea of guilty in the Southern District of Texas to one count of defrauding Medicare. The corporation falsely sought reimbursement from Medicare for a "custom fitted orthotic" (commonly known as a body jacket), when in fact the product sold was nothing more than a wheelchair pad.

❖ Defendant Joerns Healthcare, Inc. agreed to pay \$350,000 to settle civil fraud claims that it defrauded the General Services Administration (GSA) in the sale of miscellaneous homecare and hospital patient room furniture. In the course of responding to the solicitation of the contract, Joerns failed to provide current, accurate and complete discount and pricing information to GSA contract negotiators. The investigation also revealed that Joerns had sold non-contract items as GSA contract items to other government agencies and that Joerns overbilled the government agencies by failing to provide negotiated single-unit or volume discounts for contract items.

❖ A former medical doctor was convicted in the Southern District of Florida for filing claims against Medicare falsely claiming to have examined patients and for signing false prescriptions for

urable medical equipment, home health care and vascular tests totalling in excess of \$1.5-million. He admitted his involvement in a conspiracy involving the submission of approximately 416 fraudulent Medicare claims seeking a total of approximately \$255,000. On April 27, 1995, he was sentenced to 26 months in prison and ordered to pay restitution in the amount of \$441,262.

❖ A former vice president of a Mediq, Inc. subsidiary filed a qui tam action in the Middle District of Pennsylvania against Mediq, alleging illegal cross-billing of portable EKGs and portable X-rays. The subsidiary, ATS, Inc., billed services performed in one carrier's jurisdiction to the carrier in another jurisdiction where the reimbursement rate was higher. Ultimately, Mediq and ATS entered into a global settlement with the United States in which ATS and its president pleaded guilty to misprision of felony, and ATS agreed to pay a total of \$2.1 million.

### **Group Homes**

❖ Two corporate officials pleaded guilty in the Northern District of Ohio to embezzling approximately \$90,000 from the Ashtabula County Residential Services Corporation (ACRSC). The executive director and the executive assistant of ACRSC, a Medicaid-funded agency, operates three group homes for people with mental disabilities were ordered to pay full restitution and were sentenced to periods of home confinement.

### **Home Health Services**

❖ The Central District of California successfully prosecuted an administrator of a home health agency and his assistant on charges of mail fraud and conspiracy in 1995. The defendants submitted \$2.5 million in fraudulent billings to Medicare for services not rendered to patients. The case is scheduled for sentencing on February 24, 1997.

❖ In the first known prosecution of a major home health care provider in the history of the state of Georgia, in 1995, the US Attorneys Office Southern District of Georgia successfully prosecuted the owner and two other chief executives of Healthmaster, Inc., the largest home health care agency in Georgia, for defrauding the Medicare Program of millions of dollars. The defendants fraudulently billed Medicare for political contributions, "ghost employees" salaries, and lavish pleasure trips. The Healthmaster owner pleaded guilty to ten felony counts, charging conspiracy to defraud the United States and false statements, and was sentenced to serve 33 months in prison and fined \$2.5 million. She also was required to repay \$15 million to Medicare and \$1.5 million to Medicaid. Two other Healthmaster executives went to trial and were convicted on 114 counts and 72 counts respectively. One was sentenced to serve 151 months in prison, the other received a 97 month sentence.

❖ On February 4, 1996, a jury in Savannah, Georgia, convicted ABC Home Health Services, Inc. (ABC), the nation's largest privately-owned home health care provider, and its owners/operators of defrauding Medicare. From approximately 1990 until 1994, the defendants defrauded more than \$1 million by making false statements and claims for reimbursement from the Medicare

program. The case was prosecuted by the U.S. Attorney's office in Savannah (S.D. GA) and the Fraud Section, Criminal Division; the case was investigated by HHS OIG and the IRS, Criminal Investigation Division.

❖ Virtually every member of a company known as "Home Health of Louisiana" (HHL) was convicted in the Western District of Louisiana of a variety of fraudulent acts in connection with Medicare payments for home bound patients. The fraudulent acts included forged physicians' signatures authorizing home health services, claims for home health services that were never rendered, claims for services rendered to unqualified patients and the concealment of financial transactions between HHL and other companies created and owned by the primary defendant. The investigation and prosecution resulted in the seizure of equipment used by HHL, the conviction of six persons, and the end of HHL as an ongoing operation. The primary defendant was sentenced to 37 months incarceration and ordered to pay \$221,221.70 in restitution. The remaining five defendants were sentenced to between 3 and 18 months incarceration, supervised release and restitution ranging between \$62,272.53 and \$2,481.07.

### Home Infusion Therapy

❖ Throughout 1995, the United States Attorney's Office for the District of Connecticut accepted referrals from the Diversion Investigative Unit of the Drug Enforcement Administration (DEA) to bring civil penalty actions under the record keeping provisions of the Controlled Substances Act. These referrals resulted in the recovery of more than \$2.1 million in 1995. One of the largest of these recoveries was in United States v. Chartwell-Southern New England, a joint DEA and State of Connecticut, Department of Consumer Protection-Drug Control Division, investigation which revealed significant record keeping irregularities by Chartwell relating to its home infusion business. Chartwell, owned in part by Yale-New Haven Hospital, Stamford Hospital, Bridgeport Hospital, Charlotte-Hungerford Hospital, and Veterans Memorial Medical Center, agreed to pay the United States \$600,000. In addition, Chartwell agreed to furnish \$300,000 worth of medical supplies to Connecticut Hospice, Inc., in Branford; Bread and Roses Hospice in Georgetown; Hospice Care, Inc., in Stamford; and Saint Francis Hospital and Medical Center Home Health Agency in Hartford.

