



Identify Patterns of Medical Provider Fraud Through Data Base Graphic Pattern

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Civil RICO (Racketeer Influenced Corrupt Organizations)

18 U.S.C.A. §§ 1961 --1968

Introduction

A. Database Analysis

By detecting and establishing patterns of nefarious conduct between providers, attorneys and claimants, individually or collectively, insurance companies can unleash a number of powerful tools to successfully combat insurance fraud. One of those tools are databases which insurers can use to uncover patterns of fraud and commence an action under the Racketeer Influenced and Corrupt Organizations Act or "RICO."

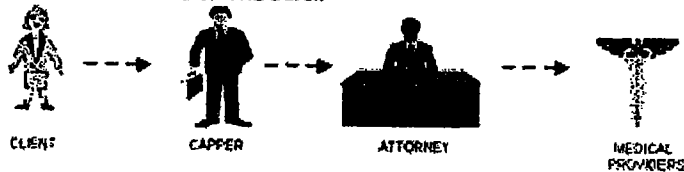
B. Examination Under Oath

To help determine which providers are suspect and therefore ripe for analysis, insurers should conduct examinations under oath ("EUO") of questionable claims containing objective elements of insurance fraud. An EUO can reveal repetitive instances in which claimants did not know why a particular treatment or modality was performed or applied or why their treating physician referred them to a particular specialist. Moreover, the EUOs may demonstrate, among other things, that the claimants were never informed of a diagnosis or asked for one; were referred by their attorney or unknown "friend" to the provider and did not seek medical treatment until such referral. Once a provider is determined to be suspect, all claims submitted by that provider that contain indicia or fraud should be referred for an examination under oath and to your expert for database analysis. The results of both referrals will be instrumental in building your RICO and other civil claims.

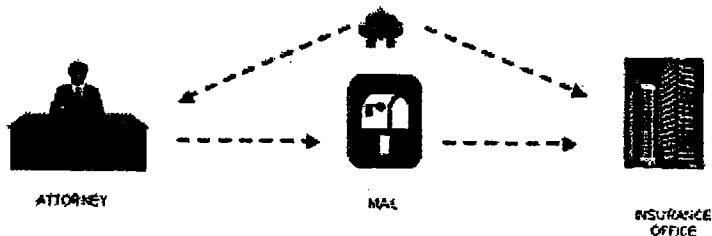
C. Personal Injury Mill

A PERSONAL INJURY MILL: THE STRUCTURE OF THE SCAM

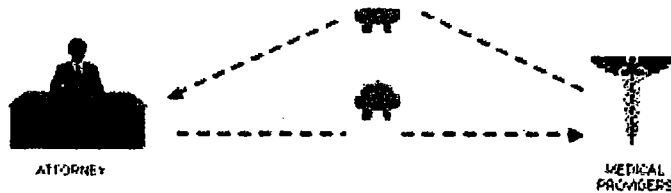
Personal injury clients are solicited by cappers who work for attorneys who refer the clients to medical providers.



The attorneys send claims to insurers who pay settlements to the attorneys.



The lawyers pay the medical providers, who kick back a portion to the attorneys



Auto accident scams commonly involve corrupt professionals in two ways:

- Corrupt doctors or chiropractors conspire with the claimant to bill the insurers for non-existent or highly exaggerated medical treatments. The "injured" individuals usually claim soft tissue traumas such as headaches, whiplash, strains, etc. Corrupt lawyers initiate lawsuits based on these fraudulent or exaggerated medical claims.
- When the staged auto accident participants conspire with doctors and chiropractors to defraud the health care and insurance industry, this scheme is referred to as a personal (medical) injury mill. A personal injury mill involves doctors and lawyers, working in concert or independently by submitting claims for injuries that never happened, or inflating the cost or extent of the injuries. Further, they may demand additional payments for lost wages and often sue with the intent of settling out of court.

