No. _____

In The
Supreme Court of the United States

BETH PALIN,

Petitioner,

V.

UNITED STATES OF AMERICA,

Respondent.

On Petition for Writ of Certiorari
to the United States Court of Appeals
for the Fourth Circuit

APPENDIX

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PUBLISHED

UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

No. 16-4522

UNITED STATES OF AMERICA,
Plaintiff – Appellee,

v.

BETH PALIN,
Defendant – Appellant.

Appeal from the United States District Court for the Western District of Virginia, at Abingdon. James P. Jones, District Judge.

(1:14CR00023)

Argued: September 13, 2017
Decided: October 30, 2017

Before MOTZ, DUNCAN, and WYNN, Circuit Judges.

Affirmed by published opinion, Judge Motz wrote the opinion, in which Judge Duncan and Judge Wynn joined.

ARGUED: Michael John Khouri, LAW OFFICES OF MICHAEL KHOURI, Laguna Hills,

California; Nancy Combs Dickenson, OFFICE OF THE FEDERAL PUBLIC DEFENDER, Abingdon, Virginia, for Appellants. Janine Marie Myatt, OFFICE OF THE UNITED STATES ATTORNEY, Abingdon, Virginia, for Appellee. **ON BRIEF**: Larry W. Shelton, Federal Public Defender, OFFICE OF THE FEDERAL PUBLIC DEFENDER, Roanoke, Virginia, for Appellant. Joseph D. Webb. Rick A. Mountcastle, Acting United States Attorney, OFFICE OF THE UNITED STATES ATTORNEY, Roanoke, Virginia, for Appellee.

MOTZ, Circuit Judge:

After a bench trial, the district court found Beth Palin and Joseph Webb (wife and husband) guilty of health care fraud and conspiracy to engage in health care fraud, in violation of 18 U.S.C. §§ 1347 and 1349. Palin and Webb appeal, principally contending the district court failed to apply the correct standard of materiality and failed to find their misrepresentations were material. For the reasons that follow, we affirm.

I.

During a two-week trial, the district court considered numerous documents and the testimony of more than twenty witnesses. We briefly summarize that evidence.

Palin owned Mountain Empire Medical Care ("MEMC"), an addiction medicine clinic, and Bristol Laboratories ("the Lab"), which processed urine drug

tests ordered by MEMC doctors, among others. Webb assisted Palin in the operation of both facilities.

The Lab performed two types of urine tests: the basic, inexpensive "quick-cup" test and a more sophisticated, more expensive "analyzer" test. Although referring doctors ordered their patients to undergo drug tests, the doctors did not specify the type of test. Palin and Webb made that decision, instituting procedures in which insured patients were treated differently than uninsured patients. In general, uninsured patients paid cash and received one test each week — the "quick-cup" test. Insured patients received both the "quick-cup" and the more expensive "analyzer" test. The Lab billed insurers (which included Medicare and private insurance companies) for the sophisticated test.

In a detailed written opinion, the district court found Palin and Webb "knowingly and willfully executed a scheme to defraud health care benefit programs" in violation of §§ 1347 and 1349. The court found that performing additional, weekly, expensive tests for insured patients was not medically necessary; that insurers have rules prohibiting providers from submitting claims for unnecessary tests; and that Palin and Webb knew the additional tests were unnecessary but hid that fact when billing the insurers. The court, however, did not expressly mention materiality.

Palin and Webb then moved for judgments of acquittal or, in the alternative, for a new trial, relying in part on *Universal Health Services, Inc. v. United States ex rel. Escobar*, — U.S. —, 136 S. Ct.

1989, 195 L. Ed. 2d 348 (2016), which issued after the district court had found them guilty. They contended that *Universal Health* changed the materiality standard applicable to health care fraud under § 1347 and, under the new standard, their asserted misrepresentations were not material.
The district court issued a careful opinion and order denying the motions. In that opinion and order, the court acknowledged that its opinion finding Palin and Webb guilty did not discuss materiality as an element of health care fraud. But the court explained that the misrepresentations at [**4] issue in this case were material, even assuming the standard outlined in *Universal Health* applied.
This appeal followed.