❖ Twelve individuals were convicted on a 35-count indictment charging conspiracy, mail fraud, false statements, money laundering, and structuring in connection with a nearly \$13 million Medicare fraud prosecuted by the Southern District of Florida. From April 1992 to October 1994, the defendants created 18 different companies for purposes of billing Medicare for Parenteral Nutritional therapy -- a milk supplement provided to people unable to digest most foods. Each company had a bank account and private mail-box, but none of the companies existed anywhere except on paper. The defendants qualified to participate in the Medicare PEN therapy program by submitting fraudulent applications to Medicare, listing the private mail-boxes as their "office locations". The defendants then billed Medicare using unlawfully-obtained Medicare patient numbers and physician identification numbers. On March 27, 1996, the court sentenced one defendant to 25 months imprisonment, and ordered him to pay restitution of \$392,954. Other defendants were placed on probation and ordered to pay restitution.

## Hospitals

❖ The Brooklyn Hospital Center and one of its physicians agreed to pay the United States \$875,000 to settle allegations that they had received federal funds in connection with consultative medical examinations of applicants for Social Security disability benefits, which were never performed or performed in part. Since 1989, defendants were paid for approximately 10,000 examinations purportedly conducted by the physician. The settlement also provides that she will be barred from the Social Security Administration's medical consultant program for a period of five years.

❖ The United States Attorneys' Offices for the Southern and Northern Districts of Ohio and HHS OIG launched an initiative targeting hospitals in Ohio that fraudulently bill Medicare for blood chemistry tests run on automated equipment as a series of tests rather than using the appropriate automated test codes. As part of the initiative, hospitals disclose outpatient laboratory unbundling practices, make monetary settlements and agree to corporate integrity agreements. For example, Timken Mercy Medical Center paid \$1,170,000 to settle claims of improper billings and agreed to hire an independent auditor to review its outpatient billing practices for any other billing improprieties.

## Insurance Companies

❖ Two San Francisco Bay Area businessmen were charged with thirty-one counts of mail fraud in connection with their failed insurance business, called Stoddard Insurance Administration. As alleged in the indictment, the defendants marketed health insurance plans to people who had "pre-existing" conditions and were unable to get insurance from other companies. Only later, after paying premiums for years in some cases, did the victims discover that in fact no insurance company was backing the policies -- they had no coverage. The alleged losses exceed \$1.5 million. In a similar case, an individual was charged with making various false claims in order to induce consumers to purchase his health plan, including claims that it was fully insured by Lloyd's of London and other insurance companies when there was no such insurance available. He also claimed that his plan met the requirements of ERISA and was therefore exempt from State insurance regulation and oversight. Consumers were left with over \$3.7 million in unpaid medical claims when the health plan went out of business.

❖ An individual was convicted and sentenced to 24 years imprisonment and he and his corporation, Integrated Network Systems, Inc., Washington state's largest preferred provider organization (PPO), agreed to pay approximately \$2.5 million to settle a qui tam action. He and INS admitted to skimming \$1.4 million from health insurance companies. They negotiated discounts with medical center hospitals and agreed to pass on the discounted prices to various rural medical service bureaus which agreed to pay the discounted prices to defendants, who, in turn, were to pay those sums to the hospitals. Defendants cheated by quoting and collecting boosted prices from medical service bureaus and paying the lesser discounted sums to the hospitals. One of the victim medical service bureaus administered FEHBP claims under contract with the U.S. Office of Personnel Management. This case was obtained by the Western District of Washington's MEDFRAUD task force.

## Laboratory Services

❖ In United States v. Prime Laboratory, Inc., U.S. Attorney for the Southern District of Florida secured a temporary restraining order and preliminary injunction against one of the largest clinical reference laboratories in Florida which was billing for nonreimbursable services. One beneficiary had a full blood analysis and urinalysis ordered by 18 different doctors from 18 different clinics in a 21-month period. Approximately \$2 million was frozen by the injunctive relief and the clinic is now out of business.

❖ The U.S. Attorney for the districts of New Jersey and Maryland, in conjunction with the Civil Division, recovered almost \$9 million from MetPath Inc., a major national blood-testing laboratory, for billing Medicare and other third-party payers for tests that were not performed due to inadequate or tainted specimen. The government alleged that MetPath was billing for thousands of tests that could not be performed because the specimen had been damaged or because there was not enough of a particular specimen to run certain tests.

❖ The owner of Nova Medical Laboratories, Inc. of Cleveland, pleaded guilty in the Northern District of Ohio to making false Medicare claims by falsely representing that Nova had performed certain blood tests. In a separate case, an Indianapolis physician pleaded guilty to taking kickbacks from Nova to conduct unnecessary blood tests on his patients. These tests purported to determine whether a patient was likely to contract any one of 50 different diseases and are widely touted in the alternative medicine community.

## Lymphedema Pumps

During 1995 and 1996, the Civil Division and U.S. Attorneys' offices in New Jersey, Maryland and the Eastern District of Pennsylvania resolved a number of cases involving the upcoding of Medicare claims for lymphedema pumps. Lymphedema pumps are used to treat a rare condition where lymph fluid buildup causes swelling in the extremities. Medicare requires that these pumps meet certain engineering requirements to qualify for a \$5,000 reimbursement rate under Code E0652.

❖ In 1995, Huntleigh Technology, a lymphedema pump manufacturer, agreed to pay \$4.9 million to settle allegations that it misrepresented to its customers that its Flowplus pump qualified for Medicare reimbursement under Code E0652, when the pump qualified for much smaller reimbursement, a difference in reimbursement of about \$4,000 per pump.

❖ In July 1995, the owner and president of Global Medical Systems, Inc., pleaded guilty to mail fraud in connection with claims for Huntleigh pumps. He first submitted upcoded claims for the pumps to the Maryland carrier. When these claims were denied, he resubmitted the claims to the California carrier misrepresenting the pumps as Talley pumps. The defendant paid \$300,000 in restitution and is awaiting sentencing. He has paid an additional \$300,000 in a civil settlement.

❖ In September 1995, a jury convicted the owner of Medfast, Inc., after a two and half week trial. Medfast submitted nearly 60 claims to two Medicare carriers and one private insurer, misrepresenting that a doctor had prescribed a lymphedema pump. Several doctors testified that their signatures on the certificates of medical necessity, submitted to Medicare by Medfast, had been forged. The owner was sentenced to 35 months, a fine of \$7,500 and restitution of \$220,000.

