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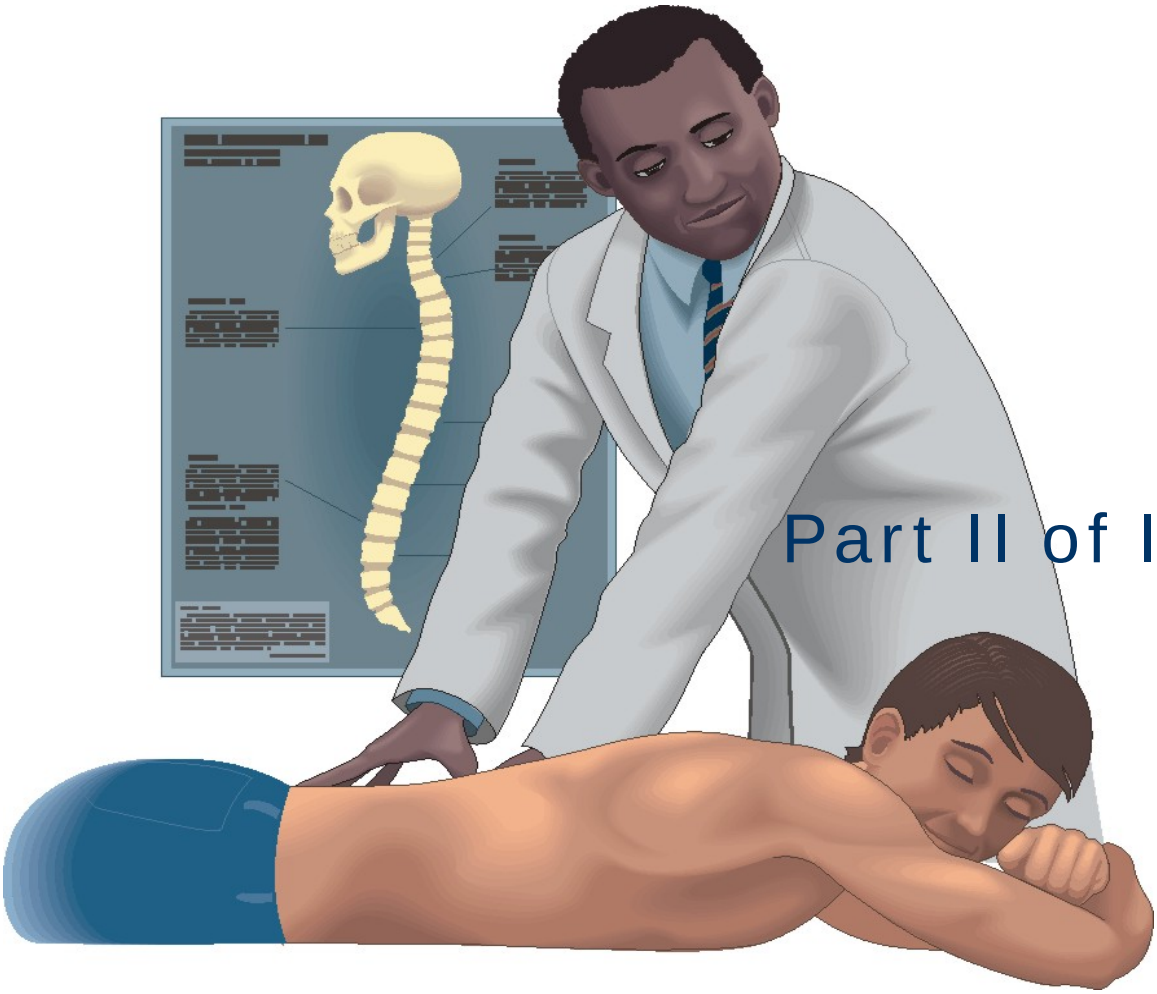
Investigators' Guide to Understanding

Chiropractic Law



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- **Investigators' Guide to Understanding Chiropractic Law - Part III**
- **The One Minute Fraud Expert - Identifying Fraud in One Minute or Less from the Medical Specials**

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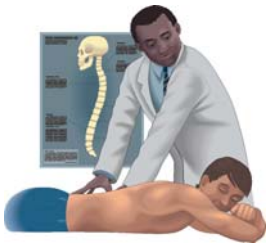

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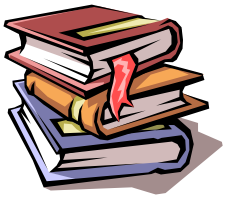

Miscellaneous:

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Feature Article

Investigators' Guide to Understanding Chiropractic Law

Part II

Part I of this article, which appeared in our last issue, discussed in detail, the Chiropractic Initiative Act of 1922, California Code of Regulations, Section 302 et seq. In this issue we continue our study of chiropractic law from the perspective of the investigator concerned with suspect claims, focusing on the California Business & Professions Code and specific case law, including the California Appellate Court decisions cited as Crees vs. State Board of Medical Examiners, People v Fowler and People v Mangiagli.

In addition to the Chiropractic Initiative Act of 1922, the underlying legal authority and administrative regulations established by the Chiropractic Board in the California Code of Regulations, Title 16, Section 301 et seq., significant chiropractic regulations are found in the California Business & Professions Code.

The California Business & Professions Code, Section 1000 Et Seq:
This section of the B&P Code details additional responsibility of the Board and requirements of chiropractic corporations. Of these, the most useful is section 1050, which mandates that chiropractic corporations must be registered with the Board in order to provide chiropractic services and must apply for and obtain a certificate of registration from the Board. The corporate certificate is issued in the same manner as a chiropractic license and can be verified through the Board in the same manner as one would verify a professional chiropractic license. This section also mandates compliance with the Moscone-Knox Professional Corporations Act.

The related and imminently useful statute is Section 1054, which limits the name under which a chiropractic corporation can practice to the name or names of current, former or prospective shareholders, who must also be licensed chiropractors. This regulation is a direct by-product of Section 10(b) of the Chiropractic Initiative Act, which prohibits the practice of chiropractic under a false (fictitious) or assumed name. One therefore knows immediately if a chiropractic clinic is operating legally by the mere fact that it may be operating under a fictitious business name, whether a corporation or not, but especially when the clinic is a corporation, as the Board will not issue a corporate certificate to a clinic operating under a false or fictitious name. Other corporate regulations are referenced in this section and are frequently useful when a chiropractic corporation is involved.