II.
A.
On appeal, the Government agrees with the defendants that materiality constitutes an element of health care fraud and conspiracy to commit health care fraud. That concession is well-advised. Section 1347 provides that it is a crime to "knowingly and willfully execute[] . . . a scheme or artifice . . . to defraud any health care benefit program" or obtain money or property from a health care benefit program "by means of false or fraudulent pretenses, representations, or promises." This language mirrors that in the longstanding federal mail fraud (18 U.S.C. § 1341), wire fraud (§ 1343), and bank fraud (§ 1344) statutes, which similarly prohibit any "scheme or artifice to defraud" or obtaining money or property "by means of false or fraudulent pretenses, representations, or promises." In *Neder v. United States*, 527 U.S. 1, 21-25, 119 S. Ct. 1827, 144 L. Ed.

2d 35 (1999), the Supreme Court held that the mail, wire, and bank fraud statutes incorporated the common-law definition of "fraud," which requires "a misrepresentation or concealment of *material* fact," meaning materiality is an implicit element of those statutes. Although *Neder* did not examine § 1347, the same analysis applies and compels [**5] the same result — materiality constitutes an element of health care fraud. *See United States v. Perry*, 757 F.3d 166, 175-76 (4th Cir. 2014).

Because materiality constitutes an element of their offenses, we must examine whether, as Palin and Webb contend, the district court erred by not expressly ruling on materiality when finding them guilty. The extent to which the court considered materiality at that stage is unclear. On one hand, as the court acknowledged in denying the post-trial motions, it "did not include any reference to a materiality element" in its opinion finding Palin and Webb guilty. On the other, the court never stated in that opinion that it had concluded materiality was *not* an element of health care fraud. Moreover, its findings suggest that it viewed the misrepresentations at issue here — that the sophisticated tests were medically necessary — as material to the decision by insurers to pay for claims submitted by the Lab. For example, the district court found that Palin and Webb performed medically unnecessary tests, hid this fact from insurers, and sought payment for those tests from insurers when applicable rules prohibited the submission of claims for medically unnecessary tests.

Assuming the district court did err in failing to consider materiality expressly when assessing guilt, harmless error review applies. *See Neder*, 527 U.S. at 15 a court reviews an omission of an element of an offense for harmless error). An error is harmless only if the reviewing court concludes beyond a reasonable doubt that the verdict would have been the same absent the error. *See id.* at 19. In the context of a bench trial, that inquiry turns on whether "it is clear that a rational fact finder would have found [the defendant] guilty absent the error." *See United States v. Poole*, 640 F.3d 114, 120 (4th Cir. 2011). Moreover, in determining if an error is harmless, a reviewing court may consider the entire record, including the trial court's discussion of its error during post-trial proceedings. *See id.*
Even if the district court failed to consider materiality when finding Palin and Webb guilty, the error was harmless. The record contains no evidence "that could rationally lead to a contrary finding with respect to that omitted element." *See United States v. Brown*, 202 F.3d 691, 700-01 (4th Cir. 2000) (quoting *Neder*, 527 U.S. at 19) (internal quotation marks omitted). Rather, the record conclusively establishes that insurers would not have paid for the second, more sophisticated tests had they known those tests were not medically necessary. No rational fact finder could conclude otherwise.

B.
Nor does *Universal Health* compel a different conclusion. Palin and Webb maintain that *Universal Health* established a new materiality standard that applies to all criminal fraud statutes, including §

1347. *See* Appellants' Br. 15-16 (claiming *Universal Health* "overruled the old standard for materiality"). We do not believe that is so, but even if it is, that purported new standard does not assist Palin and Webb here.

In *Universal Health*, the Court considered materiality under the False Claims Act ("FCA"). The Court generally noted that, "[u]nder any understanding of the concept, materiality 'looks to the effect on the likely or actual behavior of the recipient of the alleged misrepresentation.'" 136 S. Ct. at 2002 (bracket omitted) (quoting 26 Samuel Williston & Richard A. Lord, A Treatise on the Law of Contracts § 69:12 (4th ed. 2003)). It then discussed how materiality applies under a specific theory of FCA liability known as "implied false certification." *See id.* at 1995, 2003-04. In that context, the Court noted that, if the government pays a particular claim despite knowing certain requirements for payment were violated, "that is very strong evidence that those requirements are not material." *Id.* at 2003.

