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Proving intended loss in criminal health care cases

By Byron J. McLain and Pamela Johnston

Three criminal health care fraud-related cases are pending before the 9th U.S. Circuit Court of Appeals: *United States v. Michael Mirando*,17-50386 (J. Gould, Nguyen, Marbley) (argued Feb. 8, 2019) (16-CR-215-PA); *United States v. Wijegoonaratna*, 17-50255 (Gould, Nguyen, Owens) (argued Feb. 5, 2019) (14-CR-512-SJO-VAP-3); and *United States v. Abdul King Garba and Queen Anieze-Smith*, 16-50204 & 16-50208 (Gould, Nguyen, Benitez) (argued Feb. 4, 2019) (13-CR- 220-DMG). These three cases are on the radar of U.S. attorney's offices in the 9th Circuit as they could affect how health care fraud cases are litigated, how loss amounts are calculated, and how sentencing hearings are conducted. The issue is how "usual and customary" billing rates interact with the concepts of intended loss and actual loss in criminal health care cases.

First, a quick summary of the district courts actions is warranted. In *Mirando*, the defendant allegedly billed private insurance companies for diagnostic tests not performed and for duplicate billing of heart monitoring tests. The government claims $8.4 million in intended losses, which includes $7.3 million for unperformed services billed and $1.1 million for duplicate services billed. Actual losses totaled approximately $3 million. After a jury trial where the defendant was convicted of 15 counts of health care fraud, the defendant testified at his sentencing that he never expected the private insurance companies to pay the $8.4 million billed amount. However, he never submitted a declaration with his sentencing position paper, and he admitted that if the insurance companies would have paid more money for his claims he probably would have taken it.

In *Wijegoonaratna*, the defendant allegedly misdiagnosed patients as terminally ill requiring hospice care and recruited these patients to a hospice care company in return for kickback payments. The government claims that Medicare was billed $4,014,989 and paid $3,384,202 for these patients who supposedly ended up not being terminally ill. After a jury trial where the defendant was convicted of seven counts of health care fraud and sentenced to 108 months in prison, the defendant argued, among other issues, that the district court used the incorrect sentencing guidelines manual and thus violated the ex post facto clause. The defendant also argued on appeal that the application of a +18 loss enhancement required clear and convincing evidence.

In *Abdul King Garba and Queen Anieze-Smith*, the defendants allegedly engaged in a scheme to defraud Medicare by billing for power wheelchairs that were medically unnecessary and based on fraudulent documentation. The government claims that defendants billed Medicare $1.9 million for these wheelchairs, and Medicare paid approximately $815,000. After two jury trials, the defendants were convicted of five counts of health care fraud and ordered to jointly and severally make restitution to Medicare for approximately $815,000.

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Regardless of how the 9th Circuit decides each of these cases, there are already instructive takeaways for defense counsel:

1. Try to file a declaration with your sentencing position paper. The defendant in *Mirando* could have avoided a sentencing enhancement for intended losses of $8.4 million if he had filed a truthful declaration with his sentencing position. Instead of waiting until the sentencing hearing where he responded under oath to a judge's questions sua sponte, the defendant could have carefully drafted a declaration with the assistance of counsel where he stated that he understood the "usual and customary" reimbursement rates of the insurance companies were never more than 25 percent of the bills claimed. Based on the rebuttable presumption outlined in *United States v. Popov*, 742 F.3d 911, 916 (9th Cir. 2014) (holding that "in health care fraud cases, the amount billed to an insurer shall constitute prima facie evidence of intended loss for sentencing purposes"), the defendant bears the burden for proving a reduced loss amount of actual losses as opposed to intended losses. Unfortunately for the defendant in this case, since he failed to file a declaration, he has to hope that the 9th Circuit still grants the lower actual loss amount based on his statements in court at sentencing. And of course, any defendant declaration filed should always be truthful or otherwise the defendant risks an obstruction of justice enhancement.

2. Silence can be the right approach. The defendant in *Mirando* told the sentencing judge under oath that if the insurance company paid him more than the "usual and customary" 20 or 30 percent reimbursement rate, he would "probably [keep] the money." The government highlighted this statement throughout its appellate argument to indicate that the appropriate loss amount for sentencing purposes should be millions more than the defendant actually received because that was what he intended to keep. First, do not be surprised if more judges try to ask you and your clients similar questions at sentencing about their intentions concerning recouping money from insurance providers. Second, and more importantly, make sure you and your client have a more thoughtful and "honest" answer in response. Perhaps your client could acknowledge that even if the insurance company accidentally paid more than expected in reimbursement for Medicare claims, he would not take the money because (i) he wants to deal with the insurance companies in good faith and (ii) he knows that insurance claims are often audited so the insurance company would eventually recognize its error anyway. And third, remaining silent on the point would have been an even better choice.

3. Know ahead which book of the Sentencing Guidelines applies. The defense counsel in *Wijegoonaratna* did a good job of knowing exactly when the key provisions of the sentencing guidelines changed and how they impacted each of the individual charges that her client faced. As a result, the defendant in this case will almost definitely have her case remanded back to the district court to correct its ex post facto violation and sentence of 108 months. However, based on the posture of the case, the district court may still impose the same sentence but now just create a stronger record that meets a Rule 32 analysis. Alternatively, the defense counsel probably should have highlighted the district court's error immediately at the initial sentencing and argued for a lower sentence based on the 30-month difference in the two independent Guidelines calculations — one based on a sentence of 78 months under the 2010 Guidelines for six of the seven charges and the other based on a sentence of 108 months under the 2016 Guidelines for the other remaining charge.

4. Identify specific legitimate claims that the government mistakenly utilizes in its loss calculation. The defendants in *Abdul King Garba and Queen Anieze-Smith* argued that the restitution amount overstated the actual loss by almost $800,000 — over 97 percent of the amount ordered by the district court. They are likely to lose this argument on appeal as the government alleged that the scheme was permeated with fraud. Although the burden is on the government to prove their loss amounts (often by clear and convincing evidence), the defendant's attempt to undermine the restitution amount would have been much stronger and more persuasive if it had cited at least one specific and completely legitimate sale of medical device equipment (here, power wheelchairs) during trial in its case in chief and in its sentencing papers.

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