Crees V. State Board Of Medical Examiners:
On April 20, 1963 the California District Court of Appeals, Second District, Division 2, heard an appeal by plaintiffs in re a case originally heard in Los Angles, Superior Court and cited as Crees vs. California State Board of Medical Examiners, et al. A rehearing was denied on March 21, 1963 and again on April 17, 1963. To our knowledge, this decision has not subsequently been overturned.

The trial court was upheld in its decision and various opinions, including the following:

The statute authorizing chiropractors to practice chiropractic “as taught in the chiropractic schools or colleges” (Chiropractic Initiative Act Section 7) does not authorize the practice by a chiropractor of “anything” taught in chiropractic schools, but only that which is actually “chiropractic” and only as chiropractic was understood in 1922.

We would point out that if the term “anything taught in chiropractic schools” was taken literally,

the chiropractic schools could undertake to teach black magic, broadening the scope of chiropractic practice therefore to include the use of black magic in correcting vertebral subluxations.

The court also ruled that practices that had developed in the chiropractic profession were not admissible in determining what practice and procedures could properly be performed under a chiropractic license. One notable development in chiropractic practice has been the additional practice of physical therapy, a separate healing art also requiring a license to practice in California.

Anyone familiar with the advent of chiropractic by Dr. D.D. Palmer and his son B.J. Palmer understands that the entire basis of chiropractic during the years of its discovery and development by the Palmers, was subluxated (or displaced) vertebrae.

It was believed by the Palmers that displaced vertebrae impinged on nerves, causing virtually all disease. D.D. Palmer claims to have cured the flu, epilepsy and heart disease with chiropractic. What is less commonly known is that D.D. began his healing career as a magnetic healer, curing all manor of infirmity by the application of magnets to various areas of the body. In 1905 Palmer was convicted of practicing medicine without a license and spent time in jail.

B.J. Palmer who took his father's chiropractic ball and ran with it was also known as a bit of an eccentric at the time. B.J. liked to go to bed early and, when his bed time came, he would bid his guests good night and simply get up and go, regardless of the guests or the activities occurring at the time. B.J. was also known to insist upon sleeping with his head pointed toward the north pole and his feet toward the south, believing this was the only way the earth's currents would flow through him properly and make for a restful night's sleep. He was also known to have a collection of human spines, which he hung in rows along the walls of the third floor of his home.

But all that is the topic of another discussion. The point is, the original chiropractic theory of vertebral subluxations has since largely debunked by legitimate science. Even the elite of modern day chiropractic do not subscribe to the subluxation theory. According to the modern chiropractic elite, chiropractic is not about subluxation, it is about mobilization.

That may be true in other states, but not in California, where the practice of chiropractic is limited to chiropractic as it was understood in 1922.

With regard to the unlicensed practice of physical therapy, by either doctors of chiropractic or their unlicensed, minimum wage, "chiropractic assistants", the trial court in Crees was upheld by the appeals court in ruling that regulations adopted by the Board of Chiropractic Examiners which purported to alter or enlarge the scope of practice of chiropractic were invalid.

The court further held that "a duly licensed chiropractor may only practice or attempt to practice or hold himself out as practicing a system of treatment by manipulation of the joints of the human body by manipulation of anatomical displacements..."

Use of "other measures" was limited and could not be utilized "for the purpose of treatment" apparently ruling out the use of physical therapy modalities which are clearly used for the purpose of treating soft tissue injuries. The absence of any documented clinical need to manipulate the spine would therefore appear to rule out the involvement of a chiropractor in the treatment of any condition.

Moreover, the cases cited in this article specifically prohibit chiropractors from "invading the practice of medicine". Physical therapy, technically referred to as "physical medicine" has historically been included under the practice of medicine, requiring a medical license until the physical therapy practice Act was passed, thereafter requiring either a medical or physical therapy license.

People V. Fowler, 32 Cal.App.2d Supp. 737 (1938)

In People v Fowler, the defendant was convicted of practicing medicine without a license. Fowler appealed the conviction and the following excerpt is taken from the appellate ruling. This case, along with People v Mangiagli, provided the bases for the Crees decision.

In Fowler, the appellant cited Section 7 of the California Chiropractic Initiative Act, which is the one and only statute that legitimately establishes the scope and limitations of practice for chiropractors. That portion of the Act cited by Fowler states that chiropractors may practice chiropractic and "anything taught in the chiropractic schools." The appellate court in Fowler was the first to interpret the meaning of that phrase to be "anything" as long as it was chiropractic, as chiropractic was understood at the time the Act was passed in 1922.

The following excerpt from the cited case provides a number of sources providing a clear understanding of what chiropractic was understood to be in 1922:

> "In volume 11 of Corpus Juris, which was published in 1917, the following definition is given for "chiropractics": "A system of healing that treats disease by manipulation of the spinal column; the specific science that removes pressure on the nerves by the adjustment of the spinal vertebrae. There are no instruments used, the treatment being by hand only"; in support of which Webster's Dictionary is cited, also several court decisions. In State v. Barnes, (1922) 119 S. C. 213 [112 S.E. 62, 63], the court [32 Cal.App.2d Supp. 746**]** said: "Chiropractic has been defined, and is commonly understood, as a system of treatment by manipulation of anatomical displace-ments, especially the articulation of the spinal column, including its vertebrae and cord." In State v. Hopkins, (1917) 54 Mont. 52 [166 P. 304, 306, Ann. Cas. 1918D, 956], the court quoted from Webster's New Standard Dictionary this definition of "Chiropractic": "A system of [or] the practice of adjusting the joints, especially of the spine, by hand for the curing of disease." In Commonwealth v. Zimmerman, (1915) 221 Mass. 184 [108 N.E. 893, 894, Ann. Cas. 1916A, 858], the court quoted from Webster's International Dictionary a definition of "chiropractic" as follows: "A system of healing that treats disease by manipulation of the spinal column." The same definition was cited in State v. Gallagher, (1911) 101 Ark. 593 [143 S.W. 98, 38 L.R.A. (N. S.) 328, 330], and State v. Johnson, (1911) 84 Kan. 411 [114 P. 390, 41 L.R.A. (N. S.) 539, 541]. In Board of Medical Examiners v. Freenor, (1916) 47 Utah, 430 [154 P. 941, 942, Ann. Cas. 1917E, 1156], the court quoted definitions of "chiropractic" as follows. "A system of therapeutic treatment for various diseases, through the adjusting of articulations of the human body, particularly those of the spine, with the object of relieving pressure or tension upon nerve filaments. The operations are performed with the hands, no drugs being administered." (taken from Nelson's Encyclopedia), and "A system of manipulations which aims to cure disease by the mechanical restoration of displaced or subluxated bones, especially the vertebrae, to their normal relation". (from International Encyclopedia)."