❖ The U.S. Attorney's Office for the Eastern District of Pennsylvania, working with the Civil Division, secured \$4 million from Advanced Care Associates, Inc. and several individuals, to settle allegations that the defendants had submitted false documentation to obtain Medicare reimbursement for hundreds of lymphedema pumps and sleeves pumps. The government alleged that the defendants falsified information and forged certificates of medical necessity, failed to collect copayments, misrepresented used equipment as new equipment, and destroyed documents to avoid detection of the scheme. The individuals are permanently barred from participating in Medicare and certain state health care programs, and the defendant corporation and its parent company have agreed to a three year compliance program.

❖ The District of New Jersey, working with the Civil Division, recovered nearly \$1 million from two other pump suppliers for upcoding. Body Recall, Inc. paid the United States \$875,000, and Cornell Healthcare Corp. paid \$100,000 to settle the Government's claims. Medicare compliance programs were established in both cases. The investigation was conducted by the HHS IG and the FBI.

❖ Lymphedema pump supplier National Medical Systems agreed to pay \$1.5 million to resolve claims of upcoding Huntleigh and Jobst pumps and systematic waiver of the copayment and co-insurance deductible, in a case brought by the U.S. Attorney's Office for the District of Maryland and the Civil Division.

❖ Intervening in a qui tam action, the U.S. Attorney's Office in the Western District of Wisconsin, with substantial assistance from the Civil Division's Commercial Litigation Branch, obtained a \$2.1 million settlement against Curative Technologies, d/b/a Ultramed to settle allegations that Ultramed submitted claims regarding lymphedema pumps that did not meet the specifications of Medicare code provision E0652.

### **Nursing Homes**

❖ In one of the nation's largest nursing home fraud cases, the U.S. Attorney's office for the Eastern District of California obtained a conviction of the owner of a nursing home who fraudulently billed Medicare. The defendant controlled a 99-bed nursing home through which he submitted false claims for medical supplies resulting in payments of \$3.9 million over a four-year period. When auditors requested documentation for the medical supplies, he created false invoices and false medical and financial records. As part of the scheme, the owner also made payoffs to employees of the insurance company which processed the Medicare claims. He was

convicted of 28 felony counts, including conspiracy to defraud the United States, and money laundering. He was sentenced to 11 years and 3 months imprisonment, a \$300,000 fine and ordered to pay \$3 million restitution.

❖ The Southern District of Indiana charged Meridian Dental Group with defrauding the Medicaid program by making false statements to the program. The corporation has agreed to waive indictment, pay investigative costs of \$12,000 and pay the United States \$150,000. Meridian entered into contracts with over 50 nursing homes in the State of Indiana to provide the residents of the homes with full service dental services. Meridian devised a scheme to defraud Medicaid by submitting claims for the repair of each tooth contained in the denture as opposed for billing for the replacement of the denture.

❖ Manor Care, Inc., the owner and operator of several nursing homes, agreed to settle a civil false claims case for \$150,000 in the District of Kansas. The false claims arose from two Cost Reports submitted to the Part A Medicare Carrier, Mutual of Omaha. The Cost Reports overstated the number of nursing hours spent caring for Medicare patients. Because an employee detected early the false Cost Reports and law enforcement promptly intervened, the corporation quickly changed its procedures for recording nursing hours, thus preventing large losses to the Medicare program.

#### **Pharmaceuticals and Pharmaceutical Services**

❖ After a six-day jury trial in the Western District of Arkansas in May 1995, a pharmacist was convicted of dispensing Schedule II and Schedule IV controlled substances outside the scope of his profession, and of making false statements in applications for payment of Medicaid funds for prescription drugs. He was sentenced to 78 months imprisonment and ordered to pay restitution in the amount of \$129,216.56. The Medicaid fraud consisted of three separate schemes, including billing Medicaid for bogus prescriptions for nursing home patients and other institutionalized Medicaid recipients, for drugs never dispensed, and for over-billing the quantity of a particular drug prescribed.

❖ A pharmacist and his business were convicted of mail fraud and money laundering in the Northern District of Florida. He fraudulently billed programs for bogus prescriptions and greatly inflated prescription amounts over a 10 month period of time. The defendant was sentenced to 87 months imprisonment and ordered to pay \$1,029,834 in restitution.

❖ In 1995, the U.S. Attorney's Office for the District of Massachusetts recovered \$1.745 million in civil penalties under the Comprehensive Drug Abuse Prevention and Control Act. Among parties paying the penalties were two large retail pharmacies, Instacare Pharmacy Services Corp. and Dunnington's Rx Services, who paid \$750,000 and \$700,000, respectively, to settle claims that they violated the security and record-keeping requirements of the Act. These two penalties were the largest ever in New England and among the largest nationwide under the Act.

❖ On December 13, 1995, the owner and operator of two pharmacies, was sentenced in the Eastern District of Michigan to 10 months incarceration and ordered to pay \$411,135 in restitution in connection with his conviction on various charges relating to operation of his business. The pharmacist, received prescription requests from individuals insured by Blue Cross/Blue Shield of Michigan (BCBSM). Defendant obtained BCBSM subscriber identification cards in names other than his own, obtained hospital prescription forms and caused unauthorized prescriptions to be written for expensive drugs for which there was no generic equivalent in the names provided on the BCBSM subscriber cards he had obtained through his pharmacies. Subsequently, he then used the prescriptions and the subscriber cards to obtain the drugs from various pharmacy outlets in the Detroit area. He then resold the drugs through his pharmacies and billed BCBSM a second time for the sale of the same drugs. He caused over \$410,000 worth of fraudulently obtained prescription drugs to be paid for by BCBSM.