Here is how the typical personal injury mill works:

1. Corrupt Attorneys

- Can initiate the scheme.
- Use cappers or runners to recruit legitimate or fake accident victims. The victims (passengers) act as grist for the mill.
- Refer clients to crooked doctors or chiropractors.
- Use the fraudulent diagnoses and treatments as basis for lawsuits. They sue for enough compensation to ensure an easy, profitable out-of-court settlement.

2. Cappers or Chasers

- Are recruited by the mill operator.
- Can be tow truck operators, emergency room attendants, ambulance operators, or pros who recruit clients full-time.
- Are usually paid a flat fee for services.
- Recruit clients-victims of auto accidents, people out of work...anyone.
- Refer clients to the attorneys or doctors, depending on the scheme.

3. Claimants

- Are often unwitting victims, unaware that the claim is being used fraudulently.
- Can be a knowing participant in the scheme, receiving payment for being involved. Acting as passengers in a car during a staged accident.

4. Medical Practitioners

- Doctors or chiropractors fabricate diagnoses and reports, while preparing false bills.
- Can run the mill, hiring cappers to recruit victims. Victims are then told they will need multiple visits. At these visits the medical treatment is minimal or non-existent. In this scheme, victims are unwitting accomplices because billing is made directly to the plaintiff attorney or insurance carrier.
- Set-up inflated billing schemes. They use claimants who pretend to be more injured than they actually are. Legitimate invoices are altered to justify the exaggerated claims.

5. Vertical Integrated Billing Management Companies

- A vertically integrated billing management company ("BMC") is one that operates and controls all aspects and facets of one or more medical clinics, from controlling the day to day management of the clinics, to supplying the clinics with a patient population, to generating fraudulent bills for the clinic(s) and maintaining all bank accounts.
- Under such operations, one or more non-doctors establish a BMC for the purposes of funneling money from medical clinics that they control to their billing company. In these situations, the company purchases the right to use the names and license numbers of various doctors, therapists, chiropractors and specialists under which they bill for services never rendered or, if rendered, that were medically unnecessary. Generally, the profile of the typical selling doctor or therapist that is not participating in the profits of the BMC's scheme to defraud tend to be frail, elderly, cash-starved or heavily indebted individuals who can be easily manipulated by the BMC.
- The BMC's will often have a fraudulent billing system in place that is automatically triggered by a claimant's initial office visit. For example, following a claimant's initial consultation, the BMC may bill an insurance company for services allegedly rendered to the claimant, including extensive physical therapy and chiropractic treatment, electroneuromyography, nerve conduction velocity tests, evoked potential studies and durable medical equipment, x-rays and MRI's, regardless of whether such treatments and tests were actually performed or medically required.
- Similarly, since the BMC's control the operations of the clinics, they generate and often sign boilerplate narrative and medial reports to document the fraudulent treatments and tests performed or conducted by the clinics.
- To maintain control over the flow of money generated by their clinics, the BMC will usually direct that payment be made to a P.O. box or address that it controls, as opposed to that of the billing clinic. Upon retrieving the checks from their designated P.O. box address, the BMC deposits them in bank accounts that the principals control, maintain and operate. Unless a doctor is participating in the profits of the BMC's scheme to defraud, a doctor will rarely be listed as a signatory on any of the bank accounts.
- To ensure a patient population for their clinics, the BMC usually employ runners and cappers to recruit, solicit or induce individuals that are not injured, or only minimally so, to seek medical treatment in return for the prospect of commencing and recovering a monetary settlement or judgment in a subsequent personal injury action. In a truly vertically integrated system, the BMC will receive financial consideration from the runners and cappers they employ as well.
- As part of its internal procedures, the BMC usually has an illegal financial relationship with a law firm that results in cross-referrals between entities. In instances where the corrupt clinic is referring to the law firm, the clinic arranges for the claimants' representation and receives a fee for doing so, either by charging excessively high fees for copies of medical reports or participating in settlement recoveries. Once again, in a truly vertically integrated system, the BMC would purchase the name of an attorney and receive a greater proportion of any settlement than the attorney.
- Finally, the BMC generally will also either own, operate and control the diagnostic facilities that the clinics refer patients to for MRIs and similar diagnostic tests or have a financial relationship with them, either of which may be violative of state and federal anti-kickback statutes prohibiting self-referrals.