People v Mangiagli 97 Cal.App.2d Supp. 935 (1950)

In People v Mangiagli, the appellate court referred to the Fowler case and confirmed that ruling. In their ruling, the Court discounted the defense submitted by the errant chiropractor, who contended that chiropractic law authorized him to practice anything taught in chiropractic schools. In shooting this theory down, the court restated the limits of chiropractic practice as “the practice of adjusting the joints, especially of the spine, by the hand…” In this case the court stated:

> “Considerable time was consumed at the trial by the introduction of evidence by defendant to show that what he did is now taught in chiropractic schools and colleges. This matter was discussed in the Fowler case, supra, where we held that section 7 authorized, by the provision, numbered as [1] above, nothing that was not chiropractic, as that term was understood in 1922, when the act was passed, and that the term was [97 Cal.App.2d Supp. 939] then defined as "A system of [or] the practice of adjusting the joints, especially of the

spine, by hand for the curing of disease" (32 Cal.App.2d Supp. 745-6). We further said, regarding chiropractic schools: "The effect of the words 'as taught in chiropractic schools or colleges' is not to set at large the signification of 'chiropractic,' leaving the schools and colleges to fix upon it any meaning they choose. Were the word 'chiropractic' of unknown, ambiguous or doubtful meaning, this clause, 'as taught' etc., might serve to provide a means of defining or fixing its signification, but there is here no such lack of clarity. The scope of chiropractic being well known, the schools and colleges, so far as the authorization of the chiropractor's license is concerned, must stay within its boundaries; they cannot exceed or enlarge them. The matter left to them is merely the ascertainment and selection of such among the possible modes of doing what is comprehended within that term as may seem to them best and most desirable, and so the fixing of the standards of action in that respect to be followed by chiropractic licensees."

Summary:

The practice of chiropractic is primarily subject to the initiative enacted by the people of California in 1922. Any subsequent statutes, codes, or regulations in conflict with this act are invalid.

Chiropractors cannot practice physical therapy. Chiropractors cannot provide physical therapy modalities in treating soft tissue injuries. Chiropractors may not direct other persons, licensed or unlicensed, to practice or provide physical therapy, in violation of the Physical Therapy Practice Act. Chiropractors may only manipulate anatomical displacements on those rare occasions when such displacements are actually present. The theory of vertebral subluxations as the cause of human disease is all but a dead concept, even by the admission of licensed chiropractors who now attempt to redefine the entire concept of chiropractic.

Whether or not the modern theory of chiropractic is correct, and whether or not chiropractic, as it is now practiced, may or may not have been proven efficacious in clinical studies, chiropractic practitioners cannot exceed the scope of practice granted them in the initiative act of 1922, nor does the chiropractic board have the authority to alter or broaden the scope of practice established in the act, nor does the California Legislature have the authority to do so, or to codify the Act.

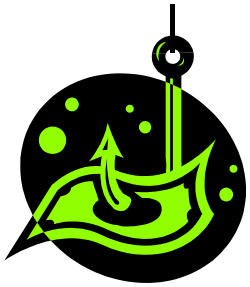
Investigators assigned the task of investigating suspect chiropractic clinics should therefore include in their investigative efforts any information and documentation that would serve to establish and document violations of any one of the three primary sources of chiropractic law and regulation, directed by existing case law as to the scope of practice. An understanding of the various and complex sources that make up chiropractic law will serve to produce a more competent investigator and result in highly effective work product of significant value to the claims professional.

In the third and concluding segment of this series in our next issue, we will discuss the various schemes used by chiropractors in false and fraudulent insurance claims, how to identify false claims and/or crooked clinics and effective protocols for the investigation of chiropractic clinics, including ever more frequently occurring chiropractic clinic masquerading as a medical group.

About the Author:

Eric Tackett is a former law enforcement investigator currently serving as director for the investigative firm of Eric Tackett & Associates. He also serves as Director of Training for the California Investigative Academy, a California Department of Insurance (CDI) approved CE provider. Mr. Tackett also serves on the Board of Directors of the Southern California Fraud Investigators' Association. He is also a member of the CDI Workers' Compensation Fraud Advisory Board Training Work Group. He has previously served on the Board of Governors of the National Health Care Anti-Fraud Association. Questions or comments on the covered topic may be directed to the author at (714)963-7102, or by email at etackett@tackettassociates.org.

Fraud Trends/New Scams



Gone Phishin'

Identity theft is not new. Nor are the various scams in use for a number of years designed to separate victims from their identification information. Among the more current and rising trends is a technique known to computer geeks and those in the know as "Phishing." And, although the earliest form of "phishing", known then as "phreaking," started in the mid-nineties, the practice has been on the rise dramatically over the past two years, increasing by 60% in 2004. It is part of the hacker jargon to replace "f" with "ph".

"Phishing" involves the use of false email communications and/or web sites for the purpose of obtaining identification or banking information, passwords, or other personal information that would make it possible for the scammers to steal your money, your identity, or both. The term derives from the use of false information as "bait" to lure unsuspecting victims to a hackers web site, convincing them to provide personal, financial, or password information through what have become elaborate but false web site fronts.

One of the more frequent versions on the rise among "phishermen" involves what appears to be an email from the target's bank. An actual example of such a false email is found on the following page.

The letter alerts the target to the increasing number of on-line banking scams being discovered. In order to safeguard your personal banking information, it is imperative that you update your account information with your bank. A link to your banks web site is provided in the email for your convenience. However, the link does not take you to your banks web site. Instead, it takes you to a virtual replica of your banks web site, complete with an information update page. The web site is actually completely under the control of the "phishermen" and the updated information you provide gives them all they need to do what they do best - steal your money and/or your ID.