❖ A nine-year joint investigation by the FBI, DEA, state and local police, narcotics officers, Medicaid investigators, and Blue Cross of criminal drug diversions resulted in convictions of an osteopathic physician and others. The investigation included a sting operation--a phony drug house run by undercover agents where people could sell prescription drugs. The osteopathic physician's "patients" would get their prescriptions from the defendant physician, fill them at another defendant's pharmacy, and then sell them at the drug house. An undercover agent wearing a wire recorded visits to physician's office and to the pharmacy. At the store, employees asked which prescriptions should be filled (for sale on the street). The pharmacy billed the unfilled prescriptions to Medicaid and BCBS. The osteopathic physician pleaded guilty on October 4, 1995. On December 21, 1995, a jury in the Eastern District of Michigan convicted the pharmacy's owner.

❖ On December 21, 1995, a jury in the Eastern District of Michigan convicted a pharmacist of conspiracy to distribute controlled prescription drugs (Valium, Tylenol 3 and 4, Vicodin, Percocet, and others containing codeine) and mail fraud. The U.S. Attorney's Office for the Eastern District of Michigan won a jury verdict with less than one hour of deliberation after a three-week trial.

❖ On December 13, 1995 also in eastern District of Michigan, a pharmacy owner pleaded guilty to obtaining BCBS reimbursement for \$7.6 million in false prescription claims. Authorities learned of the scam following a customer call to BCBS's anti-fraud hotline. Insurance company investigators and the FBI launched a two-year investigation which uncovered a prescription business that outstripped its competitors five-fold. The owner pleaded guilty and agreed to reimburse BCBS \$8.6 million--the amount of the fraud plus \$1 million in interest--almost immediately after agents searched his store and home and seized papers, records, and computers.

❖ The U.S. Attorney's Office for the Southern District of Mississippi obtained a \$25,000 settlement against Poly Pharmaceuticals for violation of the Comprehensive Drug Abuse Prevention and Control Act of 1970. Poly Pharmaceuticals' violations included failure to make, keep, or furnish proper records, reports, orders or order forms, statements, invoices, and other

information it was required to keep for the controlled substances it distributed. In addition to paying the \$25,000 settlement, Poly Pharmaceuticals agreed to surrender its DEA registration to handle controlled substances on or before September 21, 1996, agreed to dispose of all its present inventory of controlled substances, agreed not to permit its sales personnel to handle delivery of controlled substances, and agreed to maintain complete and accurate records.

❖ In 1995, the U.S. Attorney for the District of Oregon obtained two significant Medicare/Medicaid civil fraud recoveries for overpayments made to pharmacies which had billed the government for generic drugs at higher non-generic rates. The government recovered \$687,000 from Clinical Health Systems and \$225,000 from Hi-School Pharmacy.

❖ In March 1995, a pharmacy owner and operator, was sentenced in the Eastern District of Tennessee to three years probation, six months in a half-way house, fined \$10,000 after he pleaded guilty to a one-count information charging him with falsely billing Medicaid. He had been charged with submitting false claims for reimbursement for prescription medications in which he falsely represented that a Medicaid recipient had been prescribed and furnished certain medications.

❖ Circa Pharmaceuticals, Inc, formerly Bolar Pharmaceuticals, Inc., agreed to pay the Government \$2.7 million in settlement of civil claims relating to its sale of generic drugs to the Government. In tests designed to compare how the generic version compared with the brand name, Bolar substituted the brand-name drug for the generic version, thus testing the brand-name drug against itself. Bolar then submitted those test results to the FDA as part of the generic drug approval process. Bolar also deviated from the FDA-approved formula, but kept a second set of records designed to establish that it had used the approved formula. In 1991, Bolar plead guilty to a 20-count information relating to the generic drug scheme, agreed to pay \$10 million in fines, and withdrew virtually all of the generic drugs for which it had received FDA approval.

❖ In a case investigated by the FBI, the FDA, the State of Idaho Attorney General's Office, the Idaho Bureau of Narcotics and the U.S. Attorney's Office for the District of Idaho, an indictment was returned in October, 1995 which resulted in the successful prosecution of a naturopath for mail fraud and mislabeling a controlled substance. The mail fraud charges relate to the naturopath's practice of billing insurance companies through a licensed chiropractor, who was employed at the naturopath's clinic, for an unapproved and experimental blood test performed entirely by the naturopath. The naturopath obtained over \$50,000 in one year billing patients and insurance companies for the experimental test. The mislabeling charges related to "black pearls" sold to patients which contained Valium. As a part of the plea agreement the defendant has agreed to stop practicing as a naturopath. On March 19, 1996, the defendant was placed on four years probation, ordered to pay \$1,186 restitution and fined \$10,000.

## **Physicians and Other Practitioners**

- ❖ The U.S. Attorney's Office for the District of Arizona has collected over \$100,000 in civil settlements from physicians who had written prescriptions for controlled substances for persons who were not their patients, but who were connected with a non-profit medical relief organization. The purpose of the prescriptions was to allow the relief organization to obtain a supply of drugs without following DEA procedural requirements. Some of the controlled substances were diverted by a member of the relief organization to her own personal use (without the knowledge of the physicians).
- ❖ On December 5, 1995, a dentist was convicted by a federal jury in the Middle District of Florida on charges of mail fraud, health care program fraud and failure to file income and employer tax returns. While operating his dental practice under the name Affordable Dental Care, the defendant submitted fraudulent claims to Medicaid for services that had not been provided to patients or which were performed by unlicensed and unqualified individuals.
- ❖ A temporary restraining order was issued in the Southern District of Florida on November 29, 1995, against a physician freezing approximately \$1.3 million and stopping another \$500,000.00 from being paid to him by Medicare. Investigation had revealed that the amount paid by Medicare to the physician jumped from approximately \$110,000 in 1994 to approximately \$3,000,000 in 1995 (most of which was from June through November.) The primary allegations of fraud involve payment of kickbacks and performing unnecessary tests. He saw 13 patients one day and billed Medicare \$172,000.00, part of an eight-day stretch where billing exceeded \$1 million.
- ❖ The District of Hawaii prosecuted an internist who was the deputy director of the State of Hawaii Department of Health, who engaged in a broad-based fraud whereby she billed nearly \$1 million to private insurers and government programs for services which were not rendered. She also falsified medical records to support her fraud, and thereby deprived patients of meaningful medical histories for insurance and diagnostic purposes. She pleaded guilty to three counts of mail fraud and settled a parallel false claims act suit for \$150,000. She also paid \$450,000 in restitution to BCBS of Hawaii.
- ❖ A physician is currently serving a 36-month prison sentence following his conviction in the Southern District of Indiana on Medicaid fraud. The prosecution was the first health care fraud case to be tried in the district in more than 10 years and was the result of the joint investigation of the state and federal health care fraud task force.
- ❖ The Western District of Louisiana obtained a \$2.1 million judgment against a Shreveport chiropractor. The Louisiana Department of Health and Hospitals performed an audit of Medicaid reimbursements which revealed 86% of his patients were minors, and often members of the same family. The audit also revealed that billed services were not actually provided or were upcoded.