According to Palin and Webb, the Court's discussion of materiality in this specific FCA context applies here and bolsters their claims that any misrepresentations they made were not material. In short, they claim that because Palin and Webb billed insurers for the second, sophisticated tests, and because the insurers regularly paid those claims despite knowing the type of test (analyzer) and the frequency of testing (weekly), it follows that "no material misrepresentations existed." Appellants' Br. 18-19.

As an initial matter, Palin and Webb stretch *Universal Health* too far. We do not believe the Supreme Court intended to broadly "overrule" materiality standards that had previously applied in the context of criminal fraud. And we doubt the Court's examination of how materiality applies under "implied false certification" FCA cases transfers to all cases charging fraud, or even all cases charging health care fraud.

But we need not resolve today whether and how *Universal Health* may impact materiality under § 1347. As the district court concluded in denying the post-trial motions, Palin and Webb's misrepresentations were material even under the *Universal Health* standard. If materiality "looks to the effect on the likely or actual behavior of the recipient of the alleged misrepresentation," as provided in *Universal Health*, the misrepresentations here were material: insurers would not have paid for the sophisticated tests had they known those tests were unnecessary. In contrast to the example discussed in *Universal Health*, the insurers here did not reimburse claims despite knowing Palin and Webb sought payment for tests that Palin and Webb knew were not medically necessary. *See* 136 S. Ct. at 2003. No evidence even suggests that medical necessity was anything less than a critical prerequisite to payment.

III.

Palin and Webb raise three additional arguments, none of which have merit.

A.

First, they claim the district court erred in denying their motions for a new trial by failing to hear new evidence concerning materiality. Appellants' Br. 16-17. Under Fed. R. Crim. P. 33, a district court may vacate a criminal judgment and grant a new trial "if the interest of justice so requires." We review a district court's denial of a motion for a new trial for abuse of discretion, and we have noted that a court should exercise its discretion to grant a new trial "sparingly." *United States v. Arrington*, 757 F.2d 1484, 1486 (4th Cir. 1985). Here, the court's holding that the misrepresentations at issue were material is amply supported by an extensive record. Accordingly, it did not abuse its discretion in refusing to order a new trial.

B.

Second, Palin and Webb claim the district court erred by convicting them on the basis of an insufficiently specific indictment. Appellants' Br. 26-28. We review the sufficiency of the indictment *de novo*; our review is heightened here because Palin and Webb objected to the indictment pre-verdict. *See United States v. Kingrea*, 573 F.3d 186, 191 (4th Cir. 2009). "An indictment must contain the elements of the offense charged, fairly inform a defendant of the charge, and enable the defendant to plead double jeopardy as a defense in a future prosecution for the same offense." *United States v. Daniels*, 973 F.2d 272, 274 (4th Cir. 1992). Absent a charge of "[e]very essential element of an offense," an indictment is invalid. *Id.* "When the words of a statute are used to describe the offense generally,

they 'must be accompanied with such a statement of the facts and circumstances as will inform the accused of the specific offence, coming under the general description, with which he is charged.'" *United States v. Brandon*, 298 F.3d 307, 310 (4th Cir. 2002) (quoting *Hamling v. United States*, 418 U.S. 87, 117-18, 94 S. Ct. 2887, 41 L. Ed. 2d 590 (1974)).

The indictment challenged here was valid. It cites the statutes that Palin and Webb were charged with violating and uses the relevant statutory language to describe the charged crimes. The indictment also sets out the facts and circumstances of the alleged offenses in sufficient detail. For instance, it alleges that Palin and Webb — not the referring doctors — decided the type of test that a patient received. It further alleges that Palin and Webb treated patients differently based on insurance status: uninsured patients received only the basic test while insured patients received both that test and a second more sophisticated and expensive test. This differentiation was not based on patient needs, the indictment adds. The indictment further asserts that Palin and Webb "required" referring physicians to order the medically unnecessary tests for insured patients and then charged insurers for those tests.

C.

Finally, Palin and Webb claim the evidence at trial was insufficient to convict. Appellants' Br. 20-26. "We review the sufficiency of the evidence *de novo*." *United States v. McLean*, 715 F.3d 129, 137 (4th Cir. 2013). Our review is limited to determining whether, viewing the evidence and reasonable

inferences to be drawn from it in the light most favorable to the Government, "substantial evidence" supports the conviction. *Id.* Substantial evidence is evidence that a reasonable factfinder could accept as sufficient to support a conclusion of a defendant's guilt beyond a reasonable doubt. *Id.* Determinations of credibility lie within the sole province of the fact finder. *United States v. Lomax*, 293 F.3d 701, 705 (4th Cir. 2002). A reviewing court will overturn a conviction only if the Government's failure is clear; we do not determine whether we are convinced of guilt beyond a reasonable doubt but only whether the evidence "could support any rational determination of guilty beyond a reasonable doubt." *Perry*, 757 F.3d at 175 (internal quotation marks and citation omitted).