Although it is thought that only about 5% of targets actually respond to these emails, providing their personal, financial or password information, the fact that these are sent out in bulk to thousands and perhaps even hundreds of thousands of potential victims makes it worth the effort.

There are a number of key points in detecting these scams. The first and most significant is that your bank is not going to contact you in an email asking you to provide personal information. As seen in the example on the next page, the greeting is generic. The actual text of the message indicates either a lack of education or English as a second language. Hacker jargon in the message is also a giveaway. There will also typically be some urgency, perhaps giving a very short time limit for response. The time limit is, of course, because the entire scam will have changed locations by the following day to avoid detection.

See how may of these and other indicators you can find in the sample on the next page.

Legislative Update

SB 12

Introduced by Senator Figueroa
February 20, 2004

Workers' Compensation False Claims Act

SB 12, introduced by Senator Figueroa in February of this year. The purpose of the bill is to enact legislation similar to the federal and state false claims acts already in existence.

Although, upon first blush it would appear to be redundant, since there are an abundance of laws prohibiting fraudulent false claims, including those specifically relating to workers' compensation fraud. However, there are a few key differences.

As is the case with the California False Claims Act, as set forth in Section 1871.7 of the California Insurance Code, this statute would provide an excellent civil tool for combating fraud. Like 1871.7, this legislation would provide a civil tool making it possible for insurers to take legal matters into their own hands and in their own defense. And, as in the case of the other whistleblower statutes, anyone with original information can file suit.

The key differences between this legislation and the CIC 1871.7 are these:

The statute would become part of the Labor Code.

The qui tam plaintiff is eligible to receive at least 15% and up to 33% of the proceeds of the action or settlement in cases where the Attorney General intervenes. CIC 1871.7 currently provides for at least 15%, but not more than 25% of the proceeds.

In cases where the Attorney General does not intervene, the qui tam plaintiff is eligible for at least 33% of the proceeds of the action or settlement and as much as 60%. CIC 1871.7 currently provides for at least 25%, but no more than 30%.

There are, of course, other stipulations and exceptions, but these are the key features.

We'll be keeping an eye on this one for you and report its progress through the senate.

~

For the full text of
Senate Bill 12
Click Here

For the full text of the new
Work Comp Reform Bill
Click Here

Provider Spotlight

New Member: Clinic of the Month Club

Galen, LLC

Although you can't really tell it from the company name, Galen, LLC is not a clinic. As a matter of fact, you can't really tell anything about the company by the name, except that it is a limited liability company. Maybe it was intended that way. Moreover, on the surface and based on preliminary research of the business filing and principal, there's not much to know. Galen is a provider of services of a sort, however. You see, Galen is a third party billing company.

For reasons that will become obvious, we have decided to forego our usual criterion for the Provider Spotlight and admission to the Clinic of the Month Club, especially for Galen, LLC

While seemingly somewhat innocuous and, perhaps even a little boring, with a little bit of additional research, this third party billing company becomes quite interesting. The history of the business interests and associations of the principal of record gives rise to serious case for concern for anyone receiving billing documents from this source. If you have any paper with the name Galen, LLC on it, the name of the principal, or the name of her primary business associate, you should seriously think about taking another look at those claims and billing forms – particularly if you are receiving healthcare claims for emergency services south of the border.

According to the Secretary of State, the principal for Galen, LLC is one Julissa Alexander. The company is located at 3450 Bonita Rd. #206, Chula Vista, CA 91910. LLC documents were filed on 05/31/2002. The current status is listed as "Active." The company type is listed as "Billing Service". There is very little else on record about this company or about its principal, other than a couple of previous business filings.

One of those business filings was for a company of similar purpose, identified in an 11 year old fictitious business name (FBN) filing only as Medical Provider Services. The one item of interest in this filing was the co-owner, identified as Leroy Alexander. It was when research was conducted on Leroy that it became very interesting.

It seems Leroy was the corporate president of record for a California corporation doing business as Medical Provider Services, Inc. The corporation was formed three years after Julissa and Leroy filed the original FBN documents for the same company. This corporation is currently suspended, having been suspended by the Franchise Tax Board in March of 2000. Interestingly, this was only two months before Leroy was released from federal prison. Perhaps if he'd gotten out a little sooner, he might have been able to save the corporation from suspension; but then again, maybe not.

You see, Leroy had been serving time for health care fraud. He was operating Medical Provider Services, Inc. at the same time as the FBI was operating sting as part of an investigation into a huge false billing ring that involved a number of Mexican doctors operating in Mexico.

The scam worked with a number of variations that resulted in U.S. insurers being billed either for services that were never provided, or that were not covered by the healthcare plans. One of the more popular variations was providing patients plastic surgery and billing as emergency services.

In all cases the billing was inflated, if services were provided at all.

The FBI Sting operation was dubbed Operation Sure Buck. It resulted in the arrest and conviction of more than 21 persons, including 15 doctors licensed in Mexico and operating out of Tijuana. Alexander plead guilty in 1998 and was out in 2000.

In addition to the medical billing service in operation at the time of the FBI sting, Alexander also owned two corporations purporting to be Mexican hospitals, in addition to a number of other companies of unknown purpose. The hospitals operated under the names Ready Med Hospital, S.A. De C.V. and America's Hospital, S.A. De C.V. Both were registered with the California Secretary of State as foreign (Mexican) corporations. Both are inactive at this time; one was forfeited and the other was "surrendered."

Of some concern is the fact that Alexander apparently has a currently active company, operating as Alme International, LLC. The purpose listed in the filing is "Medical Evacuation and Consulting." If you're getting bills from this company for any reason – heads up!

Now, we don't know at this point whether there is any documented connection between Leroy and Galen, LLC, but there are numerous connections between Julissa Alexander and Leroy Alexander. Not only are there past business connections, including the billing company in operation at the time of the FBI Sting, but also at least one current business operation (Alme International), property filings, and business telephone listings. In addition, both use the same attorney for their business filings and corporate/LLC agent of record.

Alexander was put on the OIG's Excluded Provider list in September of 2000 and was still listed at the time of this writing.

No, Galen is not a clinic, but welcome to the club anyway!

"Book `Em!"

Names in the News

We Told You So!