RICO AS A TOOL

A. Different Remedies

Once a medical mill or insurance fraud ring has been identified, there are a number of remedies available to insurance companies. For instance, insurers can sue for common law fraud, money had and received and conversion. If the fraud was perpetrated against a government third-party administrator, such as an insurance company that processes Medicare payments for the government, the participants in the ring can be sued under the federal False Claim Act or the recent federal insurance fraud statute. RICO, however, still provides the most effective tool available to insurers in their fight against insurance fraud.

B. Elements of a Civil RICO Claim

In addition to the award of treble damages and attorney's fees, which is an attractive inducement in its own right, RICO carries a broad mandate that particularly lends itself to insurance fraud prosecution.

The elements of the offense or claim under RICO are the same whether the case is civil or criminal. The plaintiff must plead that the defendant has violated at least one of the substantive provisions of RICO contained at 18 U.S.C.A. § 1962 and specify which subsection has been violated. Section 1962 is divided into subsections (a)-(d), each subsection creating a different criminal offense. Generally, RICO proscribes the use or investment of income gained from a

"pattern of racketeering activity, (1) to acquire an interest in or to establish or operate an enterprise engaged in or affecting interstate commerce (18 U.S.C.A. § 1962[a]); or (2) to acquire or maintain an interest in such an enterprise through a pattern of racketeering activity (18 U.S.C.A. § 1962 [b]); or (3) conduct or participate in the conducting of such an enterprise through a pattern of racketeering activity (18 U.S.C.A. § 1962 [c]); or (4) to conspire to violate any of the first three subdivisions noted above. (18 U.S.C.A. § 1962[d])." Any person injured by the conduct of enterprise through a pattern of racketeering activity has standing to commence an action under RICO.

C. Insurance Context

In the insurance context, the most important section is 1962 (c) which provides that "It shall be unlawful for any person employed by or associated with any enterprise engaged in, or the activities of which affect, interstate or foreign commerce, to conduct or participate, directly or indirectly, in the conduct of such enterprise's affairs through a pattern of racketeering activity or collection of unlawful debt." Under this section, insurance companies typically denominate the clinics, law firms or the insurance company itself (under an "innocent victim theory") as the enterprise in which a billing management company, doctor or other individual participated in its conduct in furtherance of a scheme to defraud. The United States Supreme Court has stated that a violation of 18 U.S.C.A. § 1962 (c) requires (1) conduct (2) of an enterprise (3) through a pattern (4) of racketeering activity, and requires that the plaintiff allege each of these elements to state a RICO claim.

D. Racketeering Activity

Therefore, the key to understanding RICO begins with the definition of "racketeering activity." As with virtually all aspects of RICO's enactment, Congress has adopted an expansive view of racketeering activity. In addition to the traditional lines of racketeering activities one would expect to find in its definition, such as "any act or threat involving murder, kidnapping, gambling, arson, robbery, bribery, extortion, dealing in obscene matter, or dealing in a controlled substance . . . , RICO includes less sensational crimes often used in combating insurance related crimes, such as wire and mail fraud as predicate acts that may give rise to a claim.

