HEALTH CARE FRAUD

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Table of Contents

I. INTRODUCTION AND OVERVIEW 1

II. HEALTH CARE FRAUD STATUTES 9

III. SELECTED ISSUES REGARDING THE HEALTH CARE STATUTES 16

A. Unit Of Prosecution 16

B. Intent 16

C. Knowledge & Deliberate Ignorance 18

D. Violations Of Regulations And Policies 19

E. Vagueness Issues 20

F. Jury Charge In Multi-Objective Conspiracy Case 21

G. Statute Of Limitations 25

H. Entrapment By Estoppel 25

IV. CONCLUSION 26

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BY: DAVID L. BOTSFORD

1. INTRODUCTION AND OVERVIEW

This paper is designed to afford you an **introduction** -- and only an introduction -- to health care fraud because the topic is one that is **not** capable of being covered in a single paper.[1] Health care fraud is effectuated in virtually all segments of the health care system using various methods. But the two major programs which are consistently the target of health care fraud are Medicare and Medicaid (in addition to private insurance companies). The rules and regulations governing Medicare and Medicaid make the Internal Revenue Code look like a Dr. Suses book: to say that it is an incredibly complex morass of laws is a gross understatement. But to handle a health care fraud case, we have to understand at least the basics of Medicare and Medicaid.

Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395ggg (the "Medicare Act"), established the Health Insurance for the Aged and Disabled program, which is commonly known as "the Medicare program" or "Medicare." Medicare is comprised of four parts, Part A, which is hospitalization, and Part B, which provides federal funds to help pay for services and products, for Medicare beneficiaries. Part C covers Medicare Advantage Plans and Part D covers Prescription Drug Plans. Medicare is funded by the United States and by insurance premiums that are paid by enrolled Medicare beneficiaries. It typically applies to people age 65 or older or people under the age of 65 with certain disabilities.

Medicaid is a federal/state cost-sharing program that provides health care to people who are unable to pay for such care. In Texas, the Medicaid program is administered by the Texas Health and Human Services Commission. According to the Attorney General’s website, there are more than 3.7 million Texans eligible for Medicaid, and there are more than 57,000 active Medicaid providers. A provider can be any person, group of people, or health care facility that supplies medical services to Medicaid recipients. Providers include doctors, medical equipment companies, podiatrists, dentists, licensed professional counselors, hospitals, adult day care centers, nursing homes, clinics, pharmacies, ambulance companies, case management centers and others.

Congress has charged the Secretary of the Department of Health and Human Services of the United States ("HHS") with the administration of the Medicare program, and the Centers for Medicare & Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"), is the part of HHS that administers the Medicare program for the Secretary. CMS, pursuant to the Secretary's powers, is authorized to contract with private insurance companies ("carriers") to administer Medicare reimbursements to Medicare providers from the Federal Supplementary Medical Insurance Trust Fund. The carriers are authorized by federal law and regulation to process claims for payment, to determine whether the claims submitted are for reasonable and medically necessary services, to perform payment safeguard functions, and to serve as a channel for communication of information relating to the administration of the Medicare program. One means of communication employed by carriers is the use of newsletters sent to providers, as well as provider books designed to outline what each class of providers needs to know about the delivery of services and/or products to Medicare and Medicaid beneficiaries.

CMS has divided the United States into different regions/jurisdictions for purposes of enrolling providers of services and/or products and processing claims submitted by those providers as well as beneficiaries. These regions/jurisdictions have been modified through the years and it is important to ascertain the region/jurisdiction in existence at the time of the alleged health care fraud. CMS also chooses the companies (for instance, CNGS, Cahaba GBA, Palmetto GBA, Trailblazer Health Enterprises, LLC)[2] to act as the Medicare carrier and/or fiscal

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[1] This paper was originally published in the 2012 Advanced Criminal Law Course. It has been updated and modified where necessary and/or appropriate.

[2] CMS (Center for Medicare and Medicaid Services) uses several types of contractors to attempt to prevent improper payments from being made for Medicare claims and admissions including Medicare Administrative Contractors (MACs), Carriers, and Fiscal Intermediaries (FI's). These are also known as the Medicare fee-for-service contractors which manage Medicare for CMS. Their primary goal is to "pay it right" by paying the right amount to the right provider for covered and correctly coded services. Since almost a billion claims are electronically paid each year, it is easy to understand why so few of the claims are actually reviewed.

intermediary to process and pay claims for various types of services and/or products in each of the regions/jurisdictions created by CMS. Different carriers/fiscal intermediaries within each region/jurisdiction may process and pay claims for different services and/or products. These entities change from time to time and so again, it is essential to ascertain who the entity is for the particular services and/or products which are being delivered to the Medicare beneficiaries in the region/jurisdiction at the time of the alleged health care offense.[3] Each of the States also choose their own carrier to administer the State Medicaid program.

Section 1395y(a) (1) (A) of the Medicare Act provides that "no payment may be made under ... for any expenses incurred for items or services ... which...are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." The Act does not define what services are reasonable and necessary. Rather, pursuant to section 1395ff(a) of the Act, the HHS Secretary is authorized to define what services meet that criteria. The Secretary has done this through regulations and interpretive rules that are published in manuals provided by CMS to carriers and providers. You should always obtain the provider manuals, interpretative rules and check the Code of Federal Regulations for the regulations applicable to the particular type of medical service or product that is involved in your health care fraud case.

A review of the cases reveals that while private health care insurers are certainly subject to fraud, the Medicare and Medicaid programs are the most easily victimized. In part, this is a function of the billing systems: one a person or entity signs up to provide services or supplies through Medicare or Medicaid and obtains a "provider" number, that entity or person can bill Medicare and Medicaid through the electronic billing system and will receive payment for those services or products directly from the financial intermediaries that process the claims for CMS. There are virtually no "checks and balances" on the front end of the enrollment process that would keep a fairly intelligent criminal from obtaining a provider number. And, once a person or entity has a provider number, it is a simple task to buy, borrow or steal Medicare and Medicaid numbers of beneficiaries. In other works, as long as the person or entity has a provider number and the patients' Medicare or Medicaid numbers (which are required on the electronic submission of the CMS 1500 claim form), that person or entity can conduct electronic billing all day long. In other words, the potential for abuse and fraud are virtually unlimited.[4]

Health care fraud includes altered or fabricated medical bills and other documents submitted to obtain funds for excessive or unnecessary treatments and billing schemes, such as charging for a service more expensive than the one provided, charging for services that were not provided, duplicate charges, false or exaggerated medical disability, and collecting on multiple policies for the same illness or injury. Some of the typical schemes employed against Medicare and Medicaid (as well as private insurance carriers) include:

An A/B MAC (Medicare Administrative Contractor) or carrier processes enrollment applications submitted by physicians, non-physician practitioners and different organizations, including ambulance service suppliers, ambulatory surgical centers, clinics and group practices, independent clinical laboratories, independent diagnostic testing facilities, mammography centers, portable x-ray suppliers, and radiation therapy centers. An A/B MAC or fiscal intermediary processes enrollment applications submitted by health care organizations including community mental health centers, comprehensive outpatient rehab facilities, federally qualified health centers, home health agencies, hospices, hospitals, organ procurement organizations, rural health centers and skilled nursing facilities. Additionally, the National Supplier Clearinghouse processes enrollment applications submitted by durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) suppliers. Each of these entities would also pay claims electronically submitted to it by providers who supplied services or products to beneficiaries.

[3] TrailBlazer is the Part A and Part B Jurisdiction 4 MAC for Texas, and also serves as a Fiscal Intermediary and a carrier for Texas (as well as other states).

[4] Providers billing for covered Medicare and Medicaid services and products must utilize the "HCPCS" or Health Care Procedure Coding System in their electronic billings. The HCPCS is a standardized coding system for describing and identifying health care services and supplies. It was developed by, and is maintained by, the federal government to provide a uniform language that accurately describes the specific medical services and items delivered to a patient, and in many cases, the qualifications of the person providing the services. HCPCS keys off of the CPT (Current Procedural Terminology) code set maintained by the American Medical Association through the CPT Editorial Panel. The CPT code set describes medical, surgical, and diagnostic services. CPT is used by CMS as Level 1 of the HCPCS.

(1) Billing for Services not Rendered: These schemes can have several meanings and could include any of the following:

> No medical service of any kind was rendered;
>
> The service was not rendered as described in the claim for payment (for instance, the service was rendered in violation of the Medicare or Medicaid rules applicable to the procedure or service)(or a power scooter is provided when a motorized wheelchair is billed for being provided);
>
> The service was previously billed and the claim had been paid;

(2) Upcoding of Services: This type of scheme involves a billing practice where the health care provider submits a bill using a procedure code that yields a higher payment than the code for the service that was actually rendered. The upcoding of services varies according to the provider type. Examples of service upcoding include:

> A routine, follow-up doctor's office visit being billed as an initial or comprehensive office visit (which are paid at higher rates than a routine follow-up visit).
>
> Group therapy being billed as individual therapy.
>
> Unilateral procedures being billed as bilateral procedures.
>
> A 30 minute session being billed as a 50 minute session.

(3) Upcoding of Items: A medical supplier is upcoding when, for example, the supplier delivers to the patient a basic, manually propelled wheelchair, but bills the patient's health insurance plan for a more expensive motorized version of the wheelchair.

(4) Duplicate Claims: A duplicate claim usually involves a certain item or service for which two claims are filed. In this scheme, an exact copy of the claim is not filed a second time; rather, the provider usually changes a portion, most often the date of service on the claim, so that the health insurer will not realize the claim is a duplicate. In other words, the exact claim is not filed twice, but one service is billed two times, in an attempt to be paid twice for one service.

(5) Unbundling: This is the practice of submitting bills in a fragmented fashion in order to maximize the reimbursement for various tests or procedures that are required to be billed together at a reduced cost. For example, clinical laboratory tests may be ordered individually, or in a "panel" (i.e., a lipid panel, an arthritis panel, a hepatitis panel). Billing tests within each panel as though they were done individually on subsequent days is an example of unbundling.