With respect to sufficiency of the evidence, Palin and Webb make three principal claims. First, they claim there is "no evidence" that they "had a duty to vet medical necessity of the laboratory tests their company performed." Appellants' Reply Br. 9. In short, they claim their Lab was bound to perform drug screens ordered by referring physicians. Actually, the Government offered substantial evidence that Palin and Webb determined the frequency and type of tests ordered by referring physicians, billed insurers for sophisticated tests despite knowing they were not medically necessary, and hid from insurers the fact that they were billing for unnecessary tests. Thus, Palin and Webb's claim that they had no duty to vet medical necessity is beside the point: Palin and Webb were not following doctors' orders but rather determining what those orders would be.

Second, Palin and Webb claim there is "no evidence" they knowingly and willfully billed for medically unnecessary tests. Appellants' Reply Br. 9. Not so. Taken in the light most favorable to the Government, abundant evidence demonstrates that Palin and Webb knew the second tests — the sophisticated tests — were not medically necessary but ordered them anyway to generate income for themselves. Palin and Webb (not the referring doctors) decided that insured patients would receive both the basic and the sophisticated tests while uninsured patients would receive only the basic test. Indeed, Palin and Webb concede that they did this and did so to increase their profits. *See* Appellants' Br. 3, 24 & n.10. They urged referring doctors to require more frequent testing and did not give insured patients the choice of receiving only the basic test. Insured patients received an additional test even if they agreed with the results of the initial, basic test. Palin and Webb did not bill insurers for the basic test, which suggests they did not want insurers to know that insured patients received two tests each week. The record also offers evidence that Palin and Webb knew the weekly tests ordered by at least one doctor were not even used in patient treatment.

Finally, Palin and Webb claim the Government "did not identify a single piece of evidence that showed Defendants lied, presented a false statement, omitted a material piece of information, or in any way committed a bad act." Put differently, they claim they are innocent, because they only billed for tests that were performed on real patients pursuant

to a real order from a real physician. Appellants' Reply Br. 11-12. This argument simply ignores the lengthy trial record. As we explained above, considered in the light most favorable to the Government, the evidence establishes that Palin and Webb originated and executed a corrupt scheme pursuant to which they determined the frequency and type of tests ordered by referring physicians, performed and billed insurers for tests they knew were medically unnecessary, and hid the fact that the tests were unnecessary from insurers so that insurers would not reject their claims. That constitutes a scheme to defraud under § 1347. *See Perry*, 757 F.3d at 176 (suggesting that, under § 1347, a scheme to defraud may center on "acts taken to conceal, create a false impression, mislead, or otherwise deceive in order to prevent the other party from acquiring material information" (quoting *United States v. Colton*, 231 F.3d 890, 898 (4th Cir. 2000) (internal quotation marks omitted)).

IV.

For the foregoing reasons, the judgment of the district court is

AFFIRMED.

United States v. Palin

United States District Court for the Western District of Virginia, Abingdon Division

August 2, 2016, Decided.

Case No. 1:14CR00023

Reporter
2016 U.S. Dist. LEXIS 100743 *

UNITED STATES OF AMERICA
v.
BETH PALIN, ET AL., Defendants.

Subsequent History: Affirmed by United States v. Palin, 874 F.3d 418 (4th Cir. Va. 2017)

Prior History: United States v. Palin, 2015 U.S. Dist. LEXIS 127417 (W.D. Va., Sept. 23, 2015)

Counsel: Janine M. Myatt, Special Assistant United States Attorney, and Zachary T. Lee, Assistant United States Attorney, Abingdon, Virginia, for United States. Michael J. Khouri, Khouri Law Firm, Irvine, California, for Defendant Beth Palin. Nancy C. Dickenson, Assistant Federal Public Defender, Abingdon, Virginia, for Defendant Joseph D. Webb.