In March of this year, we submitted a report to one of our clients who asked us to complete a medical file review and conduct a preliminary background check of two providers, Greybor Medical Transportation and Utrans. Upon completion of our assignment, we recommended that the claim be immediately referred to the the CDI Fraud Division and the L.A. D.A.'s office.

The following month, on April 5, 2004, the U.S. Department of Justice issued a press release announcing the conviction of the principals, who were also the subjects of our investigation and research. Our findings are too complex to include here, but the following provides a listing of all the various business enterprises the three principals were involved in. If you had any claims that included services or supplies provided or associated in any way with any of those persons or business entities listed below, you may want to take a closer look at them. Included in the following is the USDOJ press release, detailing some of what these characters were doing.

BORIS SHPIRT:
Boris Shpirt is listed in corporate filings as the current president of Greybor Medical Transportation, Inc. In addition, Shpirt has been associated with all of the following business entities:

Greybor Medical Center Cyber 21 Productions
Belmont Medical Supplies, Inc.
Medical Emergency Vehicles Admin. Center, LLC
BJSH Enterprises, Inc.
The Great American International Lycee, Ltd.
Lexington Undertakings, Inc.
Best World Products, Inc.
Pride Medical Industries, Inc.

Shpirt has also been sued by all of the following:

State Farm Mutual Insurance
State Farm Fire & Casualty
Farmers Insurance Group
Home Savings of America
The People of California
East L.A. Health Task Force

JENNY SHPIRT:
Jenny Shpirt is listed as the primary principal and agent for Utrans, LLC. She is also identified in a number of other business entities and named in law suits associated with Boris Shpirt and his various enterprises. Jenny Shpirt has been associated with all of the following business entities:

Floras Supps Co.
Mutifit Ser Co.
Sherwood
Atlantis Group, LLC.
Medical Emergency Vehicles Admin. Center, LLC.
BJSH Enterprises, Inc.
The Great American International Lycee, Ltd.
Peaceful Mind Foundation

Jenny is named in most of the same civil actions as Boris.

GREGORY PLOTKIN:
Gregory Plotkin is named as one of the principals of Greybor Medical Transportation, Inc. In addition, Plotkin is associated with all of the following business entities:

Friendly Landlord Enterprises
Infinity Merchandise Co.
International Film Exchange
The Vilana Co.
GM Medical Management
New Ways, Inc.
Gaba Medical Industries
Octogon Internet Enterprises, Inc.

Plotkin is also named in a number of civil actions, both as plaintiff and defendant.

DEBRA W. YANG
United States Attorney
Central District of California

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April 5, 2004

PRINCIPAL OF GREYBOR MEDICAL TRANSPORTATION GUILTY OF FEDERAL HEALTH CARE FRAUD, MONEY LAUNDERING CHARGES

An owner and operator of Greybor Medical Transportation, a Los Angeles-based ambulance company, was convicted today on federal health care fraud and money laundering charges for, among other things, billing Medicare for the transportation of bedridden patients who were in fact ambulatory.

Boris Shpirt, 50, of Beverly Hills, was convicted this afternoon by a federal jury in Los Angeles. The jury convicted Shpirt of conspiracy, 11 counts of health care fraud, six counts of money laundering, two counts of filing false tax returns and six counts of laundering money for the purpose of defrauding the Internal Revenue Service.

Shpirt's wife, Jenny, 43, was also convicted this afternoon when the jury found her guilty of conspiracy, two counts of health care fraud, two counts of filing false tax returns and six counts of laundering money for the purpose of defrauding the IRS.

This case marks the first time that anyone has been convicted in this district of money laundering for the purpose of defrauding the IRS.

Greybor itself was convicted of conspiracy and nine counts of health care fraud. A fourth defendant, Daniel Gonzalez, a 29-year-old Pico Rivera man, who was a supervisor at Greybor, was found guilty of conspiracy and eight counts of health care fraud. (The jury was unable to reach a verdict on one count of health care fraud against Gonzalez.)

Boris Shpirt's partner and co-owner of Greybor, 50- year-old Gregory Plotkin of Beverly Hill, previously pleaded guilty and testified at trial against his co-defendants. Plotkin pleaded guilty to conspiracy to commit health care fraud.

A sixth defendant in this case, Robert White, died prior to trial.

The evidence presented during a four-week trial showed that Greybor regularly submitted claims to Medicare that falsely stated a patient was "bed-confined," when in fact the Medicare beneficiary was not. In some cases, the patient was transported while sitting in the front seat of the ambulance. These false statements to the government insurance program allowed Greybor to be reimbursed by Medicare when it was not entitled to receive payment. Medicare will pay for ambulance transportation only if no other option is available and only if the patient is bed-confined.

On many occasions, Greybor ambulances were used to transport four or five patients simultaneously, but Greybor later submitted claims to Medicare which indicated the Medicare beneficiaries were being transported individually.

Furthermore, Greybor falsely claimed that patients were being taken to dialysis treatment, which would be reimbursed by Medicare, when in fact they were being transported for other treatments that would not lead to reimbursement by Medicare.

The fraudulent bills submitted by Greybor to the Medicare program caused losses of more than $5 million.

Shpirt and Plotkin also ran two durable medical equipment companies - Pride Medical Industries and GABA Medical Industries. The indictment alleges that Boris Shpirt and White provided medical equipment to Spanish-speaking individuals who did not want or need the equipment. Medicare will pay for medical equipment only if the item is necessary and reasonable for the treatment of an illness or injury.

Employees of Pride and GABA would use counterfeit prescriptions to deliver inexpensive and unnecessary medical equipment to Medicare beneficiaries. The employees would convince the Spanish-speaking beneficiaries to sign English-language documents that turned out to be receipts for the unnecessary equipment, as well as more expensive equipment that was never delivered. Boris Shpirt submitted claims to Medicare for the unnecessary and non-existent medical equipment.

The Shpirts' scheme to defraud the IRS led the couple to launder proceeds from Greybor through a company they set up. In addition to claiming that money from Greybor represented loan repayments instead of income, the Shpirts used income from their company to pay rent and to pay for the construction of their Beverly Hills home. In 1999 and 2000, the Shpirts underreported their income by more than $1.1 million.

The conspiracy charge carries a maximum penalty of five years in federal prison. The health care fraud charges carry a penalty of up to 10 years for each count. The money laundering charges each carry a maximum penalty of 10 years. And the charges related to the false tax returns carry maximum penalties of three years in prison.