(6) Excessive Services: These schemes normally involve the provision of medical services or items which are in excess of the patient's actual needs. Examples of excessive services include:

> A medical supply company delivering and billing for more wound care kits per week for a nursing home patient who only requires a small number of dressings.
>
> Daily medical office visits conducted and billed for when monthly office visits would be more than adequate.

(7) Medically Unnecessary Services: A service is medically unnecessary and may give rise to a fraudulent scheme when the service is not justified by the patient's medical condition or diagnosis. For example, a claim for payment for an electrocardiogram test may be fraudulent if the patient has no conditions, complaints, or factors which would necessitate the test.

(8) Kickbacks: A health care provider or other person engages in an illegal kickback scheme when he or she offers, solicits, pays, or accepts money, or something of value, in exchange for the referral of a patient for health care services that may be paid for by Medicare or Medicaid. A laboratory owner and doctor each violate the Anti-Kickback Statute when the laboratory owner pays the doctor, for instance, $25.00 for each Medicare patient a doctor sends to the laboratory for testing. Although

kickbacks are often paid in cash based on a percentage of the amount paid by Medicare or Medicaid for a service, kickbacks may take other forms such as jewelry, free paid vacations, or other valuable items, or reduced rent on an office sharing arrangement

Some of the newer types of fraud schemes include:

(1) physical therapy/occupational therapy fraud: The crux of these schemes was billing Medicare for services not rendered. In most cases, the subjects created fictitious patient files by paying Medicare beneficiaries, therapists, and doctors to fill out and sign documentation indicating services had been provided when in fact they had not been. These files were then systematically distributed to Medicare providers for illicit billing.

(2) infusion therapy fraud: Several infusion therapy companies providing medication for AIDS, HIV-positive, and Hepatitis C patients were allegedly billing Medicare for services not actually performed, were medically unnecessary, or were medically unlikely (medicines not normally prescribed for particular conditions). Note: infusion therapy involves giving medicine intravenously to patients whose conditions are so severe they can't be treated with oral medication.

According to the Texas Attorney General's website, Medicaid fraud includes but is not limited to the following:[5]

(1) billing Medicaid for X-rays, blood tests and other procedures that were never performed or falsifying a patient's diagnosis to justify unnecessary tests;

(2) giving a patient a generic drug and billing for the name-brand version of the medication;

(3) giving a recipient a motorized scooter and billing for an electric wheelchair, which can cost three times more;

(4) billing Medicaid for care not given, for care given to patients who have died or who are no longer eligible, or for care given to patients who have transferred to another facility;

(5) transporting Medicaid patients by ambulance when it is not medically necessary;

(6) requiring vendors to "kick back" part of the money they receive for rendering services to Medicaid patients (kickbacks may also include vacations, merchandise, etc.);

(7) billing patients for services already paid for by Medicaid.

The Texas Medicaid Fraud Control Unit (MFCU) was created in 1979 as a division of the Office of the Attorney General. The Attorney General's Medicaid Fraud Control Unit investigates allegations of Medicaid fraud and works closely with the FBI and state and federal prosecutors around the state. MFCU has four primary responsibilities: (1) investigating criminal and civil fraud by Medicaid providers; (2) investigating physical abuse and criminal neglect of patients in health care facilities licensed by the Medicaid program, including nursing homes and Texas Department of Aging and Disability Services homes; (3) prosecuting criminal fraud

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[5] The Civil Medicaid Fraud Section (CMF) of the Texas Attorney General is nationally recognized as a leader in the recovery of funds wrongfully taken from the Medicaid program. CMF enforces the Texas Medicaid Fraud Prevention Act (TMFPA), chapter 36 of the Texas Human Resources Code. The TMFPA permits private citizens to file lawsuits on behalf of the state against those who violate the TMFPA. These private citizens are referred to as "relators" and they assist the state in identifying and pursuing fraudulent activity committed against the Medicaid program. Relators in successful matters receive a portion of the recovery. The Texas Attorney General may also pursue cases on its own on behalf of the Medicaid program.

CMF not only litigates civil Medicaid fraud in state and federal courts, it also works with relators, the criminal Medicaid Fraud Control Unit, the federal government, other state governments, and law enforcement to recover fraud. Over ½ billion dollars have been recovered by the Attorney General on behalf of the Texas Medicaid system.

by Medicaid providers or assisting local and federal authorities with such prosecution;[6] and (4) investigating fraud within the administration of the Medicaid program. MFCU does not look into fraud committed by Medicaid recipients. The Texas Health and Human Services Commission Office of Inspector General is responsible for investigating Medicaid recipient fraud.

In February 2012, the Department of Justice and Department of Health and Human Services (HHS) released the annual Health Care Fraud and Abuse Control Program (HCFAC) report for Fiscal Year 2011. The report reflects that approximately $4.1 billion in taxpayer dollars were recovered in fiscal year 2011.

The government's efforts to eliminate fraud, waste, and abuse rely in no small measure upon the Health Care Fraud Prevention & Enforcement Action Team (HEAT), created in 2009 to prevent fraud, waste and abuse in the Medicare and Medicaid programs. The efforts to reduce fraud may continue to improve with the new tools and resources provided by the Affordable Care Act (upheld by the Supreme Court in June 2012).[7]

Since 2009, the Departments of Justice and HHS have enhanced their coordination through HEAT and have increased the number of Medicare Fraud Strike Force teams. In Fiscal Year 2011, the total number of cities with strike force prosecution teams was increased to nine, all of which have teams of investigators and prosecutors from the Justice Department, the FBI and the HHS Office of Inspector General.

The strike force teams use advanced data analysis techniques to identify high-billing levels in health care fraud hot spots so that interagency teams can target emerging or migrating schemes by providers or suppliers. In Fiscal Year 2011, strike force operations charged a record number of 323 defendants, who allegedly collectively billed the Medicare program more than $1 billion. Strike force teams secured 172 guilty pleas, convicted 26 defendants at trial and sentenced 175 defendants to prison. The average prison sentence in strike force cases in Fiscal Year 2011 was more than 47 months.

Including strike force matters, federal prosecutors filed criminal charges against a total of 1,430 defendants for health care fraud related crimes. Including strike force matters, a total of 743 defendants were convicted for health care fraud-related crimes during the year.

The departments also pursued civil health care fraud enforcement during Fiscal Year 2011. Approximately $2.4 billion was recovered through civil health care fraud cases brought under the False Claims Act (FCA). These matters included unlawful pricing by pharmaceutical manufacturers, illegal marketing of medical devices and pharmaceutical products for uses not approved by the FDA, Medicare fraud by hospitals and other institutional providers, and violations of laws against self-referrals and kickbacks. Since January 2009, the department has used the False Claims Act to recover more than $6.6 billion in federal health care dollars.

The fraud prevention and enforcement report coincides with the announcement of a proposed rule from the Centers for Medicare and Medicaid Services (CMS) aimed at recollecting overpayments in the Medicare program. Before the Affordable Care Act, providers and suppliers did not face a deadline for returning taxpayers' money. Thanks to the Affordable Care Act, there will be a specific time frame by which self-identified overpayments must be returned.

It is certainly worth noting the press releases from the HEAT Task Force as a current indicator of the type of cases they have been pursuing:

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[6] Of course, the Texas Penal Code also contains many statutes that can be used to prosecute health care fraud related offenses, including but not limited to Chapter 35A, entitled Medicaid Fraud. Typically, even when MFCU (Medicaid Fraud Control Unit) investigators from the Attorney General's Office "make" a state criminal offense, it will often be prosecuted as a federal offense in federal court due to the impact of the federal sentencing guidelines (which are fairly onerous) and the fact that MFCU works hand in hand with federal law enforcement investigators.

[7] The recently enacted Affordable Care Act provides additional tools and resources to help fight fraud that will help boost these efforts, including an additional $350 million for HCFAC activities. The administration is already using tools authorized by the Affordable Care Act, including enhanced screenings and enrollment requirements, increased data sharing across government, expanded overpayment recovery efforts, and greater oversight of private insurance abuses.

> Florida: March 13, 2012: Miami area resident pleads guilty to participating in $200 million dollar Medicare fraud scheme;
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> Florida: March 9, 2012: Area halfway house owner sentenced to 24 months for participating in fraud and kickback scheme;
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> Texas: March 9, 2012: Owner of Houston health care company sentenced to 30 months in connection with Medicare fraud scheme;
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> Texas: February 28, 2012: Dallas Doctor arrested for alleged role in nearly $375 million dollar health care fraud scheme;
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> Texas: February 8, 2012: Assistant Administrator of Houston Hospital indicted for alleged role in $116 million dollar medicare fraud scheme
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> Louisiana: February 6, 2012: Louisiana patient recruiter pleads guilty in health care fraud scheme;
>
> Louisiana: February 3, 2012: Louisiana medical equipment owner pleads guilty in $21 million dollar fraud scheme; and
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> Michigan: February 2, 2012: Detroit rehabilitation agency owner found guilty for role in $2 million dollar therapy scheme.

On May 10, 2013, our Texas Attorney General released a news release regarding the sentencing of Godwin Chiedo Nzeocha, a naturalized U.S. citizen originally from the Nigeria. He was sentenced to 109 months in prison due to health care fraud in a 45 million dollar fraud scheme. He was the 8th person to be convicted in the scheme and had worked for a company named City Nursing, which had billed Medicare and medicaid for approximately $35,819,508 worth of physical therapy services (between 12/3/2007 and 6/26/2009) and had been paid $26,233.122. Simply amazing that an entity would be paid that much money without some sort of audit.