Opinion by: James P. Jones

OPINION AND ORDER

By: James P. Jones

United States District Judge

The remaining defendants in this criminal case, Beth Palin and Joseph D. Webb, have separately filed motions for judgment of acquittal, or for a new trial in the alternative, challenging their convictions of healthcare fraud and conspiracy to commit healthcare fraud. For the following reasons, I will deny the motions.

I.

The facts of this case are set forth in detail in my earlier opinion stating my findings following a bench trial (Op., Apr. 7, 2016, ECF No. 297) and I will not repeat them here. Palin owned both Mtn. Empire Medical Care LLC ("MEMC"), an addiction medicine clinic, and Bristol Laboratories, LLC ("Bristol Labs"), the lab that processed the urine drug screens ordered for patients of MEMC and patients of a deceased coconspirator, Charles K. Wagner, M.D. Webb, Palin's husband, was not an owner of the clinic but held himself out as one and was heavily involved in the operation of both MEMC and Bristol Labs. The government alleged and proved, in a nonjury trial, that Palin and Webb devised a scheme to defraud Medicare, two state Medicaid programs, and various private insurers by conducting and billing for urine drug screens that they knew were not medically necessary.

Palin seeks acquittal or a new trial on two grounds: (1) that the Supreme Court's recent decision in *Universal Health Services, Inc. v. United States*, 136 S. Ct. 1989, 195 L. Ed. 2d 348 (2016), altered the applicable law, and (2) that there was insufficient

evidence to support her conviction. Webb's post-trial motion asserts that the evidence was insufficient to support his conviction. The motions have been fully briefed and are ripe for decision. I will dispense with oral argument because the facts and legal contentions are adequately presented in the materials before the court and argument would not significantly aide the decisional process.

II.

"[T]here is only one ground for a motion for judgment of acquittal. This is that the evidence is insufficient to sustain a conviction of one or more of the offenses charged in the indictment or information." *United States v. Hoover-Hankerson*, 406 F. Supp. 2d 76, 81-82 (D.D.C. 2005) (citation omitted), *aff'd*, 511 F.3d 164, 379 U.S. App. D.C. 135 (D.C. Cir. 2007). "A defendant challenging the sufficiency of the evidence faces 'a heavy burden.'" *United States v. Thorne*, 614 F. App'x 646, 647 (4th Cir. 2015) (unpublished) (quoting *United States v. McLean*, 715 F.3d 129, 137 (4th Cir. 2013)).

On review of a motion for acquittal under Rule 29, the court "must sustain the verdict if there is substantial evidence" to uphold the verdict. *Burks v. United States*, 437 U.S. 1, 17, 98 S. Ct. 2141, 57 L. Ed. 2d 1 (1978). In the context of a criminal conviction, the Fourth Circuit has defined substantial evidence as "that evidence which 'a reasonable finder of fact could accept as adequate and sufficient to support a conclusion of a defendant's guilt beyond a reasonable doubt.'" *United States v. Newsome*, 322 F.3d 328, 333 (4th Cir. 2003) (quoting *United States v. Burgos*, 94

F.3d 849, 862-63 (4th Cir. 1996) (en banc)). The court must consider "circumstantial as well as direct evidence." *United States v. Tresvant*, 677 F.2d 1018, 1021 (4th Cir. 1982).

Federal Rule of Criminal Procedure 33(a) provides, "Upon the defendant's motion, the court may vacate any judgment and grant a new trial if the interest of justice so requires. If the case was tried without a jury, the court may take additional testimony and enter a new judgment." "The issue of whether to grant a new trial is firmly committed to the discretion of the trial court." *United States v. Head*, Nos. 94-5858,94-5859, 94-5906, 94-5907, 1996 U.S. App. LEXIS 2031, 1996 WL 60445, at *2 (4th Cir. Feb. 12, 1996) (unpublished).