❖ A dermatologist and weight loss specialist was convicted in December 1995 in the District of Massachusetts on 50 counts of mail fraud relating to a false billing scheme that defrauded the Medicare Program as well as a number of private insurance companies. The doctor would see a patient and provide weight loss advice, a service not covered by the Medicare program, or provide some other minor dermatological care to a patient, but then bill Medicare and private insurers for expensive dermatological procedures, primarily the destruction or removal of skin lesions. The false bills for what were typically 5 or 10 minute appointments often ran as high as \$1,400. During the investigation of the case, a number of retired FBI agents, acting as patients, were used as undercover operatives and made appointments with the doctor to seek advice on matters concerning weight loss.

❖ A podiatrist practicing in the Southern District of Mississippi agreed to pay the United States \$30,000 for filing false claims for Medicare payments and reimbursements. submitted claims for Medicare payments and reimbursements for deceased patients and for living patients who had not actually received any services from her. The United States was able to prevent payment on almost all of these false claims as a result of an internal investigation by the HHS OIG. In addition to the \$30,000 sum paid by Dr. Joiner, she was also placed on a restrictive education and prepayment review regimen by the Medicare carrier and HHS OIG.

❖ The U.S. Attorney for the Eastern District of New York settled a qui tam against Brooklyn doctor. The suit alleged that the doctor collected \$550,000 from the Social Security Administration for performing complete physicals on 10,000 people seeking Social Security disability benefits from 1990-94, when only cursory reviews had been performed, if at all. The doctor then submitted false medical reports to make it appear as though an examination had taken place. In one case, she reported that a man with an amputated leg and a permanently frozen shoulder joint had a normal gait and could bend over and touch his toes without pain. The man was denied disability benefits based on her medical report. The qui tam action was filed by five persons who similarly were denied benefits based on her reports. Since filing the action, the relators have obtained benefits and, in addition, have received \$113,700 as their share in the proceeds of the action.

❖ In July, 1995, in the Northern District of New York, a general practitioner with a sizable Medicaid clientele agreed to pay \$40,000 to settle allegations that he submitted false claims for EKGs that were not actually provided in violation of the False Claims Act, common law fraud, breach of contract, and unjust enrichment.

❖ In 1995, a federal grand jury in the District of Oregon returned a 51-count indictment against an ophthalmologist for charges of false claims against the United States and mail fraud. The indictment alleges that he performed unnecessary cataract surgery on Medicare patients. In Oregon, professional guidelines provide that cataract surgery is not medically necessary unless the cataract causes a person's best corrected vision to be 20/50 or below. The indictment charges that the defendant falsified the results of visual acuity tests of his patients in written reports submitted to the hospitals where the surgery was performed in order to justify the surgeries. He plead guilty to the charges in May 1996 and was sentenced to two years probation and \$10,371.52 in restitution.

❖ A four-week trial culminated in the conviction in June 1995 in the Eastern District of Pennsylvania of the two principals of a speech therapy company responsible for \$250,000 in fraudulent Medicare over-billings. Universal Rehabilitation Service, Inc. was a rehabilitation therapy company that provided speech therapy to Medicare Part B patients in nursing homes. Because the nursing homes were not rehabilitative, there were not enough Medicare-appropriate patients. The defendants directed that the documentation be falsified to insure that Medicare would reimburse for the therapy already given. The defendants have not yet been sentenced, due to pending post trial motions. A parallel civil False Claims Act action also is pending.

❖ Two doctors were convicted in the Middle District of Pennsylvania of submitting false Medicare claims. They performed acupuncture on patients, then billed for different procedures to obtain Medicare reimbursement. They both were convicted of conspiracy to present false statements to Pennsylvania Blue Shield. They were sentenced to 30 months and 27 months respectively, and ordered to pay restitution of \$300,000.

❖ The United States Attorney's Office for the Southern District of Texas brought criminal and civil charges against a physician and his wife and the Northshore Eye Clinic for fraudulently billing Medicare, Medicaid and private insurance plans. Northshore used the mail to submit false claims for various covered procedures when the procedure actually performed was a radial keratotomy -- a procedure not covered under most insurance policies. In addition, the criminal information alleged that Northshore and the physician paid kickbacks for the referral of patients. He was sentenced to 18 months in prison and his wife was sentenced to 4 months home detention and 8 months probation. They also were ordered to pay \$271,761 in restitution. In a separate civil settlement, they jointly agreed to pay \$800,000. The investigation was commenced after a referral was received by the Houston area health care fraud hotline (800-535-9541). The hotline is staffed 24 hours a day by representatives of the U.S. Postal Inspection Service.

### **Psychiatrists, Psychiatric Hospitals and Mental Health Services**

❖ On August 23, 1996, the former Administrator and Controller of the Springwood Psychiatric Institution, pleaded guilty in the Eastern District of Virginia to conspiring to: 1) defraud the Office of Personnel Management and the U.S. Postal Service; 2) mail false billing claims to federal and private health insurance plans; and 3) pay gratuities to a U.S. Postal Service employee. As part of the plea agreement, he stipulated to losses in the amount of \$325,000. [The guilty plea and indictment are part of an ongoing investigation into fraudulent billing practices by Springwood, and its former corporate parent, National Medical Enterprises (NME) Inc.] On September 26, 1996 in a related development, Gregory Z. Cantrell, a former Vice President of NME and an administrator of Springwood, was indicted in the Eastern District of Virginia on one count of conspiracy to defraud the United States, and two counts of bribery and 175 mail fraud counts arising from the same scheme to which Klutz pleaded guilty.