Most recently, on May 14, 2013, a nationwide takedown by Medicare Fraud Strike Force operations in eight cities resulted in charges against 89 individuals, including doctors, nurses and other licensed medical professionals, for their alleged participation in Medicare fraud schemes involving approximately $223 million in false billings. According to the DOJ press release:

> This coordinated takedown was the sixth national Medicare fraud takedown in Strike Force history. In total, almost 600 individuals have been charged in connection with schemes involving almost $2 billion in fraudulent billings in these national takedown operations alone. The Medicare Fraud Strike Force operations are part of the Health Care Fraud Prevention & Enforcement Action Team (HEAT), a joint initiative announced in May 2009 between the Department of Justice and HHS to focus their efforts to prevent and deter fraud and enforce current anti-fraud laws around the country.
>
> Since their inception in March 2007, Strike Force operations in nine locations have charged more than 1,500 defendants who collectively have falsely billed the Medicare program for more than $5 billion. In addition, CMS, working in conjunction with HHS-OIG, are taking steps to increase accountability and decrease the presence of fraudulent providers.
>
> The joint Department of Justice and HHS Medicare Fraud Strike Force is a multi-agency team of federal, state and local investigators designed to combat Medicare fraud through the use of Medicare data analysis techniques and an increased focus on community policing.
>
> Approximately 400 law enforcement agents from the FBI, HHS-OIG, multiple Medicaid Fraud Control Units and other state and local law enforcement agencies participated in the takedown. "Today's announcement marks the latest step forward in our comprehensive efforts to combat fraud and abuse in our health-care systems," said Attorney General Holder. "These significant actions build on the remarkable progress that the HEAT has enabled us to make alongside key federal, state, and local partners in identifying and shutting down fraud schemes. They are helping to deter would-be criminals from engaging in fraudulent activities in the first place. And they underscore our ongoing commitment to protecting the American people from all forms of health-care fraud, safeguarding taxpayer resources and ensuring the integrity of essential health-care programs."

"The Affordable Care Act has given us additional tools to preserve Medicare and protect the tens of millions of Americans who rely on it each day," said Secretary Sebelius. "By expanding our authority to suspend Medicare payments and reimbursements when fraud is suspected, the law allows us to better preserve the system and save taxpayer dollars. Today we're sending a strong, clear message to anyone seeking to defraud Medicare: You will get caught and you will pay the price. We will protect a sacred trust and an earned guarantee."

The defendants charged are accused of various health care fraud-related crimes, including conspiracy to commit health care fraud, violations of the anti-kickback statutes and money laundering. The charges are based on a variety of alleged fraud schemes involving various medical treatments and services, primarily home health care, but also mental health services, psychotherapy, physical and occupational therapy, durable medical equipment (DME) and ambulance services.

According to court documents, the defendants allegedly participated in schemes to submit claims to Medicare for treatments that were medically unnecessary and often never provided. In many cases, court documents allege that patient recruiters, Medicare beneficiaries and other co-conspirators were paid cash kickbacks in return for supplying beneficiary information to providers, so that the providers could then submit fraudulent billing to Medicare for services that were medically unnecessary or never performed. Collectively, the doctors, nurses, licensed medical professionals, health care company owners and others charged are accused of conspiring to submit a total of approximately $223 million in fraudulent billing.

In Miami, a total of 25 defendants, including two nurses, a paramedic and a radiographer, were charged today and yesterday for their participation in various fraud schemes involving a total of $44 million in false billings for home health care, mental health services, occupational and physical therapy, DME and HIV infusion. In one case, three defendants were charged for participating in a $20 million home health fraud scheme involving a home health agency, Trust Care Health Services. Court documents allege that the defendants bribed Medicare beneficiaries for their Medicare information, which was used to bill for home health services that were not rendered or that were not medically necessary. According to court documents, the lead defendant spent much of the money from the scheme, and purchased multiple luxury vehicles, including two Lamborghinis, a Ferrari and a Bentley.

Eleven individuals were charged by the Baton Rouge Strike Force. Five individuals were charged today, including two doctors, in New Orleans by the Baton Rouge Strike force for participating in a different $51 million home health fraud scheme. According to court documents, the defendants recruited beneficiaries, offering cash and other incentives in exchange for their Medicare information, which was used to bill medically unnecessary home health services. The Baton Rouge Strike Force also announced a superseding indictment and an information charging six individuals, including another doctor, with over $30 million in fraud in connection with a community mental health center called Shifa Texas. These charges come on top of charges brought against the owners and operators of Shifa Baton Rouge, a related community mental health center which is at the center of an alleged $225 million scheme charged in an earlier indictment.
In Houston, two individuals, including a nurse and a social worker, were charged today with fraud schemes involving at total of $8.1 million in false billings for home health care. The defendants, who are brother and sister, allegedly used patient recruiters to obtain Medicare beneficiary information that they then used to bill for services that were not medically necessary and not provided.

Thirteen defendants were charged in Los Angeles for their roles in schemes to defraud Medicare of approximately $23 million. In one case, three individuals allegedly billed Medicare for more than $8.7 million in fraudulent billing for DME. According to the indictment, the defendants allegedly paid illicit kickbacks to patient recruiters to bribe beneficiaries to participate in the scheme. Once the individuals provided their Medicare information to recruiters, doctors and medical clinics conspiring with the defendants allegedly wrote prescriptions for medically unnecessary power wheelchairs, which they sold to the defendants for illegal kickbacks.

In Detroit, 18 defendants, including two doctors, a physician's assistant and two therapists, were charged for their roles in fraud schemes involving approximately $49 million in false claims for medically unnecessary services, including home health, psychotherapy and infusion therapy. In one case, three individuals were charged in a $12 million scheme where they allegedly held themselves

out to be licensed physicians which they were not and signed prescriptions for drugs and documents about purported psychotherapy they provided.

In Tampa, nine individuals were charged in a variety of schemes, ranging from pharmacy fraud health care-related money laundering. In one case, four individuals were charged for their alleged roles in establishing and operating four supposed healthcare clinics in Tampa, Fl. Palmetto General Health Care Inc., United Healthcare Center Inc., New Imaging Center Inc. and Lord Physical Rehabilitation Center Inc. which they allegedly used to steal more than $2.5 million from Medicare for surgical procedures that were never performed. The defendants allegedly billed Medicare for surgical procedures used to treat patients with high blood pressure by collapsing veins in the legs, but they did not actually perform the procedures.

In Chicago, seven individuals were charged, including two doctors, with a variety of health care fraud schemes.

In Brooklyn, N.Y., four individuals, including two doctors, were charged in fraud schemes involving $9.1 million in false claims. In one case, three additional individuals were allegedly involved in what is now alleged to be a $15 million scheme where massages by unlicensed therapists were billed to Medicare as physical therapy. Six defendants were previously charged in the scheme.

The cases announced today are being prosecuted and investigated by Medicare Fraud Strike Force teams comprised of attorneys from the Fraud Section of the Justice Department's Criminal Division and from the U.S. Attorney's Offices for the Southern District of Florida, the Eastern District of Michigan, the Eastern District of New York, the Southern District of Texas, the Central District of California, the Middle District of Louisiana; the Northern District of Illinois, and the Middle District of Florida; and agents from the FBI, HHS-OIG and state Medicaid Fraud Control Units.

Estimates of fraudulent billings to health care programs, both public and private, are estimated between 3 and 10 percent of total health care expenditures. The fraud schemes exist throughout the entire country, and target not just health care programs, but also the beneficiaries of health care services and products. Certain schemes tend to be worked more often in certain geographical areas, and certain ethnic or national groups tend to also employ the same fraud schemes. In Houston, for instance, certain durable medical equipment (motorized wheelchairs) schemes seemed to involve an overwhelmingly large percentage of individuals from Nigeria. The fraud schemes have, over time, become more sophisticated and complex and are now being perpetrated by more organized crime groups. But the point remains that due to the "easy" money, the health care system will continue to be targeted by those who wish to purloin its coffers.

II. THE HEALTH CARE FRAUD STATUTES

In addition to the general conspiracy statute (18 U.S.C. § 371), the mail fraud statute (18 U.S.C. § 1341), the wire fraud statute (18 U.S.C. § 1033), the RICO statutes (18 U.S.C. § 1961 to 1968), and the money laundering statutes[8] (18 U.S.C § 1956 and 1957),[9] health care fraud cases are typically prosecuted under one or more of the following specific statutes:[10]

18 U.S.C. § 1035. False statements relating to health care matters

(a) Whoever, in any matter involving a health care benefit program, knowingly and willfully–

(1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or

(2) makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry,

in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 5 years, or both.

(b) As used in this section, the term "health care benefit program" has the meaning given such term in section 24(b) of this title.

18 U.S.C.§ 1347. Health care fraud

(a) Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice--

(1) to defraud any health care benefit program; or

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[8] The money laundering statutes have typically been utilized due to enhanced penalties associated with the laundering of the proceeds of health care fraud. Recent amendments to the Federal Sentencing Guidelines have reduced the significant sentencing exposure previously associated with laundering as opposed to the underlying fraud statutes.

[9] Typically, the government would rely upon 18 U.S.C. 1956(a)(1)(B)(I) and show that the defendant (1) conducted financial transactions with (2) knowledge that the subject of the transactions was the proceeds from unlawful activity/crime – proceeds from submitting false Medicare or Medicaid claims – and (3) knowledge that the transactions were designed to conceal or disguise the nature, the location, the source, the ownership, or the control of the proceeds. *See United States v. Odiodio*, 244 F.3d 398, 403 (5th Cir. 2001).

[10] Of course, there are additional statutes, including, for instance, the federal civil false claims act, 31 U.S.C. § 3729-3733 (the civil counterpart to 18 U.S.C. § 287) and the Stark Law (Physician Self-Referral Law) contained at 42 U.S.C. § 1395nn. In particular, the Stark Law prohibits a physician from making a referral for designated health services to an entity in which the he or an immediate member of his family has an ownership/investment interest or with he has a compensation contract, unless one of the exceptions applies. Violations of the Stark Law include civil monetary penalties and exclusion from participation in all federal health care programs. And of course, under 42 U.S.C. § 1320a-7, the Department of Health and Human Services (HHS), Office of Inspector General (OIG), is required to impose exclusions from participation in all federal health care programs on providers and suppliers who have been convicted of (1) Medicare fraud; (2) patient abuse or neglect; (3) felony convictions for other health care related fraud, theft or financial misconduct; and (4) felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances. There are also permissive exclusions and the varying lengths of time from being able to participate in (and hence get paid for) rendering services as a provider. The General Services Administration maintains the "Excluded Parties List System" (EPLS) that includes information on entities and persons who have been debarred, suspended, proposed for debarment, excluded, or disqualified throughout the government. *See* https://www.epls.gov.