Thus, merely alleging that the mails or wires were used in furtherance of a scheme to defraud may satisfy the predicate racketeering acts. Other relevant crimes (inclusive of mail & wire fraud), pertaining to fraudulent personal injury claims are:

1. mail fraud, 18 U.S.C.A. § 1341
2. wire fraud, 18 U.S.C.A. § 1343
3. Tampering with a witness, victim, or informant, 18 U.S.C.A. § 1512
4. interstate travel for the purpose of engaging in unlawful activity, followed thereafter by some attempt to perform such unlawful activity (e.g., traveling between states to launder money from fraud scheme, 18 U.S.C.A. § 1952
5. money laundering, 18 U.S.C.A. § 1956
6. engaging in monetary transactions in property derived from unlawful activity (e.g., \$10,000 or more of funds deposited, withdrawn, or transferred through a financial institution), 18 U.S.C.A. § 1957

E. Mail and Wire Fraud

It is not a requirement of either a mail or wire fraud that the person be a participant in the racketeering scheme. All that needs to be proven is that any use of the interstate wires or mails was the foreseeable result of the defendant's acts. Each and every use of interstate wires or mails, even innocent use by the insurer, is a separate predicate act under RICO.

Wire Fraud is the use of wire, radio, or television communication in the execution of a fraudulent scheme. It is important to note the communication must have an interstate nexus. However, the interstate nature of the communication need not be foreseeable, nor does the interstate communication have to be in furtherance of the fraudulent scheme. It is sufficient if the communication is made for the purpose of executing the scheme. Establishing a mail fraud violation requires proof of three elements: (1) the defendant participated in some scheme to defraud, (2) the defendant or someone associated with this scheme used the mails or "caused" the mails to be used, and (3) the use of the mails was for the purpose of executing the scheme.

F. Conspiracy

Under RICO, an insurance company can neatly ensnare all the participants involved in a scheme to defraud by pleading either the wrongdoing itself or a conspiracy to commit wrongdoing. The essence of the crime of conspiracy is an agreement among two or more persons to commit an unlawful act. A RICO conspiracy requires an agreement to

a pattern of racketeering activity as proscribed by subsection 1962 (c). Thus, a conspiracy to violate RICO (18 U.S.C.A. § 1962 (d)) is distinct from a conspiracy to commit each of the predicate acts. The defendant need not have agreed to actually commit the predicate acts itself or even to participate in the commission of those acts so long as it agreed that the acts would be committed on behalf of the conspiracy.

G. Two (2) RICO Violations & Pattern of Racketeering Activity Required

Indeed, as a threshold matter, a RICO complaint must allege at least two acts of "racketeering activity" within a period of ten years of one another.

1. Pattern (mail and wire fraud)

The statutory definition of "pattern of racketeering activity" will be satisfied in virtually every case of commercial mail or wire fraud in light of the prevalence of mail and interstate telephone calls in commercial transactions. It is difficult to conceive a business transaction where either mail or interstate telephone system is not used on at least two occasions. Each letter or interstate telephone call, even if arising out of the same fraudulent scheme or transaction, constitutes a separate act of racketeering activity under the mail and wire fraud statutes. It is not necessary that the predicate acts arise out of a different scheme or unconnected factual circumstances to satisfy the "pattern" requirements under the statute. A "pattern" of racketeering activity is met where there exists two acts of the same predicate activity, i.e., two mailings or two interstate telephone calls, or a combination of two different predicate acts, i.e., one mailing and one interstate telephone call or one mailing and one fraudulent insurance claim. Where multiple defendants are named in a RICO suit, proof that each defendant committed at least two predicate acts of racketeering is necessary.

2. Insurance Context

In applying the above guidelines in the context of a fraudulent insurance claim, an insurer should have little difficulty in establishing the requisite "pattern of racketeering activity." The personal injury scheme and the subsequent fraudulent claims made by the clinic to the insurer includes: 1) billing the insurer for services that have not been provided, when representing that they had been; 2) requesting payment for treatment when the clinic intends that some portion of the payment be used to pay illegal referral fees or, 3) providing treatment to a patient that was "reasonable and necessary" when in reality the patient did not need such treatment.

3. Two-Prong "Racketeering Activity" Test

The interpretation of what satisfies a pattern of racketeering activity has evolved into a two-prong analysis, occasionally referred to as the "continuity plus relationship test." To prove a RICO pattern, the plaintiff must show that "the commission of the predicate offense [a defined racketeering activity] is related in furtherance of a common scheme, and that such predicate acts either constitute or threaten long-term criminal activity It is the factor of continuity plus relationship which combines to produce a pattern."