❖ On January 16, 1996, a federal grand jury in the Middle District of Florida returned a twenty-eight count indictment charging a clinical psychologist, with felony offenses relating to health care

fraud. He is charged with having conspired to defraud the United States, and to commit mail fraud and false claims offenses, by causing claims for psychological services to be submitted to the Medicare Part B and Railroad Retirement Trust Fund programs, in violation of Medicare payment rules. The indictment also charges that He back-dated entries in progress notes falsely stating that patients had been contacted about their co-payment obligations. Additionally, he is alleged to have forged patient signatures on psychological treatment consent forms, in files submitted to Medicare Part B. He plead guilty to the charges and was sentenced to 33 months imprisonment and ordered to pay \$81,893 in restitution.

❖ On December 2, 1994, the former Medical Director of Harbor Oaks Hospital in Fort Walton Beach pleaded guilty in the Northern District of Florida to a one-count information charging him with engaging in a scheme of mail fraud which, during the years of 1987-1991, resulted in the defendant receiving approximately \$365,711.14 in overpayments for up-coded and other false billings for psychiatric medical services rendered to drug and alcohol dependant adolescents, many of whom were military dependents, and submitted to CHAMPUS and to 42 private insurance companies. He was sentenced to 15 months imprisonment, 7 ½ months to be served in prison and 7 ½ months to be served in electronically monitored home detention, three years supervised release, fined \$25,000 and ordered to pay restitution to CHAMPUS of \$202,035.58, restitution to the 42 private insurance companies of \$163,675.56, and to pay the United States an additional \$202,035.58 in settlement of its civil fraud claims. The doctor's professional association was sentenced to three years probation, to be jointly and severally liable for the restitution and for the civil settlement, and ordered to pay the government investigative costs of \$40,146.10.

❖ In 1995, a licensed psychologist pleaded guilty in the Middle District of Georgia and was sentenced to five years probation, a \$1,000.00 fine, and restitution totaling \$6,789.16 for billing for services alleged rendered by himself, when in fact, an assistant had performed unrelated activities, and the psychologist was not present at the time.

❖ The U.S. Attorney's Office for the Central District of Illinois brought a series of successful civil false claims actions against psychiatrists, psychotherapists and others. In one case, a \$4.17 million judgment was obtained against a psychiatrist who had filed more than 800 false claims for psychotherapy. In another case, the Office recovered \$200,000 from another psychiatrist for 400 false claims. In both cases the psychiatrists billed for psychotherapy sessions which had not been performed.

❖ On August 2, 1995, a psychiatrist was convicted in the District of Massachusetts on 136 counts of mail fraud, Medicare fraud and obstruction of justice. During his three-week trial, the government proved that he billed the Medicare Program and other insurers for the treatment of patients on days when he was out of the country on vacation in Mexico or the Caribbean or on his honeymoon in Portugal. In addition, once He became aware of the federal investigation, he attempted to obstruct it by asking patients to lie about his treatment of them. In one instance, the psychiatrist threatened a patient's family member with disclosure of confidential psychiatric records. He defended the case, in part, by claiming that he was insane and that his insanity had caused him to overbill.

❖ The U.S. Attorney's Office for the Southern District of Mississippi successfully prosecuted a psychiatrist and his partner, an unlicensed social worker, for submission of false claims to CHAMPUS. After the social worker pleaded guilty to an information and agreed to testify against the psychiatrist, ultimately also entered a guilty plea. Both defendants received probation (with a portion to be served on home confinement) and both were ordered to pay approximately \$11,200 in restitution, for a total of approximately \$22,500.

❖ The U.S. Attorney's Office for the District of Nebraska together with the Department of Justice pursued a Medicaid fraud case against Rivendell Psychiatric Hospital ("Rivendell"), a 60-bed facility in Seward, Nebraska. Rivendell cared for severely emotionally troubled children and adolescents. Rivendell billed psychiatrists' minimal patient visits at maximum time increments during the late 1980s and early 1990s. On September 29, 1995, Rivendell's parent company, Vendell Healthcare, Inc., tendered a check for payment in full of \$554,694.

❖ In January 1995, a former hospital administrator of Psychiatric Institute of Fort Worth and a Regional Vice President of Psychiatric Institute of America was sentenced to 5 years probation on his plea to conspiracy to pay kickbacks. He also agreed to pay a civil settlement of \$221,000 in the Northern District of Texas, and agreed to cooperate and assist in all other cases.

❖ In April 1995, a former psychiatric counselor with the Psychiatric Institute of Fort Worth (PIFW) was sentenced to 97 months in prison, a criminal fine of 375,000 and was assessed a civil liability in the amount of \$1.5 million in the Northern District of Texas.

❖ A medical doctor specializing in psychiatric care for approximately 20 years in the Greater Milwaukee Area agreed to the entry of a \$35,000 monetary judgment in the Eastern District of Wisconsin against him individually and against his corporation for fraudulent billing practices over a several-year period in the late 1980s and early 1990s. He routinely billed Medicaid for in-person, hands-on psychiatric care for the residents of two major local nursing homes when, in fact, he visited patients only infrequently and merely reviewed records of their status on a monthly basis.

❖ On March 6, 1996, a licensed clinical psychologist with a private practice in Covina, California, pleaded guilty in the Central District of California to conspiracy and receiving illegal kickbacks for referring patients to a psychiatric hospital. In exchange for \$150,000 in payments over a 2 year period and other financial benefits including office furniture and marketing personnel, He referred approximately 143 patients to Glenbrook Hospital and to another NME hospital, Yorba Hills Hospital and Mental Health Center in Yorba Linda, California. He admitted that he did not perform any consulting services for Glenbrook Hospital and his only obligation for his monthly "stipend" paid by Glenbrook was to refer patients. Sentencing is scheduled for August 4, 1997.