(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program,

in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title), such person shall be fined under this title or imprisoned not more than 20 years, or both; and if the violation results in death, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.

(b) With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.[11]

18 U.S.C. § 24. Definitions relating to Federal health care offense

(a) As used in this title, the term "Federal health care offense" means a violation of, or a criminal conspiracy to violate--

(1) section 669, 1035, 1347, or 1518 of this title or section 1128B of the Social Security Act (42 U.S.C. 1320a-7b); or

(2) section 287, 371, 664, 666, 1001, 1027, 1341, 1343, 1349, or 1954 of this title section 301 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331), or section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131), or section 411, 518, or 511 of the Employee Retirement Income Security Act of 1974, if the violation or conspiracy relates to a health care benefit program.

(b) As used in this title, the term "health care benefit program" means any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract.

18 U.S.C. § 1518. Obstruction of criminal investigations of health care offenses

(a) Whoever willfully prevents, obstructs, misleads, delays or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a Federal health care offense to a criminal investigator shall be fined under this title or imprisoned not more than 5 years, or both.

(b) As used in this section the term "criminal investigator" means any individual duly authorized by a department, agency, or armed force of the United States to conduct or engage in investigations for prosecutions for violations of health care offenses.

18 U.S.C. § 1349. Attempt and conspiracy

Any person who attempts or conspires to commit any offense under this chapter shall be subject to the same penalties as those prescribed for the offense, the commission of which was the object of the attempt or conspiracy.

28 U.S.C. § 287. False, fictitious or fraudulent claims

Whoever makes or presents to any person or officer in the civil, military, or naval service of the United States, or to any department or agency thereof, any claim upon or against the United States, or any department or agency thereof, knowing such claim to be false, fictitious, or fraudulent, shall be imprisoned not more than five years and shall be subject to a fine in the amount provided in this title.

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[11] This provision was added March 2010 to dilute the intent requirement previously applied to the statute by the various courts of appeals.

42 U.S.C. § 1320a-7b. Criminal penalties for acts involving Federal health care programs[12]

(a) Making or causing to be made false statements or representations

Whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program (as defined in subsection (f) of this section),

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized,

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

(5) presents or causes to be presented a claim for a physician's service for which payment may be made under a Federal health care program and knows that the individual who furnished the service was not licensed as a physician, or

(6) for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under subchapter XIX of this chapter, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1396p© of this title,

shall (I) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, conversion, or provision of counsel or assistance by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a Federal health care program is convicted of an offense under the preceding provisions of this subsection, the administrator of such program may at its option (notwithstanding any other provision of such program) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

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[12] The continuing vitality of this provision had been called into question by the lower court opinion in *National Federation of Independent Business v. Sebelius, Secretary of Health and Human Services*, but in light of the Supreme Court's action in upholding the majority of the act on June 28, 2012, that question appears to have been put to bed. *See* __U.S.__, 132 S.Ct. 2566, 183 L.Ed.2d 450 (2012).

(b) Illegal remunerations[13]

(1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under a Federal health care program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under a Federal health care program;

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[13] This is what is commonly referred to as the anti-kickback statute. It addresses instances of patient referrals by providers of government financed health care services for economic benefit. Social Security Act, Section 1128B(b); 42 U.S.C. Section 1320a-7b(b). The statute prohibits the willful and knowing offer, solicitation, payment, or receipt of any remuneration (including any kickback, bribe, or rebate), directly or indirectly, overtly or covertly, in cash or in kind, (a) for referring an individual for a service or item covered by a government health program or arranging for such a referral; or (b) for purchasing, leasing, ordering, arranging for, or recommending the purchase, lease, or order of any good, facility, service, or item covered under the government health programs. Government health program patients include individuals covered by all federal health benefit programs, other than the Federal Employee Health Benefits Program.

The term "remuneration" has been broadly defined to encompass virtually anything of value or economic benefit, although the following items are excluded: disclosed and reflected discounts; payments to employees; payments to purchasing agents in certain group purchasing arrangements; waiver of Part B coinsurance by federally qualified health care centers for patients qualifying for subsidized services; the safe harbors created by regulation; and HIPAA exception for risk-sharing organizations.

The term "referrals" has been interpreted by the OIG to include any action taken by physicians, hospitals, other health care providers, and other individuals to influence a provider's or patient's decision in the use of health care services.

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services;

© any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under a Federal health care program if--

(I) the person has a written contract, with each such individual or entity, which specifies the amount to be paid the person, which amount may be a fixed amount or a fixed percentage of the value of the purchases made by each such individual or entity under the contract, and

(ii) in the case of an entity that is a provider of services (as defined in section 1395x(u) of this title), the person discloses (in such form and manner as the Secretary requires) to the entity and, upon request, to the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity;

(D) a waiver of any coinsurance under part B of subchapter XVIII of this chapter by a Federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act [42 U.S.C.A. § 201 et seq.];

(E) any payment practice specified by the Secretary in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987 or in regulations under section 1395w-104(e)(6) of this title;

(F) any remuneration between an organization and an individual or entity providing items or services, or a combination thereof, pursuant to a written agreement between the organization and the individual or entity if the organization is an eligible organization under section 1395mm of this title or if the written agreement, through a risk-sharing arrangement, places the individual or entity at substantial financial risk for the cost or utilization of the items or services, or a combination thereof, which the individual or entity is obligated to provide;

(G) the waiver or reduction by pharmacies (including pharmacies of the Indian Health Service, Indian tribes, tribal organizations, and urban Indian organizations) of any cost-sharing imposed under part D of subchapter XVIII of this chapter, if the conditions described in clauses (I) through (iii) of section 1320a-7a(i)(6)(A) of this title are met with respect to the waiver or reduction (except that, in the case of such a waiver or reduction on behalf of a subsidy eligible individual (as defined in section 1395w-114(a)(3) of this title), section 1320a-7a(i)(6)(A) of this title shall be applied without regard to clauses (ii) and (iii) of that section);

(H) any remuneration between a federally qualified health center (or an entity controlled by such a health center) and an MA organization pursuant to a written agreement described in section 1395w-23(a)(4) of this title;

(I) any remuneration between a health center entity described under clause (I) or (ii) of section 1396d(l)(2)(B) of this title and any individual or entity providing goods, items, services, donations, loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other agreement, if such agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity; and

(J) a discount in the price of an applicable drug (as defined in paragraph (2) of section 1395w-114a(g) of this title) of a manufacturer that is furnished to an applicable beneficiary (as defined in paragraph (1) of such section) under the Medicare coverage gap discount program under section 1395w-114a of this title.

© False statements or representations with respect to condition or operation of institutions

Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution, facility, or entity in order that such institution, facility, or entity may qualify (either upon initial certification or upon recertification) as a hospital, critical access hospital, skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, home health agency, or other entity (including an eligible organization under section 1395mm(b) of this title) for which certification is required under subchapter XVIII of this chapter or a State health care program (as defined in section 1320a-7(h) of this title), or with respect to information required to be provided under section 1320a-3a of this title, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Illegal patient admittance and retention practices

Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under subchapter XIX of this chapter, money or other consideration at a rate in excess of the rates established by the State (or, in the case of services provided to an individual enrolled with a medicaid managed care organization under subchapter XIX of this chapter under a contract under section 1396b(m) of this title or under a contractual, referral, or other arrangement under such contract, at a rate in excess of the rate permitted under such contract), or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under subchapter XIX of this chapter, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for the mentally retarded, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(e) Violation of assignment terms

Whoever accepts assignments described in section 1395u(b)(3)(B)(ii) of this title or agrees to be a participating physician or supplier under section 1395u(h)(1) of this title and knowingly, willfully, and repeatedly violates the term of such assignments or agreement, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than six months, or both.

(f) "Federal health care program" defined[14]

For purposes of this section, the term "Federal health care program" means--

(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United

[14] The definition of "federal health care program" contained in this subsection is necessary because the definition contained within 18 U.S.C. § 24 only applies to provisions within Title 18 of the United States Code.

States Government (other than the health insurance program under chapter 89 of Title 5); or

(2) any State health care program, as defined in section 1320a-7(h) of this title.

(g) Liability under subchapter III of chapter 37 of Title 31

In addition to the penalties provided for in this section or section 1320a-7a of this title, a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of Title 31.

(h) Actual knowledge or specific intent not required

With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.[15]

In addition to the criminal penalties associated with the above statute, a person is also subject to exclusion from Medicaid and/or Medicare, a civil monetary penalty of $50,000 per act plus three times the remuneration offered. The Office of Inspector General (OIG) has discretionary authority to institute an exclusion action based on its own assessment that a violation has occurred, without waiting for a criminal conviction to trigger exclusion.

You should also be aware of the safe harbor regulations specify certain types of transactions that are not subject to criminal or civil prosecution (assuming your client has complied with the regulations governing them). The regulations, however, are not intended to identify every possible instance in which a provider's conduct would be safe from prosecution under the anti-kickback statute, nor do they preclude providers from prosecution under state illegal remuneration laws, which may vary significantly from the federal statute. The safe harbor regulations are posted through the OIG's website at www.dhhs.gov/progorg/oig. OIG has issued safe harbor regulations on a number of activities. *See* 42 C.F.R. Section 1001.952(a)-(v).

Additionally, you should be aware that OIG can and does issue advisory opinions regarding compliance with the anti-kickback statute. OIG advisory opinions address the application of the statute and other OIG sanction statutes in specific factual situations. These advisory opinions are binding only on the Secretary of the Department of HHS and the party who requested the opinion. Nevertheless, they provide guidance with respect to the position of the OIG on certain issues. The advisory opinions are also on the OIG website at http://org.hhs.gov/fraud/advisory opinions/opinions.html.