This case is the product of an investigation conducted by the Department of Health and Human Services, Office of Inspector General; IRS-Criminal Investigation; and the California Bureau of Medi-Cal Fraud and Elder Abuse.

Release No. 04-045

Other Press Releases
2nd Quarter 2004

DEBRA W. YANG
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February 18, 2004

ORANGE COUNTY PODIATRIST CONVICTED IN $800,000 MEDICARE BILLING SCAM

An Orange County podiatrist has been convicted on charges of fraudulently billing Medicare for more than $800,000 in procedures that were never performed.

Mark Douglas Little, 43, of Anaheim Hills, was convicted Tuesday afternoon by a federal jury in Santa Ana of 26 counts of health care fraud. Little operates Astra Foot and Ankle Center in Orange, and he works out of numerous other offices and hospitals throughout Orange County.

The evidence presented at trial showed that Little used the names and Medicare beneficiary numbers belonging to a few of his elderly patients to create and submit bogus claims for services that were never performed. Specifically, Little submitted claims for daily or almost-daily surgical procedures and casting on these same patients for months, sometimes years, at a time.

The investigation into Little began when a Medicare beneficiary reviewed her Medicare statement and noticed that Little had billed Medicare for more than 70 procedures he had never performed. That beneficiary called Medicare's hotline number to complain. In its investigation, Medicare noticed the same type of daily or almost-daily billing for Little's top-ten highest billed patients. When these patients were interviewed, they stated that they only saw Little once every two weeks or once a month, and then they only received toenail clippings.

Among podiatrists in Orange County, Little submitted the largest amount of claims to Medicare, even though he had far fewer patients then the next highest-billing podiatrists. In fact, Little's ten highest-billed patients generated approximately $800,000 in Medicare claims and accounted for 90 percent of his total Medicare income.

Little is scheduled to be sentenced on April 9 by United States District Judge David O. Carter. Little faces a statutory maximum sentence of 10 years in federal prison for each count, although his actual sentence will be determined by the United States Sentencing Guidelines.

The case was investigated by the Federal Bureau of Investigation and the United States Department of Health and Human Services, Office of Inspector General.

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February 4, 2004

OPERATOR OF LONG-RUNNING PONZI SCHEME IN ORANGE COUNTY INDICTED ON FEDERAL FRAUD, MONEY LAUNDERING CHARGES

James P. Lewis Jr., who ran Financial Advisory Consultants, claimed to have nearly $814 million under management - but had only $2 million in bank

The man who ran Financial Advisory Consultants (FAC), allegedly bilking several thousand victims out of millions of dollars, was indicted today on federal mail fraud and money laundering charges for allegedly operating a massive Ponzi scheme

James Paul Lewis Jr., a 57-year-old resident of Villa Park, was indicted today by a federal grand jury in Santa Ana on five counts of mail fraud and nine counts of money laundering.

After special agents with the Federal Bureau of Investigation executed a search warrant at FAC on December 22, 2003, Lewis apparently fled Southern California. Lewis was named in a federal criminal complaint filed on January 14. Lewis was arrested on January 22 by FBI agents at a hotel in Houston, and he is currently being transported back to Orange County by the United States Marshals Service.

"The swift action in this case demonstrates the Justice Department's resolve to aggressively pursue and prosecute con men, fraudsters and other white-collar crooks," said United States Attorney Debra W. Yang, who is a member of the Corporate Fraud Task Force. "While FAC operated for many years, a grand jury has indicted Mr. Lewis only six weeks after the FBI first searched his company. In addition to seeking the appropriate punishment for Mr. Lewis, we will also diligently work to recover as much of the victims' money as possible."

According to court documents, Lewis offered investors two purported investment opportunities: a Growth Fund and an Income Fund. Lewis, through false and fraudulent brochures and other promotional material issued by FAC, told investors that they would earn annual rates of return of up to 18 percent in the Income Fund, which claimed to generate revenue from the leasing of medical equipment, commercial lending and financing insurance premiums. FAC promised investors 40 percent annual returns in the Growth Fund, which claimed to generate revenue through the purchase and sale of distressed businesses.

Lewis induced investors to contribute at least $200 million to FAC.

Instead of using the investors' money as promised, Lewis used the funds to further the scheme and to enrich himself and others. Lewis used investors' funds to purchase homes in Villa Park, Laguna Niguel, Palm Desert, San Diego and Greenwich, Connecticut. He also allegedly used investors' money to purchase luxury automobiles, jewelry and other gifts for himself, friends and family members.

In addition to spending the money on consumer goods, Lewis used FAC money from 1996 to 2003 to trade currency futures, incurring losses of at least $22 million. Lewis also utilized investors' funds to invest in companies, including one where he served as president.

To conceal the scheme at FAC, Lewis used the money of new investors, or subsequent investments of existing investors, to pay the rates of return promised to prior investors to effectuate a Ponzi scheme.

As of December 2003, according to court documents, FAC's computer records showed that FAC had nearly 3,300 investors with a purported total balance of $813,932,080. However, on December 22, 2003, FAC and Lewis's bank accounts held only slightly more than $2 million. Investigators and a court-appointed receiver are still calculating the actual losses suffered by victims.

"The accused, James Paul Lewis Jr., will face swift and certain justice at the hands of the United States Department of Justice and on behalf of the many victims who entrusted him with their life savings," said James Sheehan, Acting Assistant Director in Charge of the FBI Field Office in Los Angeles. "This case should serve as a reminder to the investing public that they should closely scrutinize how they invest their hard-earned money and with whom, and to be ever mindful of the old financial truism that if it sounds too good to be true, it probably is."

An indictment contains allegations that a defendant has committed a crime. Every defendant is presumed innocent until and unless proven guilty.

If he is convicted of all 14 counts in the indictment, Lewis faces a maximum possible sentence of 240 years in federal prison.

This case is the product of an extensive and ongoing investigation by the Federal Bureau of Investigation and IRS-Criminal Investigation.