❖ The former Chief Executive Officer (CEO) of Southwood Psychiatric Centers, Inc. in Chula Vista, California was indicted in the Southern District of California for obstructing a federal investigation and mailing threatening letters. The charges stemmed from a broadcast of a

television news magazine program, Front Page, which described a nationwide criminal investigation of practices at psychiatric hospitals, (including Southwood) owned and operated by National Medical Enterprises, Inc. (NME). After the broadcast, the former CEO sent a threatening letter to the parents of thirteen year old who committed suicide in 1992 while she was a patient at Southwood. He was also charged with sending a threatening letter to a former employee of Southwood who was interviewed by Front Page. He was convicted and sentenced to 6 months in a half-way house and a fine of \$10,000 on August 7, 1996.

❖ A psychologist who provided outpatient therapy to patients through the Center for Mental Health Services, Inc. in Leavenworth, Kansas, was convicted in the Western District of Missouri of all charges in a 19-count indictment, including 1-count of conspiracy to receive kickbacks from North Hills Hospital in the Medicare and CHAMPUS programs, mail fraud counts and § 666 counts. On July 6, 1995, he was sentenced to 5 years probation with six months home detention, and a fine of \$10,000. The Center for Mental Health Services received a special assessment of \$3,400. In April 1996 the appeal was argued before the Eighth Circuit Court of Appeals.

❖ On December 1, 1994 in the Northern District of Texas, a licensed professional counselor who operated a counseling clinic, the Center for Human Growth, in Burleson, Texas, was charged with two counts of conspiring to commit mail fraud and conspiring to receive payments from Psychiatric Institute of Fort Worth (PIFW) for patient referrals. He entered into agreements with representatives of PIFW to bill it for services rendered to patients that were never performed. In April 1995 he was sentenced to ninety-seven months imprisonment, a criminal fine of \$375,000 (in addition to his \$1.5 million civil settlement with the government), and 3 years supervised release.

❖ On September 17, 1996, a grand jury in the Northern District of Texas indicted a Dr. Robert Gross, for mail fraud involving a number of matters. Gross, who worked at both PIA Fort Worth and Bedford Meadows Hospital as a Unit Director, and Medical Coordinator is charged with accepting approximately \$800,000 as a reward for his agreement to maximize the number of patients and keeping census high; and submitting false claims for treatment which he did not provide, including claims for services when he was out of town and/or for services that were provided by a person who was not a medical doctor. Dr. Gross is a fugitive and also charged with making a false statement to obtain a passport, and criminal contempt both for leaving Texas in violation of a court order and for failure to appear at the grand jury as required by a court order. Dr. Gross is still a fugitive.

❖ On May 15, 1996, a grand jury in the Northern District of Texas returned an indictment against the former Medical Director of the Psychiatric Institute of Fort Worth (PIFW), charging him with 8 counts of mail fraud, in violation of 18 U.S.C. Sections 1341 & 2. The indictment charged that Burgos between December 1985 through 1993 admitted patients to PIFW in order to receive more than \$1 million false billings from PIFW and to submit false claims to insurance companies for services that were not rendered. On November 7, 1996, a jury convicted Hernan Burgos of all 14 counts of mail fraud involving false billing for services not rendered. Sentencing is scheduled for February 7, 1997.

## **Staged Automobile Accidents/Workers Compensation Fraud.**

❖ As a part of the national FBI initiative targeting "accident scams" (Sudden Impact), two doctors and their wives were successfully prosecuted in the District of Kansas for fraudulent billing of numerous insurance companies. The doctors and their wives, along with other co-conspirators, created false medical bills and patient charts for patients who had been in minor or staged auto accidents and who had not been injured. The purpose of creating the false bills was to meet the state tort threshold of \$2,000 in medical expenses, a threshold required before damages for pain and suffering can be sought. These false bills were submitted to insurance companies to encourage the companies to pay the accident "victims" large settlements. Both doctors received jail time.

❖ On November 30, 1995, a family practitioner from Morristown, New Jersey, pleaded guilty in the District of New Jersey to charges that he defrauded insurance companies and took affirmative steps to conceal those frauds. His prosecution grew out of an undercover investigation in which federal and state law enforcement authorities staged a bus crash in downtown Newark. Six undercover law enforcement agents who were aboard the undercover bus posed as "injured" patients in seeking treatment from the doctor who then submitted false bills to insurance companies for his purported treatment of the patients. He falsely billed the insurance companies for examinations, physiotherapy sessions and medical equipment that he never provided to the patients and certified to insurance companies that he personally administered all physiotherapy to patients, when in fact the therapy was either unsupervised or was provided by untrained clerical personnel. The defendant tried to conceal his fraud in a number of ways including creating false physician's progress notes and by requiring patients to sign affidavits, before treatment, which falsely stated that his bill was accurate. After he learned that he was the target of an investigation he attempted to obstruct the probe by attempting to persuade witnesses to lie before the federal grand jury that was investigating him.

❖ A psychiatrist who operated a pain clinic pleaded guilty to a two-count information in the Western District of Texas charging him with filing a false claim with the Department of Labor in violation of 18 U.S.C. § 287 and one count of making a false income tax return in violation of 26 U.S.C. § 7206(1). The defendant submitted false payments to the Department of Labor's workers' compensation program in connection with "biofeedback" treatment and failed to disclose certain payments received from insurance companies and personal injury lawyers on his 1989, 1990, and 1991 federal income tax returns. On July 19, 1995, he was ordered to serve 21 months imprisonment, to pay a \$50,000 fine, \$200,000 in restitution and all back taxes, penalties and interest; and to serve three years supervised release.