Furthermore, OIG has issued numerous Special Fraud Alerts that describe certain business arrangements that have the potential to violate the anti-kickback statute. You should be aware of the existence of these Special Fraud Alerts and ascertain whether the conduct of your client falls within any of them, if only to be prepared to combat the prosecutor who will assume that your client was aware of the Special Fraud Alert that he or she allegedly violated. OIG also releases periodic bulletins and other guidance that identifies activities OIG considers to be highly suspect. Special Fraud Alerts, bulletins and other OIG guidance is available on the OIG website at http://oig.hhs.gov/fraud/fraud alerts.html.[16]

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[15] This provision was added March 2010 to dilute the intent requirement previously applied to the statute by the various courts of appeals.

[16] The civil counterpart to the anti-kickback statute, for lack of a better term, is the Stark Law (Stark I and Stark II). *See* footnote 9, *supra*. Under Stark, a physician (or immediate family member) who has a financial relationship with an entity is prohibited from making a referral to the entity for the furnishing of designated health services for which payment may be made under Medicare or Medicaid. Moreover, the entity may not present or cause to be presented a claim to any individual, third-party payer, or other entity for designated health services furnished pursuant to a prohibited referral. The rules under Stark provide bright-line definitions of these services covered, including a list of CPT and HCPCS codes. There are also many exceptions. Stark does not require proof of intent before civil sanctions can be imposed (including denial of payment, refunds of amounts collected in violation of Stark, civil monetary penalties for each bill/claim submitted and exclusion from Medicaid and/or Medicare).

III. SELECTED ISSUES REGARDING THE HEALTH CARE STATUTES

The following selected issues are presented for your consideration regarding, in general, the health care fraud statutes discussed above.

A. Unit Of Prosecution

In *United States v. Hickman*, 331 F.3d 439 (5th Cir. 2003), the Court confronted the proper interpretation of 18 U.S.C.§ 1347 in the context of an ex post facto clause argument. The Court noted that the statute punishes one who "knowingly and willfully executes, or attempts to execute, a scheme or artifice ... to defraud any health care benefit program ... or ... to obtain, by means of false or fraudulent pretenses ... any of the money or property ... of ... any health care benefit program...." The Court noted there was a "paucity of case law interpreting this provision," and that its language and structure are almost identical to the bank fraud statute, 18 U.S.C. § 1344. 331 F.3d at 446. The Court noted that in *United States v. Lemons*, 941 F.2d 309 (5th Cir.1991), it had interpreted § 1344 to punish "each execution of the scheme." *Id.* at 318. The Court had contrasted it with the mail and wire fraud statutes, which punish "each act in furtherance, or execution, of the scheme." *Id.; see also United States v. Hord,* 6 F.3d 276, 281 (5th Cir.1993) (affirming *Lemons* 's construction of § 1344); *United States v. Heath,* 970 F.2d 1397, 1402 (5th Cir.1992) (same). This proposition is now well-settled law. *See, e.g., United States v. De La Mata,* 266 F.3d 1275, 1287 (11th Cir.2001) ("The unit of the offense created by § 1344 is each execution or attempted execution of the scheme to defraud, not each act in furtherance thereof."); *United States v. Longfellow,* 43 F.3d 318, 323 (7th Cir.1994) (holding that the bank fraud statute punishes execution); *United States v. Molinaro,* 11 F.3d 853, 860 (9th Cir.1993) (same). The Court therefore held, by analogy, "that the health care fraud statute, § 1347, punishes executions or attempted executions of schemes to defraud, and not simply acts in furtherance of the scheme." 331 F.3d at 446. The Court went on to state "[o]f course, although the crime of health care fraud is complete upon the execution of a scheme, any scheme can be executed a number of times, and each execution may be charged as a separate count." *Id*.[17]

B. Intent

As noted in the footnotes above, in March 2010 Congress amended 18 U.S.C. § 1347 and 42 U.S.C. § 1320a-7b to include the following identical language in subsections (b) and (h), respectively:

> With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section

Prior to those amendments, it would not be unusual to have the following language (or some minor variation on the theme) included within the jury instructions submitted under either or both of those statutes:

> The term "willfully," as that term has been used from time to time in these instructions, means that the act was committed voluntarily and purposely, with the specific intent to violate a known legal duty; that is to say, with bad purpose either to disobey or disregard the law.

See United States v. Klein, 543 F.3d 206 (5th Cir. 2008) (intent to violate a known legal duty); *United States v. Delgado*, 668 F.3d 219, 225 n. 3 (5th Cir. 2012); *United States v. Hickman,* 331 F.3d 439, 443-45 (5th

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[17] In a case where the government alleges a particular type of scheme covering a time range, it is my personal opinion that it is multiplicitous to allege each separate billing -- adopting he same "scheme" methodology -- as a separate count. Indeed, in two cases, *United States v. Behmanshah*, 49 Fed.Appx. 372, 2002 WL 31167423 (3rd Cir 2000), and *United States v. Makki*, 2007 WL 781821 (E.D.Mich. 2007), the defendants lost in arguing that each separate billing should be charged separately (in the latter there were three counts, each with a different type of falsity represented in a number of billings). On the other hand, in *United States v. Cooper*, 283 F.Supp.2d 1215 (D.Kan. 2003) the court allowed separate billings to be treated as separate counts as one "could plausibly find that the actions described in the disputed counts of the indictment, objectively viewed, constituted separate executions of the scheme," basically relying on bank fraud cases.

Cir.2003).[18] However, with the passage of the amendments to § 1347 and § 1320a-7b, this type of instruction on intent may no longer be given, although that is certainly unclear given the language of § 1347 that specifically requires that the defendant "knowingly and willfully executes, or attempts to execute, a scheme or artifice" and the language of § 1320a-7b that specifically requires that the defendant act "knowingly and willfully" in virtually every instance named within it. From my perspective, the amendments attempting to dilute the mens rea renders the statute clearly ambiguous regarding the intent actually required and it remains to be seen whether the attempted dilution of the intent requirements will pass constitutional muster.

Assuming that the amendments somehow dispense with the willfulness standard previously applied to these statutes (notwithstanding that they continue to contain that term), then there should be no issue that the following type of instruction on good faith would be proper:[19]

> The good faith of the defendant ________is a complete defense to the charge of health care fraud contained in Counts __ to ___ of the indictment because good faith on the part of the defendant is, simply, inconsistent with the intent to defraud and the intent to obtain money or property by means of false or fraudulent pretenses, representations, or promises alleged in those charges.
>
> A person who acts, or causes another person to act, on a belief or an opinion honestly held is not punishable under this statute merely because the belief or opinion turns out to be inaccurate, incorrect, or wrong. An honest mistake in judgment or an error in management does not rise to the level of intent to defraud. Even negligence or gross negligence does not rise to the level of intent to defraud.
>
> A defendant does not act in "good faith" if, even though he honestly holds a certain opinion or belief, that defendant also knowingly and willfully makes false or fraudulent pretenses, representations, or promises to others.
>
> The health care fraud statute is written to subject to criminal punishment only those people who knowingly [**and willfully**], that is, with the intent to [**violate a known legal duty**], defraud or attempt to defraud or knowingly obtain money or property or attempt to obtain money or property by means of false or fraudulent pretenses, representations, or promises.

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[18] *See also United States v. Marti*, 294 Fed.Appx. 439 (11th Cir. 2008)("To prove health care fraud under 18 U.S.C. § 1347, the government must prove `knowing and willful execution of or attempt to execute a scheme to defraud a health-care benefit program in connection with delivery of or payment for health care.' *United States v. Mitchell,* 165 Fed.Appx. 821, 824 (11th Cir.2006)"); *United States v. Dearing*, 504 F.3d 897 (9th Cir. 2007)(requiring wilfulness based on statutory language); *United States v. Mitchell*, 165 Fed.Appx. 821, 824 (11th Cir. 2006)("Health care fraud under 18 U.S.C. § 1347 requires knowing and willful execution of or attempt to execute a scheme to defraud a health-care benefit program in connection with delivery of or payment for health care").

[19] *United States v. Goss*, 650 F.2d 1336 (5th Cir. Unit A July 1981), stands for the proposition that a trial court commits reversible error if it denies a request for a good faith instruction when there is any evidentiary support for that legal defense. *See id.* at 1344. " *Goss*, however, must be read in light of later cases which indicate that the failure to instruct on good faith is not fatal when the jury is given a detailed instruction on specific intent and the defendant has the opportunity to argue good faith to the jury." *United States v. Storm,* 36 F.3d 1289, 1294 (5th Cir.1994) (citing *United States v. Rochester,* 898 F.2d 971, 978 (5th Cir.1990)); *see also United States v. Daniel,* 957 F.2d 162, 170 (5th Cir.1992) (per curiam) ("We have subsequently noted that *Goss* stands merely for the proposition that an instruction on specific intent will not always be sufficient to necessarily exclude a conclusion of good faith."). Where the jury instructions define the terms "knowingly," "willfully," and "intent to defraud," and defense counsel is able to argue good faith to the jury during trial, the denial of an instruction on good faith will not necessarily constitute reversible error. *See, e.g., Storm,* 36 F.3d at 1294–95 (finding no abuse of discretion in the district court's refusal to submit a good faith instruction to the jury, as the instructions defined "knowingly" and "willfully," and the defendant had the opportunity to present his theory as to his intentions); *Daniel,* 957 F.2d at 170 (finding a good faith instruction unnecessary, as the jury was properly instructed on the elements of the offense, and counsel presented testimony concerning good faith and argued it to the jury).

> While the term "good faith" has no precise definition, it means, among other things, a belief or opinion honestly held, an absence of malice or ill will, and an intention to avoid taking unfair advantage of another.
>
> In determining whether or not the government has proven that the defendant acted with an intent to [defraud] [obtain money or property by means of false or fraudulent pretenses, representations, or promises] or whether the defendant acted in good faith, the jury must consider all of the evidence in the case bearing on the defendant's state of mind.
>
> The burden of proving good faith does not rest with the defendant because the defendant does not have any obligation to prove anything in this case. It is the government's burden to prove to you, beyond a reasonable doubt, that the defendant _________ acted with the intent to defraud or intent to obtain money or property by means of false or fraudulent pretenses, representations, or promises.
>
> If the evidence in the case leaves the jury with a reasonable doubt as to whether the defendant acted with an intent to defraud and to obtain money or property by means of false or fraudulent pretenses, representations, or promises or in good faith, the jury must acquit the defendant ________.