Release No. 04-014

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February 2, 2004

COAST PLAZA DOCTORS HOSPITAL AND THE ESTATE OF FORMER CEO PAY $4.1 MILLION TO SETTLE MEDICARE FRAUD CLAIMS

Coast Plaza Doctors Hospital in Norwalk and the estate of the former chief executive have agreed to pay the United States more than $4.1 million to resolve allegations that Coast Plaza and the former CEO defrauded the federal Medicare program, United States Attorney Debra W. Yang announced today.

Coast Plaza and the estate of Gerald J. Garner agreed to pay $4,106,735 to resolve allegations that the hospital and Garner defrauded Medicare, the taxpayer-funded health care insurance program for many of the nation's elderly and disabled.

Coast Plaza is an approximately 123-bed acute care facility, and Garner was the hospital's chief executive officer and chairman of the board until he died after an automobile accident in April 2002.

The settlement resolves a portion of a "whistleblower" lawsuit filed in 1999 by Raul Lopez, a former chief financial officer of Coast Plaza. After the settlement was paid on January 27, the government asked that the Medicare fraud claims in the lawsuit be dismissed. The United States Attorney's Office learned that United States District Judge Gary L. Taylor today signed the dismissal.

For the fiscal years 1994 through 1999, hospitals were generally reimbursed by Medicare for their reasonable, necessary and actual expenses incurred in providing hospital services to Medicare patients. Medicare was defrauded by Coast Plaza and Garner's alleged practice of:

- writing checks to a variety of vendors and other payees;
- immediately posting the check amounts as expenses in the hospital's accounting system;
- claiming and receiving reimbursement from Medicare for a portion of the posted expenses; and
- never actually sending or delivering the checks to the payee.

The checks were allegedly voided and re-booked to general ledger accounts described by Coast Plaza as "Checks Held" and "Discount Friends of CPDH."

The lawsuit alleged that Coast Plaza and Garner failed to offset the voided amounts against allowable and reimbursable costs claimed from Medicare. As a result, Coast Plaza allegedly received reimbursement from Medicare - and ultimately from the taxpayers who fund the program - for expenses the hospital never actually paid.

Coast Plaza and Garner also allegedly made claims to Medicare for expenses that were unrelated to caring for Medicare patients or were non-allowable pursuant to applicable Medicare regulations. As a result, Coast Plaza received additional Medicare funds to which it was not entitled.

The $4,106,735 settlement represents an amount 2½ times the loss suffered by the Medicare program.

Pursuant to the *qui tam* provisions of the False Claims Act, Mr. Lopez as "whistleblower" will receive 17.5 percent - $718,678.63 - of the settlement. Coast Plaza and Garner's estate have agreed to pay Mr. Lopez an additional $27,200 to cover attorney's fees, costs and expenses.

Garner's widow, Joan Garner, in her capacity as the executor of his estate, agreed to accept financial responsibility for the settlement along with Coast Plaza.

In addition to making the settlement payment, Coast Plaza executed a separate Integrity Agreement with the United States Department of Health and Human Services, which oversees the Medicare program.

The case was prosecuted by the United States Attorney's Office for the Central District of California, which received investigative assistance from the Office of Inspector General for the Department of Health and Human Services, the Federal Bureau of Investigation, and IntegriGuard, LLC, a Medicare program safeguard contractor.

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February 2, 2004

NORTHERN CALIFORNIA MAN GUILTY IN FRAUD SCHEME THAT COST ELDERLY VICTIMS AT ORANGE COUNTY RETIREMENT COMMUNITY NEARLY $5 MILLION

SANTA ANA, Calif. - A Redding, California man has been convicted of a series of federal criminal charges stemming from his operation of a fraud scheme that defrauded elderly victims out of nearly $5 million, United States Attorney Debra W. Yang announced today.

After deliberating for five days, a federal jury late Friday convicted Christopher Peter Cook, 36, of four counts of mail fraud and eight counts of money laundering. The jury that convicted Cook heard 14 days of testimony, including several elderly individuals who said the scheme cost them their life savings. During the time of the scheme, Cook lived in several Southern California cities including Long Beach, Trabuco Canyon and Rancho Santa Margarita.

Christopher Cook's brother - Perry Cook, a 29-year-old resident of Kirkland, Washington - pleaded guilty during the course of the trial to two counts of mail fraud. Perry Cook previously lived in Long Beach, Trabuco Canyon and Snohomish, Washington.

United States District Judge Gary L. Taylor, who presided over the trial, is scheduled to sentence both defendants on May 17.

The evidence presented at trial showed that Christopher Cook and others operated several companies from July 1995 until July 1998. Those companies included CD Services, Inc. (CDSI), which had offices in Long Beach and Laguna Hills; Nationwide CD Corp. (NCD) in Laguna Hills; Leisure World Financial in Seal Beach; and U.S. Financial Advisors in Redding.

These companies solicited senior citizens to invest in certificates of deposit which the Cooks and co-schemers told victims were identical to those at local banks. The Cooks and their associates promised victims that their CDs had higher interest rates than those offered at local banks, and that the CDs could be withdrawn at any time. Additionally, victims were told that the CDs would be held by a third party custodian, namely CDSI.

In fact, CDSI and the other companies were controlled by Christopher Cook and the co-schemers. CDSI placed the money invested by the elderly and widowed victims into CDs that had maturities of up to 25 years, and they commingled victims' monies to purchase jumbo CDs exceeding the FDIC insurance limit of $100,000. CDSI also diverted significant percentages - up to 52 percent - of victims' monies to members of the scheme to pay "commissions."

When victims asked to withdraw their monies, the Cooks and representatives at CDSI explained that an "early withdrawal penalty and market valuation" of up to 50 percent would be assessed in order to disguise the fact that the scheme diverted victims' monies for the personal benefit of the Cooks and other co-schemers.

CDSI targeted elderly victims, many of whom lived in Orange County's Leisure World retirement community.

CDSI and NCD were placed into receivership by the California Department of Corporations in July 1998. The receiver appointed in the case was able to recover some of the victims' monies.

During the course of the scheme, the Cooks and the co-schemers solicited more than $12 million from elderly and infirmed investors. From that total, approximately $4.8 million was diverted to the Cooks and their associates.

When he is sentenced, Christopher Cook faces a maximum statutory penalty of 180 years in federal prison. Perry Cook faces a maximum prison term of 10 years.

This case was investigated by the Federal Bureau of Investigation, the United States Postal Inspection Service, IRS-Criminal Investigation and the California Department of Justice.

