„WHITE COLLAR" CRIME IN HEALTHCARE

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Abstract: *Although there has been some debate as to what qualifies as a white-collar crime, the term today generally encompasses a variety of nonviolent crimes usually committed in commercial situations for financial gain. Many white-collar crimes are especially difficult to prosecute because the perpetrators use sophisticated means to conceal their activities through a series of complex transactions. The most common white-collar offenses include: antitrust violations, computer and internet fraud, credit card fraud, phone and telemarketing fraud, bankruptcy fraud, healthcare fraud, environmental law violations, insurance fraud, mail fraud, government fraud, tax evasion, financial fraud, securities fraud, insider trading, bribery, kickbacks, counterfeiting, public corruption, money laundering, embezzlement, economic espionage and trade secret theft.*

Keywords: *insurance fraud, government fraud, healthcare fraud, white-collar crime, offences*

1. Introduction

The phrase "white-collar crime" was coined in 1939 during a speech given by Edwin Sutherland to the American Sociological Society. Sutherland defined the term as "crime committed by a person of respectability and high social status in the course of his occupation." Although there has been some debate as to what qualifies as a white-collar crime, the term today generally encompasses a variety of nonviolent crimes usually committed in commercial situations for financial gain. Many white-collar crimes are especially difficult to prosecute because the perpetrators use sophisticated means to conceal their activities through a series of complex transactions. The most common white-collar offenses include: antitrust violations, computer and internet fraud, credit card fraud, phone and telemarketing fraud, bankruptcy fraud, healthcare fraud, environmental law violations, insurance fraud, mail fraud, government fraud, tax evasion, financial fraud, securities fraud, insider trading, bribery, kickbacks, counterfeiting, public corruption, money laundering, embezzlement, economic espionage and trade secret theft. According to the Federal Bureau of Investigation, white-collar crime is estimated to cost the

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United States more than $300 billion annually. Although typically the government charges individuals for white-collar crimes, the government has the power to sanction corporations as well for these offenses. The penalties for white-collar offenses include fines, home detention, community confinement, paying the cost of prosecution, forfeitures, restitution, supervised release, and imprisonment. However, sanctions can be lessened if the defendant takes responsibility for the crime and assists the authorities in their investigation. Any defenses available to non-white-collar defendants in criminal court are also available to those accused of white-collar crimes. A common refrain of individuals or organizations facing white-collar criminal charges is the defense of entrapment. For instance, in United States v. Williams, 705 F.2d 603 (2nd Cir. 1983), one of the cases arising from "Operation Abscam," Abscam (sometimes written ABSCAM) was a Federal Bureau of Investigation (FBI) sting operation in the late 1970s and early 1980s that led to the convictions of seven members of the United States Congress, among others.

The two-year investigation initially targeted trafficking in stolen property and corruption of prominent businessmen, but later evolved into a public corruption investigation. The FBI was aided by the Justice Department and a convicted con-man in videotaping politicians accepting bribes from a fictitious Arabian company in return for various political favors. Senator Harrison Williams attempted unsuccessfully to argue that the government induced him into accepting a bribe.

Health care fraud is a type of white collar crime that involves the filing of dishonest health care claims in order to turn a profit. Fraudulent health care schemes come in many forms. Practitioner schemes include: individuals obtaining subsidized or fully-covered prescription pills that are actually unneeded and then selling them on the black market for a profit; billing by practitioners for care that they never rendered; filing duplicate claims for the same service rendered; altering the dates, description of services, or identities of members or providers; billing for a non-covered service as a covered service; modifying medical records; intentional incorrect reporting of diagnoses or procedures to maximize payment; use of unlicensed staff; accepting or giving kickbacks for member referrals; waiving member co-pays; and prescribing additional or unnecessary treatment. Members can commit health care fraud by providing false information when applying for programs or services, forging or selling prescription drugs, using transportation benefits for non-medical related purposes, and loaning or using another's insurance card.

Both state and federal legislation enumerate the activities that constitute white-collar criminal offenses. The Commerce Clause of the U.S. Constitution gives the federal government the authority to regulate white-collar crime, and a number

of federal agencies (see sidebar), including the FBI, the Internal Revenue Service, the Secret Service, U.S. Customs, the Environmental Protection Agency, and the Securities and Exchange Commission, participate in the enforcement of federal white-collar crime legislation. In addition, most states employ their own agencies to enforce white-collar crime laws at the state level.

When a health care fraud is perpetrated, the health care provider passes the costs along to its customers. Because of the pervasiveness of health care fraud, statistics now show that 10 cents of every dollar spent on health care goes toward paying for fraudulent health care claims.

Congressional legislation requires that health care insurance pay a legitimate claim within 30 days. The Federal Bureau of Investigation, the U.S. Postal Service, and the Office of the Inspector General all are charged with the responsibility of investigating healthcare fraud. However, because of the 30-day rule, these agencies rarely have enough time to perform an adequate investigation before an insurer has to pay.

Tax healthcare fraud and tax evasion affects us all. It occurs within a country and across countries both within the EU and globally. That is why a single country cannot solve the problem on its own. The EU and Member States need to work more together and internationally to combat the problem at home and abroad.

Open dialogue involving the European Commission, stakeholders and interested parties helps ensure that existing rules and proposals for new rules are designed to keep pace with the reality of rapid change. This dialogue helps to achieve the regulatory efficiency we need to foster best administrative and legislative practice tailored to meet the needs of business in the European Union in the third millennium.

A successful prosecution of a health care provider that ends in a conviction can have serious consequences. The health care provider faces incarceration, fines, and possibly losing the right to practice in the medical industry.