The bracketed language in bold would probably need to be extracted from the above and foregoing instruction on good faith, but otherwise, the definition of knowledge (discussed below) and the prospect of an instruction on deliberate indifference should be sufficient to justify an instruction on good faith.

C. Knowledge And Deliberate Ignorance

Often times, a district court will charge the jury on deliberate indifference as a part of its charge on "knowingly." *See Fifth Circuit Pattern Jury Instructions: Criminal* § 1.37 (2001), which provides:

> The word "knowingly," as that term has been used from time to time in these instructions, means that the act was done voluntarily and intentionally, not because of mistake or accident.
>
> You may find that a defendant had knowledge of a fact if you find that the defendant deliberately closed his eyes to what would otherwise have been obvious to him. While knowledge on the part of the defendant cannot be established merely by demonstrating that the defendant was negligent, careless, or foolish, knowledge can be inferred if the defendant deliberately blinded himself to the existence of a fact.

If a deliberate ignorance instruction is given, a "balancing" instruction should be considered upon request of defendant. See *United States v. Farfan-Carreon*, 935 F.2d 678 (5th Cir. 1991).

In reviewing whether this instruction is sufficient, the Fifth Circuit typically views the evidence and all reasonable inferences from it in the light most favorable to the government. *United States v. Wofford,* 560 F.3d 341, 352–53 (5th Cir.2009) The submission of this instruction "is proper where the evidence shows (1) subjective awareness of a high probability of the existence of illegal conduct, and (2) purposeful contrivance to avoid learning of the illegal conduct." *Id.* at 352. Such circumstances are "rare," *United States v. Mendoza–Medina,* 346 F.3d 121, 132 (5th Cir.2003), because "the district court should not instruct the jury on deliberate ignorance when the evidence raises only the inferences that the defendant had actual knowledge or no knowledge at all of the facts in question." *United States v. Conner,* 537 F.3d 480, 487 (5th Cir.2008) (internal quotation marks omitted). Deliberate indifference instructions are inappropriate in the usual case, where the evidence presents a simple choice "between a version of the facts in which the defendant had actual knowledge, and one in which the defendant was no more than negligent or stupid." *Id.* (quoting *United States v. Lara–Velasquez,* 919 F.2d 946, 951 (5th Cir.1990)). The key evidence that must be present for a deliberate indifference instruction to be appropriate is evidence of *conscious* action to avoid knowledge of illegal conduct, *Lara–Velasquez,* 919 F.2d at 951, because "[t]he purpose of the deliberate [indifference] instruction is to inform the jury that it may consider evidence of the defendant's charade of ignorance as circumstantial proof of guilty knowledge." *Id.; see also United States v. Nguyen,* 493 F.3d 613, 618 (5th Cir.2007). Where there is "substantial evidence of actual knowledge," the inclusion of a deliberate indifference cannot be reversible error. *Wofford,* 560 F.3d at 354 (internal quotation marks omitted); *United States v. Jones*, 664 F.3d 966, 978-979 (5th Cir. 2011) (upholding instruction in health care fraud case).

D. Violations Of Regulations And Policies

There are many interpretative rules and policies that apply to administration of the Medicare and Medicaid programs and it is typical for the government to introduce evidence that the defendant(s) have violated the rules and policies of Medicare or Medicaid. This can present the potential that the jury could convict your client for a violation of a rule or policy as opposed to the actual criminal statute under which he or she is indicted.

In *United States v. Christo,* 614 F.2d 486 (5th Cir.1980), the Fifth Circuit reviewed a prosecution for misapplication of bank funds in which the government presented evidence of civil banking regulations which limited the amount of credit which the bank could extend to the defendant. Finding this evidence irrelevant to the issue of criminal liability, the Court held that in view of the prosecution's arguments and "the whole tenor of the trial," jury instructions permitting a conviction based upon the civil violations constituted **plain error**. *Id*. at 492.

Subsequent cases have interpreted and understood *Christo* as being principally concerned with **bootstrapping of civil regulations and violations of those civil regulations into criminal liability**, and have permitted use of civil regulations and violations of those regulations in criminal prosecutions for more limited purposes. *See United States v. Bulter*, 429 F.3d 140, 149-151 (5th Cir. 2005)(*Christo* distinguishable because evidence of Texas Tech University Health Sciences Center's policies governing the defendant's conduct relevant to establish defendant's knowledge thereof and willfulness in scheme to defraud, given comprehensive limiting instruction further clarifying the purposes of the evidence);[20] *United States v. Schnitzer*, 145 F.3d 721, 729-731 (5th Cir. 1998)(discussing grant of new trial by district court due to admission of violation of FASB 66 in violation of *Christo*);[21] *United States v. Riddle*, 103 F.3d 423, 430-431 (5th Cir. 1997) (finding that reports of bank examiners, even if admissible under hearsay exception, had limited relevance, at best, to the charged offenses, were overly prejudicial, and should not have been admitted under *Christo*);[22] *United States v. Brechtel*, 997 F.2d 1108, 1114-1116 (5th Cir. 1993) (very limited testimony of civil regulations admissible to demonstrate motive for and assist jury in understanding actions of bank);[23] *United States v. Cordell*, 912 F.2d 769, 777 (5th Cir.1990) (evidence of civil regulation admissible to demonstrate bank's responsibility for allegedly misapplied funds); *United States v. McElroy*, 910 F.2d 1016, 1023-24 (2d Cir.1990) (evidence of regulations limiting lending for purchase of stock on margin admissible in to explain basis for bank lending policies); *United States v. Smith*, 891 F.2d 703, 710 (9th Cir.1989) (evidence of civil regulation admissible to show motive for false statements); *United States v. Stefan,* 784 F.2d 1093, 1098 (11th Cir. 1986) (evidence of civil regulation admissible to demonstrate motive for and assist jury in understanding series of "straw man" transactions).

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[20] In *Bulter*, there was an effective "comprehensive limiting instruction further clarifying the purpose of that evidence," *Butler*, *supra* at 151.

[21] In *Schnitzer*, *supra* at 730, the Court stated the following:

> These events indicate that the government `improperly focus[ed] the jury's attention to the prohibitions of' FASB 66 rather than the elements of a § 1006 violation and thus `impermissibly infected the very purpose for which the trial was being conducted.' *Christo*, 614 F.2d at 492. Thus, by not excluding evidence of the alleged regulatory violation, the district court opened the door for the government's legally impermissible `attempt to bootstrap a ...civil regulatory violation into [a] felon[y].' *Id*. at 492.

[22] The *Christo* violation in *Riddle* was also compounded by the improper "expert" opinion of a witness who was not designated as an expert by the Government and whose testimony went far beyond a lay opinion under Rule 701. *Riddle*, *supra* at 428-429.

[23] In *Brechtel*, the Court noted that [t]he situation "differs substantially from *Christo*," noting that "[t]estimony regarding civil regulations constituted only a minor portion" of the testimony. The "mention[ed of] disclosure requirements "assisted the jury in understanding the significance of" board minutes and management disclosures to regulators. The "statement concerning the prohibition on interested director transactions properly tended to demonstrate the defendants' motive for nondisclosure," and the jury was admonished that "[a] violation of banking regulations in and of itself does not amount to criminal conduct under federal law. The government must prove the elements of the offense beyond a reasonable doubt."

The Fifth Circuit and other circuits have recognized the necessity for and value of limiting instructions in attenuating any improper effect of such evidence when used for a permissible purpose, as reflected in the above cases. The key concept is whether evidence of civil regulations and violations of those regulations "impermissibly infect[ed] the very purpose for which the trial was being conducted." *United States v. Christo*, *supra*, 614 F.2d at 492.

In *United States v. Brown*, 553 F.3d 768 (5th Cir. 2008), one of the defendants (Wiley) argued on appeal that the admission of the *Texas Pharmacy Laws and Regulations (TPLR*) was irrelevant and as representing hearsay, and that its admission worked a Due Process violation by transforming a violation of the regulations and guidelines of the *TPLR* into a criminal offense. The Fifth Circuit upheld its admission into evidence (**despite the absence of evidence reflecting that the defendants had received it and reviewed it**). According to the Court, TPLR is a large volume of laws, regulations, and other information, sent to every registered Texas pharmacy, each of which is required to maintain a copy of it. The relevant portions of the *TPLR* discuss the DEA's concern about diversion of prescription drugs to illicit uses, outline the responsibilities of pharmacists in helping to prevent this diversion, and provide tips and guidance for spotting illegitimate prescriptions. At trial, the government offered extensive testimony about the *TPLR,* had witnesses read portions of it to the jury, and mentioned it during closing arguments. It used the *TPLR* to bolster its case that the pharmacists were either aware that many of the prescriptions they filled were illegitimate or deliberately chose to be ignorant of this fact. This justified the conclusion that it was admissible and not unduly prejudicial. The Court also held that the admission did not offend due process and that there was no due process violation as in *Christo*, *supra*.

Brown should be kept in mind because, in many Medicare and Medicaid cases, a provider (such as a doctor) would not be supplied with the types of manuals and instructions sheets that are supplied to other types of providers (such as Durable Medical Equipment Suppliers). It is not unusual to see warnings and materials in materials sent to some providers that are not in the material which are typically sent to other providers, and so, at a minimum, limiting instructions would be required to keep the jury from considering bulletins and materials sent to Provider A but not to Provider B. And in the absence of such limiting instructions, there may be real issues with the prejudice of global admissibility of such materials.

But at a minimum, you will want to request the following *Christo* limiting instruction:

> There are many interpretative rules and policies that apply to administration of the Medicare and Medicaid programs. That a defendant may have violated certain Medicare policies does not necessarily mean that the defendant is guilty of the crimes charged in the Superseding Indictment. Rather, you will find detailed instructions on what constitutes the crimes charged against the defendant, including the elements for proof of each of those crimes, in these Instructions. However, you may consider evidence of a defendant's failure to act in accordance with certain Medicare policies in determining whether the defendant committed the crimes charged in the Superseding Indictment.