The relationship aspect of the test is satisfied by showing that the predicate acts involve the same or similar purpose, results, participants, victims or methods of commission, or otherwise are interrelated by distinguishing characteristics. Accordingly, if the predicate acts are part of the same fraudulent scheme, courts will generally conclude that the acts are sufficiently related to each other to be considered part of a single pattern of racketeering activity, and therefore, satisfy the relationship prong of the test.

The continuity prong may be satisfied in one of two ways: (1) demonstrating that the predicate acts occurred over a substantial period of time, or (2) showing that the acts establish a threat of continued racketeering activity (i.e., illegal activity). The former looks retrospectively at the racketeering conduct in terms of duration, while the latter looks prospectively to determine whether the predicate acts create a threat of repeated racketeering conduct in the future.

4. Enterprise - Person

In addition to understanding the definition of a racketeering activity, it is important to understand the definitional roles assigned to "enterprise" and "person" under RICO. An "enterprise" may be "any individual, partnership, corporation, association, or other legal entity, and any union or group of individuals associated in fact although not a legal entity." A "person" includes "any individual or entity capable of holding a legal or beneficial interest in property." It is the RICO person that is held liable under the Act.

Depending on the RICO violation claimed, the person and enterprise may have to be distinct entities. For example, where the allegation is that the defendant used income to conduct an enterprise through a pattern of racketeering activity, a violation of 18 U.S.C. § 1962 (c), courts have held that the "person" and "enterprise" cannot be the same. By contrast, where the allegation is that the RICO "person" used or invested racketeering proceeds to acquire an interest in, or establish or operate an "enterprise," a violation of 18 U.S.C. § 1961 (a), the two entities may be the same. When

the scheme to defraud, however, involves a clinic or law firm that is being used by others to engage in racketeering activities, the enterprise and person will almost always be distinct and therefore allow for prosecution under 18 U.S.C. § 1962(c). Moreover, when the facts permit, the distinctness requirement noted can also be avoided by pleading the enterprise as an association in fact.

Statute of Limitations

A. Four Years

No explicit limitations period is provided in RICO for either civil or criminal actions. The United States Supreme Court held that the statute of limitations for civil RICO actions is four years. The Court found that civil RICO claims are analogous to private antitrust actions under the Clayton Act and, therefore, should have the same four-year limitations period.

B. Injury Discovery Rule

To determine when this limitations period begins to run, the circuit courts employ two different approaches. The first approach, which has been adopted by the First, Second, Fourth, Fifth, Seventh, and Ninth Circuits, is the "injury discovery rule." This approach contains two components. First, the civil RICO limitations period begins to run when "a plaintiff knows or should know of the injury that underlies his cause of action. The plaintiff is not required to know that the injury is part of a pattern of racketeering for this period to begin to run. The second portion of this "injury discovery rule" is the "separate accrual rule" which states that a new claim, and consequently a new four-year limitations period, accrues each time a "new and independent injury" is incurred from the same RICO violation. These circuits, however, are split in their interpretation of *Zenith Radio Corp. v. Hazeltine Research, Inc.*, in which the Supreme Court examined the effect of the "separate accrual rule" on future damages.

B. Injury and Pattern Discovery Rule

The second approach to the tolling of the statute of limitations is the "injury and pattern discovery rule" which has been adopted by the Sixth, Eighth, Tenth, and Eleventh Circuits. Under this approach the plaintiff must "discover or be in a position to discover" both the existence of the injury and the existence of a pattern of racketeering activity. Of the two approaches, the "injury discovery rule" is the less favorable to potential plaintiffs in a civil RICO action. Under this rule, the limitations period begins to run with the discovery of an injury, regardless of whether or not a pattern of racketeering activity has been established. Since a defendant must commit at least two predicate acts of racketeering activity to satisfy the pattern requirement, a potential plaintiff who has been injured as a result of one predicate act will be barred from bringing a claim as a result of this injury if the four-year limitations period has expired before the commission of the second predicate act. The "injury and pattern discovery rule" remedies this problem by delaying the start of the limitations period until the required pattern of racketeering activity exists.