Release No. 04-010

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January 20, 2004

TEAM PHYSICIANS FOR LAKERS, DODGERS AND KINGS PAY $2.65 MILLION TO SETTLE HEALTH CARE FRAUD ALLEGATIONS

Kerlan-Jobe Orthopaedic Clinic - team physicians for the Los Angeles Lakers, Dodgers and Kings - has paid the government $2.65 million to resolve allegations in a “whistleblower” lawsuit that it defrauded Medicare and other federal health insurance programs over an eight-year period, United States Attorney Debra W. Yang announced today.

Without admitting wrongdoing, the sports clinic agreed to pay the $2.65 million settlement on behalf of itself and 17 of its physicians, including founder Frank W. Jobe. In light of the settlement, the United States Attorney’s Office asked United States District Judge Consuelo B. Marshall to dismiss the case, and the United States Attorney’s Office learned today that the case had been dismissed by an order filed on January 15.

The whistleblower lawsuit, which was first filed against the clinic in 1998 and was amended in 2001 to include the individual physicians, alleged that Kerlan-Jobe and its physicians knowingly overbilled Medicare, Medi-Cal, the Department of Labor’s Office of Workers’ Compensation Programs and the Department of Defense’s TRICARE program for office visits and outpatient procedures beginning in 1993. The lawsuit alleged that Kerlan-Jobe had been made aware of the problem through internal audits but made no effort to refund the overpayments to the government.

The case was filed pursuant to the *qui tam* provisions of the False Claims Act by Trevor R. Baylor, the former director of Kerlan-Jobe’s health information systems department. Under the False Claims Act, private individuals can file suit on behalf of the government and receive up to 25 percent of the recovery when the government intervenes and takes over the case, as the government did here. The government agreed to pay Mr. Baylor 21 percent of the settlement, which equals $556,500. In addition, Kerlan-Jobe agreed to pay Mr. Baylor $195,000 to cover his attorney’s fees.

The government investigation team in the case included agents from the Office of Inspector General for the U.S. Postal Service and the U.S. Department of Labor.

Release No. 04-004

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January 12, 2004

OPERATOR OF ORANGE COUNTY 'DIPLOMA MILL' TO PLEAD GUILTY TO MAIL FRAUD CHARGES

The former owner and operator of an Orange County-based correspondence school called Columbia State University has agreed to plead guilty to all nine counts of mail fraud that were alleged against him by a federal grand jury last year.

Ronald Pellar, 75, is scheduled to plead guilty to the nine felony counts at 2:30 this afternoon in United States District Court in Santa Ana. Pellar is expected to plead guilty pursuant to a plea agreement, which was filed Friday afternoon and which outlines a scheme in which Pellar ran a "diploma mill" that offered academic degrees from the non-existent Columbia State University (CSU).

After establishing a "mail drop" for CSU in the early 1990s, Pellar started running the diploma mill in earnest in 1996 when he opened a business office in San Clemente. CSU falsely represented itself to be a government-approved university in Louisiana, and it falsely claimed to have faculty and accreditation sufficient to confer bachelor's, master's and doctoral degrees by correspondence in as little as one month. Pellar created promotional materials, including a university catalog, that falsely told prospective students that CSU had an administration composed of Ph.Ds and medical doctors, and that it had received full accreditation from legitimate accreditation agencies. The catalog cover featured a photograph of a building that bore no relation to the fictitious CSU or its San Clemente office. The mailing address was in Metairie, Louisiana, but in reality that was only a mail forwarding service that simply resent all correspondence to CSU's addresses in Southern California.

CSU took in millions of dollars from students around the country in tuition fees during the scheme. Students around the country were defrauded because CSU gave them the impression that it was a legitimate academic institution, but in reality it was nothing more than a diploma mill.

Pellar, who has been in custody since 1998 on federal contempt charges related to Federal Trade Commission violations, is scheduled to plead guilty before United States DistrictJudge Alicemarie H. Stotler.

As a result of his guilty pleas, Pellar faces a statutory maximum sentence of 45 years in federal prison, although the plea agreement contemplates a sentence in the range of 51 to 63 months. The plea agreement also contemplates restitution of at least $2 million. Furthermore, Pellar is required to forfeit his ownership of a luxury yacht, purchased with proceeds from the fraudulent scheme, that may be valued in excess of $1.5 million.

This case was investigated by the Federal Bureau of Investigation.

Release No. 04-003

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February 27, 2004

SAN FERNANDO VALLEY MAN GETS 33-MONTH SENTENCE IN IDENTITY THEFT CASE STEMMING FROM CREDIT CARD INFO STOLEN FROM SOUTHERN CALIFORNIA AMUSEMENT PARK

A Mission Hills man has been sentenced to 33 months in federal prison in an identity theft case in which he used credit card and other information stolen from customers of Six Flags Magic Mountain to make unauthorized purchases,

Nicholas E. Dean, 24, a Pierce College student, was sentenced Wednesday by United States District Judge William J. Rea. In addition to the prison sentence, Dean was ordered to pay $13,965 in restitution to Ticketmaster and Southwest Airlines.

Dean pleaded guilty on July 22, 2003 to conspiracy to commit access device fraud and access device fraud. By pleading guilty, Dean admitted that he obtained credit card, ATM card and other personal information from individuals from all over California. In total, Dean obtained credit card information belonging to more than 50 individuals. Dean then used that information to make online purchases from Ticketmaster.com and several airlines. Dean used the stolen credit card information to purchase tickets for a variety of events, including Los Angeles Lakers and Clippers games, which he then sold, often for prices well below face value.

Dean attempted to purchase tickets from Ticketmaster well over 100 times. Investigators with Ticketmaster have calculated that Dean attempted to defraud the company out of nearly $30,000, although the actual loss to Ticketmaster was less because not every purchase attempt was successful.

Dean obtained the personal information used to make the unauthorized purchases from a girlfriend who worked at Six Flags Magic Mountain in Valencia. Veronica S. Jones, a 21-year-old San Fernando resident, obtained the private information while processing requests for annual passes to the amusement park. Jones, who was terminated by Magic Mountain, pleaded guilty to conspiracy and was sentenced by Judge George H. King to 3 years of probation.

The case against Dean and Jones was investigated by the Federal Bureau of Investigation.

Release No. 04-024

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