E. Vagueness Issues

To the extent that the government's relies upon the interaction of various statutes, regulations, memoranda, and case law to support its assertion of criminal liability, there can be a real issue of whether the criminal statute is vague as applied to the defendant's conduct. Given the dilution of the intent requirement, discussed above, this is an argument that merits your close attention.

When determining whether a law is unconstitutionally vague, courts must determine whether the crime is "set out in terms that the ordinary person exercising ordinary common sense can sufficiently understand and comply with, without sacrifice to the public interest," *Dodger's Bar & Grill v. Johnson County Bd. of County Comm'rs,* 32 F.3d 1436, 1443 (10th Cir.1994) (citation omitted), and is written in a manner that does not encourage arbitrary and discriminatory enforcement, *Kolender v. Lawson,* 461 U.S. 352, 357 (1983). Thus, a statute may be unconstitutionally vague under the Due Process Clause for either of two reasons: (1) if it "fails to provide people of ordinary intelligence a reasonable opportunity to understand what conduct it prohibits," or (2) if it "authorizes or even encourages arbitrary and discriminatory enforcement." *Hill v. Colorado,* 530 U.S. 703, 732 (2000) (citing *Chicago v. Morales,* 527 U.S. 41, 56–57 (1999)). Although the vagueness doctrine considers both "actual notice to citizens and arbitrary enforcement," the "more important aspect of vagueness doctrine is ... the requirement that a legislature establish minimal guidelines to govern law enforcement." *Kolender,* 461 U.S. at 357–58.

An argument should be considered, depending upon the particular facts of your case, whether the sources upon which the government relies to establish criminal conduct are merely regulatory rules or agency policies or guidelines, which you can assert cannot form the basis of criminal liability. An as-applied challenge to the health care fraud statute on the grounds of vagueness must be considered "in light of the charged conduct." *United States v. Franklin–El,* 554 F.3d 903, 910 (10th Cir.2009), *cert. denied,* 129 S.Ct. 2813 (2009). In *Franklin-El*, the Court rejected a vagueness as applied argument to 18 U.S.C. § 1347. The defendant had asserted that § 1347 was unconstitutionally vague as applied because only by looking to several different regulations and "a provider manual, a provider agreement, and various program policies and bulletins" could it be determined what precisely the health care fraud statute prohibited. *Franklin–El,* 554 F.3d at 911. The Court reasoned that § 1347 was "not defined through other regulations," but rather—like the mail and wire fraud statutes—was "simply a fraud statute." *Id.* Of course, at the time *Franklin-El* was decided, the statute contained a strict mens rea requirement, which operated support it since the constitutionality of an arguably vague statutory standard "is closely related to whether that standard incorporates a requirement of *mens rea."* *Id.* (citing *Colautti v. Franklin,* 439 U.S. 379, 395 (1978)). The *Franklin–El* Court specifically stated:

> Moreover, and significantly, the health care fraud statute requires a specific intent to defraud or misrepresent. The constitutionality of an arguably vague statutory standard is closely related to whether that standard incorporates a *mens rea* requirement.

554 F.3d at 911. Clearly, the presence of a scienter inquiry can save an otherwise vague statute. 'The Supreme Court has recognized that a scienter requirement may mitigate a law's vagueness, especially with respect to the adequacy of notice to the complainant that his conduct is proscribed." *Ward v. Utah,* 398 F.3d 1239, 1252 (10th Cir.2005). Although a specific intent requirement does not necessarily validate a criminal statute against all vagueness challenges, it does eliminate the objection that the statute punishes the accused for an offense of which he was unaware. *Screws v. United States,* 325 U.S. 91 (1945). *See also United States v. Sachokov*, 812 F.Supp.2d 198 (E.D.N.Y. 2011)(denying pretrial challenge to 1347 on the ground that it is unconstitutionally vague because it incorporates Medicare rules on billing submissions and codes, including the Medicare Claims Processing Manual ("MCP Manual") and the American Medical Association's Current Procedural Terminology Manual ("CPT Manual")); *United States v. Janati*, 237 Fed.Appx. 843 (4th Cir.2007) (rejecting claim that any vagueness in the CPT manual created unconstitutional vagueness in § 1347; according to the court, "[t]he CPT manual simply does not contain mandates backed by legal sanctions, such that officials must enforce them or that people need sufficient notice of them so as to avoid penalties. Any vagueness in the CPT manual itself cannot be the basis for a due process challenge to the fraud violations in this case.").

Despite these opinions, the more attenuated the government's theory and the more it relies upon, for instance, the carrier's rules and regulations (as opposed to the CFR's and/or policies and rules adopted by CMS), the more likely the prospect that the statute, as applied, may infringe on due process, particularly given the dilution of the meas rea requirement.

F. Jury Charge In Multi-Objective Conspiracy Case

In a typical case, you will see the first count of the indictment allege a conspiracy under 18 U.S.C. § 371, with one, two or even three statutes being utilized as "objectives" of the conspiracy. Again, it is not unusual to see those objectives to be the commission of health care fraud under 18 U.S.C. § 1347, and violations of the anti-kickback statute (42 U.S.C. § 1320a-7b (both offering and paying or soliciting and receiving). In such a multi-objective conspiracy, the jury instructions would or should track the following:

> Title 18, United States Code, Section 371, makes it a crime for anyone to conspire with someone else to commit an offense against the laws of the United States.
>
> A "conspiracy" is an agreement between two or more persons to join together to accomplish some unlawful purpose. It is a kind of "partnership in crime" in which each member becomes the agent of every other member.
>
> Count One of the Indictment charges the defendants with conspiring to commit three federal offenses:
>
> (a) to knowingly and willfully execute and attempt to execute a scheme and artifice to defraud the Medicare program in violation of Title 18, U.S.C. § 1347; that is, to falsely bill Medicare.

(b) to knowingly and willfully solicit or receive a remuneration (including any kickback) directly or indirectly, overtly or covertly, in cash or in kind to induce the referral of an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under the Medicare and Medicaid programs, in violation of Title 42 U.S.C. § 1320a-7b(b)(1)(A); that is, to receive payment for Medicare or Medicaid patients.

© to knowingly and willfully offer to pay a remuneration (including any kickback) directly or indirectly, overtly or covertly, in cash or in kind to induce the referral of an individual to a person for the furnishing or arranging for the furnishing of an item or service for which payment may be made in whole or in part under the Medicare and Medicaid programs in violation of Title 42, U.S.C. § 1320a- 7b(b) (2) (A); that is, to pay for Medicare or Medicaid patients.

For you to find a defendant guilty of this conspiracy, you must be convinced that the Government has proved each of the following beyond a reasonable doubt:

First: That two or more persons made an agreement: (a) to commit the crime of health care fraud in connection with the delivery of or payment of durable medical equipment; and/or (b) to solicit or receive remuneration in return for referring Medicare or Medicaid patients; and/or © to offer or pay remuneration to induce a person to refer Medicare or Medicaid patients, all as described in Count One of the Indictment;

Second: That the defendant under consideration knew the unlawful purpose of the agreement and joined in it willfully, that is, with the intent to further the unlawful purpose; and

Third: That one of the conspirators during the existence of the conspiracy knowingly committed at least one of the overt acts described in the Indictment, in order to accomplish some object or purpose of the conspiracy.

One may become a member of the conspiracy without knowing all of the details of the unlawful scheme or the identities of all of the other alleged conspirators. So, if the defendant under consideration, with an understanding of the unlawful nature of a plan or scheme and knowingly and intentionally joins in that plan or scheme on one occasion, that is sufficient to convict him/her of conspiracy, even though he had not participated before and even though he/she played only a minor part.

The Government need not prove that the alleged conspirators entered into any formal agreement, nor that they directly stated between themselves all the details of the scheme. Similarly, the Government need not prove that all the details of the scheme alleged in the Indictment were actually agreed upon or carried out. Nor must it prove that all of the persons alleged to have been members of the conspiracy were such, or that the alleged conspirators actually succeeded in accomplishing their unlawful objectives.

Mere presence at the scene of an event, even with knowledge that a crime is being committed, or the mere fact that certain persons may be associated with each other, and may have assembled together and discussed common aims and interests, does not necessarily establish proof of the existence of a conspiracy. Also, a person who has no knowledge of a conspiracy, but who happens to act in a way which advances some purpose of a conspiracy, does not thereby become a conspirator.

Now I direct your attention back to the First element of the conspiracy count set forth above. As I explained, the defendants are charged in Count One with conspiracy to commit three federal offenses: first, health care fraud in connection with the delivery of or payment for durable medical equipment, specifically power wheelchairs; second, soliciting or receiving remuneration to induce a person to refer Medicare and Medicaid patients; and third, offering or paying remuneration to induce a person to refer Medicare or Medicaid patients.

To prove that a defendant conspired to commit a federal offense, the Government must prove that the defendant acted with the same intent required to be proven for commission of that federal offense. Therefore, I shall explain to you the offenses of (1) health care fraud, (2) soliciting or receiving remuneration to induce a person to refer Medicare and Medicaid patients; and (3) offering or paying remuneration to induce a person to refer Medicare and Medicaid patients.

Health care fraud is separately charged against Defendant _____in Counts Two through Sixteen, and against Defendant ____ in Counts Two through Eleven. Accordingly, you will find detailed instructions on the crime of health care fraud later in these instructions at pages ___. Bear in mind, however, that in considering the conspiracy charged in Count One, the Government is not required to prove that the defendant actually committed health care fraud, or that the crime of health care fraud was actually committed by anyone, but only that the defendants conspired to commit health care fraud.

Soliciting or receiving remuneration to induce the referral of Medicare or Medicaid patients, the second federal offense which is charged as an object of the conspiracy count, is not separately charged against the defendants. Because it is one of the separate objects of the conspiracy charged in Count One against the defendants, however, I shall instruct you here on the elements of this offense.