Damages Recoverable Under RICO

The most attractive deterrent of the RICO statute is its treble damage provision. Under RICO, a successful plaintiff shall be entitled to collect threefold the damages sustained plus costs of suit, including reasonable attorneys' fees. The usage of the term "shall" indicates that the treble damage award is mandatory and not subject to the discretion of the trial court. Attorney's fees in a civil RICO action are also mandatory. The amount of an award of attorney's fees in a civil RICO action is for the trial judge, not the jury to determine.

A. Treble Damages & Attorney Fees

The treble damage provision under RICO makes it a potent weapon to the insurance industry in the fight against insurance fraud. Assuming, for example, that payment is made to an insured arising out of an insurance claim and fraud is subsequently discovered, the insurer, if able to successfully prove a RICO action, will be entitled to recover three times the amount it paid to the insured, three times the amount it paid to its claims representative, investigator, accountant, attorney, in investigating and evaluating the claim plus costs and attorney's fees in maintaining the RICO action.

Potential Application of RICO to Insurance Fraud Claims

Although not used nearly as often as would seem advisable, RICO provides a powerful weapon for insurance

companies to combat fraud. Against the backdrop set forth above, the application of RICO is readily apparent to a myriad of scenarios. For instance, when a medical mill involving a corrupt law firm(s) and provider group is uncovered, a RICO claim against the provider group might be maintained. The law firm would serve as the enterprise engaged in a pattern of racketeering activity and in which the provider group participated, i.e., use of the mails and wires in a scheme to defraud, a violation of 18 U.S.C. § 1961 (c). Additionally, the individual attorneys associated with the law firm may also be named as a "person" or defendant in the RICO action, not to mention other defendant permutations that would be available.

The effective use of RICO against medical groups would include instances where a medical group exaggerates patients' injuries, services rendered or necessity of treatments to inflate a law firm's personal injury claim. Another example would be where the provider exaggerates treatment to allow a law firm's clients to exceed the monetary threshold governing the commencement of personal injury lawsuits in no-fault jurisdictions. In either situation, the providers participate in the illicit conduct of the law firm enterprise and are subject to treble damages and the recovery of reasonable attorneys' fees under RICO. The predicate acts would be mail and/or wire fraud.

Similarly, RICO would be effective where a billing management company is the driving catalyst in the scheme to defraud. While the actual pleading depends upon the unique facts of each case, generally each clinic that is controlled or operated by the billing management company can be named as the enterprise and the individual owners and billing management entity can be named as the defendants to be held liable under the act. To the extent the facts demonstrate that individual doctors were participating in the profits with the billing management companies, they would also be named as individual defendants.

Similarly, under an "innocent victim" theory, an insurance company can be named as the enterprise in which the RICO defendants (e.g., the billing management company, doctors and law firms, if applicable) infiltrated the legitimate business activities of the insurance company for the purpose of conducting and participating in the affairs of its business through a pattern of racketeering.

Conclusion

Since its enactment, insurance companies victimized by insurance fraud have seldom used RICO. With the increasing, effective use of examinations under oath to detect, investigate and identify patterns of fraud among providers, law firms and claimants, alike, insurance companies have a powerful incentive to use a potent weapon in their fight against fraud. Coupled with the expertise and use of databases developed by experts like Dr. Spitz, insurance companies stand to be able to prove the predicate acts necessary to prevail against those engaged in a scheme to defraud.

RICO affords the insurer the unique opportunity to take the initiative to become proactive in combating insurance fraud rather than having to sit back and passively defend fraudulent claims.

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