The following examples of healthcare fraud investigations are written from public record documents on file in the courts within the judicial district where the cases were prosecuted. On Sept. 25, 2014, in Columbia, South Carolina, Chandra Padgett, of Batesburg, was sentenced to 87 months in prison for her conviction on charges of wire fraud and tax evasion. According to court documents, Padgett was an office manager and bookkeeper for a pain clinic. Padgett set up a shell company named PSS (Padgett Specialty Scrapbooking Services). The name PSS was shared with her employer's primary vendor and allowed Padgett to send bogus invoices for payment. Between June 2008 and December 2010, Padgett created checks from

her employer's account payable to her company PSS and deposited them in to an account to which she had primary control. Padgett also used her position as bookkeeper and office manager to increase her own salary without her employer's authorization or knowledge. Padgett was ordered to pay restitution to her employer and the Internal Revenue Service[1].

On Sept. 15, 2014, in Des Moines, Iowa, Angela Shae Ellison, of Centerville, Iowa, the former owner and CEO of Cornerstone Counseling Center, was sentenced to 12 months and a day in prison and ordered to pay $724,359 in restitution. Ellison previously pleaded guilty to charges of health care fraud and money laundering. According to court documents, Ellison, who previously worked as a nurse, orchestrated a fraudulent billing scheme in which she directed employees of Cornerstone Counseling Center to bill various insurance companies over 6,000 times using the names and national provider identification number of various doctors who did not perform the services for which the bills were submitted. Many of the fraudulent bills involved the name and identification number of a doctor who never performed any work for the Center. Over $1 million in bogus bills were submitted, and the various insurance entities paid out more than $700,000 in claims.[2] On Sept. 11, 2014, in Greensboro, North Carolina, Claude Arthur Verbal II, formerly of Raleigh, North Carolina, and now of Miami, was sentenced to 135 months in prison for tax fraud, healthcare fraud and money laundering crimes in two separate cases. Verbal was also ordered to serve three years of supervised release and to pay restitution of $4,078,584 to the Internal Revenue Service (IRS) and $2,382,378 to the North Carolina Department of Health and Human Services. On April 9, Verbal pleaded guilty to one count of conspiracy to defraud the United States, one count of aiding and assisting the preparation of false tax returns, one count of healthcare fraud and one count of money laundering. Verbal was the owner of Nothing But Taxes (NBT), that operated from 2005 to at least 2012. Verbal personally prepared false tax returns for clients and taught and encouraged his employees to do so as well. Verbal and employees frequently offered clients a dramatically larger tax refund if the client agreed to make a cash payment to their tax preparer over and above the flat return preparation fee that NBT charged every client, whether or not their return was falsified. In a separate case, Verbal was the owner and operator of Infinite Wellness Concepts (IWC), a Medicaid behavioral health provider with several locations in North Carolina. IWC was contracted to

[1] https://klasing-associates.com/medical-office-manager-sentenced-prison-tax-fraud-wire-fraud-guilty-plea/

[2] https://www.justice.gov/usao-sdia/pr/nurse-ceo-sentenced-federal-prison-health-care-fraud-and-money-laundering

provide group therapy, intensive in-home services, and enhanced mental health and substance abuse services. Verbal acquired at least $1 million in fraudulently obtained funds from the Medicaid program. The money laundering charge to which Verbal pleaded guilty relates to the purchase of a $52,000 diamond ring with the proceeds of healthcare fraud[3].

On Aug. 18, 2014, in Los Angeles, California, Lianna "Lili" Ovsepian, of Tujunga, was sentenced to 96 months in prison and ordered to pay $9,146,137 in restitution to Medicare and Medi-Cal. In November 2013, Ovsepian pleaded guilty to conspiracy to commit health care fraud and conspiracy to commit identity theft. According to court documents, Ovsepian was the manager and owner of Manor Medical Imaging, Inc., which generated thousands of fraudulent prescriptions for unneeded and expensive anti-psychotic medications for "patients" who were typically low-income beneficiaries of the government-funded health care programs Medicare and Medi-Cal, and who did not need those drugs. The beneficiaries who received the prescriptions were brought to pharmacies, where the prescriptions were filled. The drugs were returned to Manor, the "patients" were given nominal payments (usually around $100), and the drugs were diverted into the black market, where they were sold to other pharmacies and re-billed to health care programs as though the drugs were being dispensed for the first time. The beneficiaries included veterans recruited from dual diagnosis programs for drug addiction and schizophrenia, elderly Medicare beneficiaries whose identities were stolen and homeless beneficiaries recruited from skid row. From September 2009 through October 27, 2011, Medi-Cal and Medicare was billed more than $20 million, and the programs paid more than $9.1 million to pharmacies based on more than 14,000 claims submitted in relation to the scheme.[4]

On Aug. 8, 2014, in Miami, Florida, Lawrence Schechtman, chiropractor, of Parkland, and Sircy Sacerio, aka "Sisi" aka "Sircy Santos", receptionist and office assistant, of Palm Springs, were sentenced for their participation in an automobile insurance fraud scheme involving staged automobile accidents. Schechtman was sentenced to 52 months in prison, two years of supervised release and ordered to pay $2,446,906 in restitution. Sacerio was sentenced to 48 months in prison, two years of supervised release and ordered to pay $1,146,824 in restitution. Both previously pleaded guilty to conspiracy to commit mail fraud and mail fraud. According to court documents, between approximately October 2006 and

[3] https://www.justice.gov/opa/pr/owner-tax-return-preparation-franchise-and-health-provider-business-sentenced-prison-tax

[4] https://www.justice.gov/usao-cdca/pr/leader-20-million-fraud-scheme-involving-bogus-prescriptions-expensive-anti-psychotics