Title 42, United States Code, Section 1320a-7b(b)(2)(A) , makes it a crime for anyone knowingly and willfully to solicit any money, including any kickback, bribe or rebate, directly or indirectly, overtly or covertly, in cash or in kind in return for referring a person to another for the furnishing of any item or service for which payment was made under a federal health care program. For one to be found guilty of this crime, if it were charged as a separate crime, the Government would be required to prove each of the following beyond a reasonable doubt:

First: that the defendant solicited or received remuneration, including any kickback or bribe, directly or indirectly, overtly or covertly, in cash or in kind to any person;

Second: that the remuneration was solicited or received to induce such person to refer an individual to a person for the furnishing or arranging of an item or service;

Third: that the item or service was one for which payment may be made in whole or in part under a federal health care program; and

Fourth: That the defendant acted knowingly and willfully.

The words "knowingly" and "willfully" are defined on pages ___above.[24]

Offering or paying remuneration to induce the referral of Medicare or Medicaid patients, the third federal offense which is charged as an object of the conspiracy, is not charged separately against the defendants. Because it is another of the separate objects of the conspiracy charged in Count One, however, I shall also instruct you on the elements of this offense. Title 42, United States Code, Section 1320a-7b(b)(2)(A), makes it a crime for anyone knowingly and willfully to offer or pay any money, including any kickback, bribe or rebate, directly or indirectly, overtly or covertly, in cash or in kind in return for referring a person to another for the furnishing of any item or service for which payment was made under a federal health care program.

For one to be found guilty of this crime, the Government would be required to prove each of the following beyond a reasonable doubt:

First: that the defendant offered or paid remuneration, including any kickback or bribe, directly or indirectly, overtly or covertly, in cash or in kind to any person;

Second: that the remuneration was offered or paid to induce such person to refer an individual to a person for the furnishing or arranging of an item or service;

Third: that the item or service was one for which payment may be made in whole or in part under a federal health care program; and

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[24] The definitions would typically be given and then adopted by reference throughout the jury instructions.

> **Fourth:** that the defendant acted knowingly and willfully.
>
> The word "offer" is defined as a representation expressing the ability and desire to pay a remuneration coupled with the intent to induce a desired action.
>
> The terms "knowingly" and "willfully," once again have the same meaning as defined on pages ____above.
>
> Bear in mind, however, that in considering the conspiracy charge in Count One, the Government is not required to prove that a defendant actually committed the offense of (1) health care fraud, (2) soliciting or receiving remuneration to induce the referral of Medicare and Medicaid patients; or (3) offering or paying remuneration to induce the referral of Medicare and Medicaid patients, or that any of such offenses was actually committed by anyone, but only that the defendant under consideration conspired to commit any of these offenses.
>
> The foregoing explanations of the substantive offenses of (1) health care fraud, (2) soliciting or receiving remuneration to induce the referral of Medicare and Medicaid patients; and (3) offering or paying remuneration to induce the referral of Medicare and Medicaid patients, should assist you in determining whether the Government has proved beyond a reasonable doubt each of the elements of conspiracy that is charged against the defendants in Count One.

Thereafter, there would (or should) be a charge on the necessity of jury unanimity of the theory on Count One of the indictment, as follows:

> Your verdict, whether it is guilty or not guilty, must be unanimous. The following instruction applies to the unanimity requirement as to Count One.
>
> As I have explained, Count One of the Indictment accuses the defendant of committing the crime of conspiracy in three different ways. The first is that the defendant conspired to commit health care fraud in connection with the delivery of or payment for durable medical equipment, namely power wheelchairs. The second is that the defendant conspired to solicit or receive remuneration to induce the referral of Medicare or Medicaid patients. The third is that the defendant conspired to offer or pay remuneration in return for referring Medicare or Medicaid patients. The Government does not have to prove all three of these objects of conspiracy for you to return a guilty verdict on this charge. Proof beyond a reasonable doubt on one object of conspiracy is enough. But in order to return a guilty verdict, all twelve of you must agree upon the particular object that has been proved. In other words, all of you must agree that the Government proved beyond a reasonable doubt that the defendant conspired to commit health care fraud in connection with the delivery of or payment for durable medical equipment; or all of you must agree that the Government proved beyond a reasonable doubt that the defendant conspired to solicit or receive remuneration to induce the referral of Medicare or Medicaid patients; or all of you must agree that the Government proved beyond a reasonable doubt that the defendant conspired to offer or pay remuneration to induce the referral of Medicare or Medicaid patients. Of course, all of you may also agree that the conspiracy, if you have so found, has as its object the commission of more than one of the alleged federal offenses so long as you are unanimous on each of such federal offenses.

Then, instructions on the substantive offenses contained in Counts Two through Sixteen (or whatever the case may be) would be given:

> Title 18, United States Code, Section 1347, makes it a crime for anyone knowingly and willfully to execute, or attempt to execute, a scheme or artifice to defraud any health care benefit program.
>
> For you to find a defendant guilty of this crime, you must be convinced that the Government has proved, with respect to each Count, each of the following beyond a reasonable doubt:
>
> **First:** That the defendant executed a scheme or artifice to defraud any health care benefit program in connection with the delivery of or payment for health care benefits, items, or services;
>
> **Second:** That the defendant acted knowingly and willfully with a specific intent to defraud, that is, to deceive or cheat someone;

Third: That the scheme to defraud employed false material representations; and

Fourth: That the health care benefit program was a public plan or contract, affecting commerce, under which medical benefits, items, or services were provided to any individual.

A "scheme or artifice to defraud" includes any scheme to deprive another of money or property by means of false or fraudulent pretenses, representations, or promises. The terms "knowingly" and "willfully" are defined at pages ____, above.

An "intent to defraud" means an intent to deceive or cheat someone.

A representation is "false" or "fraudulent" if it is known to be untrue or is made with reckless indifference as to its truth or falsity. A representation would also be "false" or "fraudulent" when it constitutes a half truth, or effectively omits or conceals a material fact, provided it is made with intent to defraud.

A false or fraudulent representation is "material" if it has a natural tendency to influence, or is capable of influencing, the decision of the person or entity to which it is addressed.

The term "health care benefit program" is defined at Title 18, United States Code Section 24(b) as "any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract."

The Indictment alleges that Medicare and Medicaid are health care benefit programs.

“Affecting commerce" means affecting interstate commerce.

"Interstate Commerce" means commerce or travel between one state, territory or possession of the United States and another state, territory or possession of the United States, including the District of Columbia.

It is not necessary that the Government prove all of the details alleged in the Indictment concerning the precise nature and purpose of the alleged scheme, or that the alleged scheme actually succeeded in defrauding someone. What must be proven beyond a reasonable doubt is that the defendant you are considering knowingly and willfully executed or attempted to execute a scheme to defraud that was substantially the same as the one alleged in the Indictment.

G. Statute Of Limitations

There is no "special" statute of limitations for the health care fraud statutes set forth above. Rather, the general five year statute of limitations contained with 18 U.S.C § 3282 applies to these statutes. I suspect, however, that just as the bank fraud crisis caused Congress to enact a special ten year statute of limitations regarding financial institution offenses, Congress will soon move to enact a similar ten year statute of limitations for health care fraud statutes.

H. Entrapment By Estoppel

Often times, medical providers obtain oral and/or written input from CMS or their State Medicaid officials regarding important questions to their service and/or billing. Reliance on such officials is important from the standpoint of the defense of entrapment by estoppel.

The defense of entrapment by estoppel is “an equitable doctrine,” *United States v. Ortegon-Uvalde,* 179 F.3d 956, 960 (5th Cir. 1999), and “a narrow exception to the general rule that ignorance of the law is no excuse and is based on fundamental fairness concerns of the Due Process Clause [where] the focus of the inquiry is on the conduct of the government not the intent of the accused.” *United States v. Spires*, 79 F.3d 464 (5th Cir. 1996).

The defense applies when “a government official or an agent actively assures a defendant that certain conduct is legal and the defendant reasonably relies on that advice and continues or initiates the conduct.”

Spires, at 466.[25] The person rendering the advice may be either "a federal government official" or "an authorized agent of the federal government who has been granted authority from the federal government to render such advice." *Id*., 467. In the Fifth Circuit, the defense also applies when "a government official tells a defendant that certain conduct is legal and the defendant commits what would otherwise be a crime in reasonable reliance on the official's representation." *Oretgon-Uvlade*, at 959 (citing *United States Baptista-Rodriguez*, 17 F.3d 1354, 1368 n.18 (11th Cir. 1994)). A defendant's reliance is reasonable if he can show that he accepted the authorized agent's advice as true, "and would not have been put on notice to make further inquiries." *United States v. Trevino-Martinez*, 86 F.3d 65, 69 (5th Cir. 1996). A defendant does not have to receive the advice directly from the authorized government agent, if the advice was circulated in the targeted professional community. *United States v. Levine*, 973 F.2d 463, 465 (6th Cir. 1992).[26]

IV. CONCLUSION

Health care fraud will continue to run rampant due to the tremendous amounts of money available to medical providers by virtue of electronic billing. The potential for abuse and fraud is simply incredible, as any provider, armed with his or her provider number and patient identifying numbers (Medicare number, Medicaid number and/or social security number), can bill for virtually any service or product without any "up front" supervision. The system is based entirely upon trust, but yet the procedures for being accepted as "providers" by Medicare and Medicaid are lax at best. Simply stated, the system is a wreck and despite more intensive computerized monitoring of claims submitted by providers, the fraud and abuse will undoubtedly never end.

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[25] The defense is not the same as the public authority defense. The public authority defense arises where a defendant is asked by an official to engage in criminal conduct that the defendant knows is illegal, while in the case of entrapment by estoppel, the defendant relies on statements from an official to reasonably believe his conduct constitutes no offense. *Unites v. Strahan*, 565 F.3d 1047, 1051 (7th Cir. 2009).

[26] Where the defense can be supported by a preponderance of undisputed evidence, a court may dismiss charges prior to trial under Fed.R.Crim. Proc. 12(b)(2). *See Levine*, 973 F.2d 463, 465-67 (6th Cir. 1992) (noting that a lengthy trial would be of no assistance to the court in deciding legal issues given undisputed evidence that government agency approved of merchandising campaign where medical goods were provided to physicians); *see also*, *United States v. Conley*, 859 F.Supp. 909, 927 (W.D. Pa. 1994) (holding "the defense should be raised by pretrial motion and the Court may conclusively determine the defense, resolving factual disputes as necessary").