❖ On July 12, 1995, the owner and operator and the chief financial officer of a temporary employment company and an employee leasing firm which provided leased employees to businesses in approximately 38 states, were charged in the District of Connecticut with conspiracy and multiple counts of mail and wire fraud in executing a multi-million dollar fraud scheme. The defendants defrauded insurance companies and regulatory agencies by obtaining workers' compensation benefits for its employees at artificially low premiums by submitting false information including understating the numbers and types of employees to be covered under the

policies. Once a policy was obtained, one of the defendants would submit claims for benefits for injured workers who had never been disclosed to the insurer. The various insurers affected by the scheme have paid an estimated \$10 million in fraudulent claims. The defendants also were charged with conspiracy to defraud the IRS and the Social Security Administration by failing to report employees' earnings and wages, and failing to pay and report withholding taxes and social security taxes that were taken out of hundreds of their employees' paychecks from 1990 to 1992. The defendant was convicted following a trial in November 1996, and is currently scheduled for sentencing in March 1997.

❖ In February 1995, a Tennessee man was convicted and sentenced to five years probation and 12 months home detention and to pay restitution for submitting false claims for reimbursement for medical services and prescription drugs to the Office of Workers' Compensation Programs, U.S. Department of Labor, and using the mails to further his scheme to submit false claims. He submitted false claims seeking reimbursement for physical therapy and prescription drugs, creating fictitious billing statements and other documents to promote the scheme.

❖ A chiropractor, with high billing rates, and his wife were convicted of numerous counts of mail fraud involving the padding of bills in the treatment of victims of automobile accidents. Their scheme had two principal components: the making of fraudulent disability findings for potential plaintiffs in auto accidents and in workers' compensation claims, and performing fraudulently excessive testing and treatment of such individuals, often in order to raise the cost of the medical care provided to an accident victim above the dollar threshold set forth in Massachusetts' no-fault statute. The chiropractor was sentenced to a fifteen-month prison term, fined more than \$300,000 and ordered to pay more than \$136,000 in restitution. The Court sentenced his wife to three years of probation.

### **Miscellaneous**

❖ On December 13, 1995, after a two-week trial, a jury in the District of Massachusetts convicted an operator of health care facilities in four states of structuring and tax charges. He stripped \$5.6 million in cash from his companies through structured transactions, all the while not paying his employees' withholding taxes and not paying thousands of dollars of his employees' health care claims. Testimony revealed a pattern of disrupted patient care, including the eviction of one head injured patient because he had not paid the rent on his supported living apartment and the refusal to pay the cost of chemotherapy treatment for one employee. Ultimately, he declared bankruptcy, defrauding creditors of more than \$10 million. He was sentenced to 13 months imprisonment.

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II.2.a.2	6.5	RUNNING - SEPARATE COVER	2.50	16.25
II.2.c.1	44.0	MAKEREADY - SADDLE-STITCHED	4.00	176.00
II.2.c.2	286.0	RUNNING - SADDLE-STITCHED	0.13	37.18
III.b.2	143.0	60# WHITE OFFSET	0.62	88.66
III.h.1	13.0	80# WHITE LITHO COATED COVER	5.00	65.00
			SUB TOTAL	477.09
			GPO SURCHARGE	30.13
			GRAND TOTAL	507.22

175

~~\$582~~

890



## BASSETT HEALTHCARE

July 25, 1997

Chris Jennings  
Assistant to the President  
for Domestic Policy and Planning  
216 Old Executive Office Building  
1700 Pennsylvania Avenue  
Washington, DC 20502

Dear Conferee:

I am writing to you as a member of the Conference Committee on the Balanced Budget Act of 1997 regarding the Medicare Disproportionate Share Hospital (DSH) payments and the Directed/Indirected Medical Education payments.

I strongly support the position of carving out all of these dollars from the payments made to Managed Care plans.

As you know, the Senate and House versions of the bills pertaining to these issues gradually reduce Medicare Managed Care payments; i.e., the Adjusted Average Per Capita Cost (AAPCC) by the amount attributable to the Direct Graduate Medical Education, Indirect Medical Education, and DSH payments to hospitals. Appropriately, payments would be made directly to the organizations incurring the costs for these programs. It is noteworthy that the House Ways and Means Bill does not include a similar provision.

My reasoning for my stance on this issue is as follows: These payments are geared toward offsetting additional costs health care organizations incur in Medical Education and in making services available to medically indigent patients. Presently, these payments are included into payments to managed care plans and these plans have no legal responsibility to pass these dollars along to the teaching and DSH hospitals or other organizations who are actually incurring the costs to provide the services as described. The purpose of the carve-out therefore is intended to assure that Medicare support of these vital social objectives are reaching the organizations that actually incur the costs. In conclusion, therefore, I urge you to include the DME, IME, and DSH payments in the carve-outs. Both the Senate and the House Commerce Committee Bills phase in the carve-out over a four-year period providing an appropriate amount of time for managed care organizations to adjust. I urge you to adopt the Senate and Commerce carve-out provisions intact which include the three components described above.

I appreciate your responsiveness and attention to this most important matter.

Sincerely yours,

Jeffrey J. Woepfel  
Vice President, Hospital Services

JJW/tsn

One Atwell Road • Cooperstown, New York 13326-1394



MEMORIAL MEDICAL CENTER

One Pershing Circle  
North Little Rock, AR 72114-1899

July 30, 1997

Chris Jennings  
Special Assistant for Health Policy  
The White House  
Washington, D.C. 20009

Dear Mr. Jennings:

I learned today from the Arkansas Hospital Association that Congressional Republicans are willing to drop the attempt to expand the definition of hospital transfers. This has been a critically important issue for hospitals due to the potential financial impact and Medicare revenues that would be lost if hospital discharges to post-acute services are deemed to be transfers rather than true discharges. Expanding the definition could be devastating to hospitals, perhaps more so than the proposed PPS freeze.

I would like to go on record stating my opposition to the expansion of the definition of transfers. Your close review of the true impact of this issue is greatly appreciated.

Sincerely,

Pam Fulks, R.N., M.S.N.  
Vice President, Patient Care

PF:rjp

c: Arkansas Hospital Association