Because this case was decided by the court after a bench trial, I have already thoroughly reviewed the evidence and concluded that it was sufficient to convict the defendants. Palin argues that there was insufficient evidence of fraud because "the Government failed to provide evidence to the trier of fact of any material lie, misrepresentation, or misleading act or omission." (Def. Beth Palin's Mot. for J. of Acquittal or, In the Alternative, New Trial 15, ECF No. 338.) I disagree with this assessment of the evidence. Palin committed fraud when she developed a scheme by which her subordinates and agents, who were not medical professionals, would order and bill for medically unnecessary urine drug screens that were not used in patient treatment. By submitting claims for payment, Palin misrepresented that the tests had been ordered for individual patients by physicians based on medical

necessity, as the insurers required, when in fact the orders were usually completed by non-physician staff members automatically, at Palin's direction, without any individually determined medical need for the tests. The various healthcare benefit programs prohibited Bristol Labs from submitting claims for medically unnecessary services and would not have paid for the urine drug screens had they known the tests were medically unnecessary. That is sufficient evidence to support a conviction of health care fraud. The evidence further showed that Palin entered into an agreement with Webb and Wagner and took acts in furtherance of that agreement, supporting her conviction of conspiracy to commit health care fraud.

Webb contends that he is entitled to judgment of acquittal because "the government did not prove that Medicare was a health care benefit program affecting commerce as defined in the statute because there was not adequate testimony about commerce." (Renewed Mot. for J. of Acquittal or In the Alternative Mot. for New Trial 1-2, ECF No. 339.) For purposes of the health care fraud statute, a "health care benefit program" is "any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract." 18 U.S.C. § 24(b). "Courts have interpreted 'affecting commerce' to mean affecting interstate commerce." *United States v. Natale*, 719 F.3d 719, 732 n.5 (7th Cir. 2013). Courts of appeal that have considered challenges like Webb's have found sufficient

evidence of interstate commerce where the record showed that: (1) defrauded insurance companies were based out of state and did business throughout the United States, *United States v. Gelin*, 712 F.3d 612, 620 (1st Cir. 2013); (2) the federal government funded 60% of a defrauded state Medicaid program, *United States v. Kpohanu*, 377 F. App'x 519, 523 (6th Cir. 2010) (unpublished); and (3) "the fraud was to Medicaid, a federally funded program that affects commerce," *United States v. Girod*, 646 F.3d 304, 316 (5th Cir. 2011). Indeed, the Fifth Circuit has stated,

[I]t cannot seriously be contended that Medicare and Medicaid do not affect commerce. The provision of medical services affects interstate commerce because both physicians and hospitals serve nonresident patients and receive reimbursement through Medicare payments, and the regulated activity in this case substantially affects commerce and is linked to interstate commerce. *United States v. Ogba*, 526 F.3d 214, 238 (5th Cir. 2008) (internal quotation marks, footnotes, and alterations omitted).

In this case, the evidence showed that MEMC and Bristol Labs, both of which were located in Virginia, served patients who lived in Tennessee and billed insurers that operated in Tennessee and elsewhere. Both Virginia Medicaid and TennCare, the Tennessee Medicaid program, are federally funded, as is Medicare. For the reasons stated by the Fifth Circuit in *Ogba*, I find that the government presented sufficient evidence to show that the defrauded benefit programs affect interstate commerce.

Webb argues that there was insufficient evidence to prove he intended to defraud a health care benefit program. The evidence demonstrated that Webb held himself out to be an owner of MEMC and Bristol Labs, and numerous witnesses testified that they believed he was a co-owner. Webb was heavily involved in recruiting and hiring physicians and counselors, including Dr. Wagner, who later moved his practice next to Bristol Labs. Several witnesses testified that both Palin and Webb were in charge of operations at MEMC and Bristol Labs. One doctor testified that Webb had asked him to take an online course and test so that he could prescribe buprenorphine, and Webb arranged for payment of the course fee. One witness described the Bristol Labs operation as the vision of Palin and Webb, and stated that a predecessor medical clinic called MedPath had been set up under the direction of Palin and Webb. The same witness described a conversation in which he had discussed with Webb the legal implications of Palin and Webb's ownership of both Bristol Labs and MEMC, and Webb indicated that the legality of the relationship was unclear. Another witness testified that Webb had offered to pay her a per-patient referral fee if she could convince the doctors with whom she worked to send urine drug screens to Bristol Labs for processing. Training and marketing materials used by Webb indicate that he was intimately familiar with the operations of Bristol Labs and MEMC, including urine drug screen protocols. A consultant emailed both Palin and Webb to warn them of increased scrutiny of buprenorphine clinics by federal law enforcement and advised that they review their billing and prescribing practices with legal counsel.

Mary E. Curtiss, M.D., an addiction medicine practitioner who worked for MEMC and who was charged but acquitted in this case, told a federal agent that Palin and Webb had decided MEMC's fee structure and that MEMC would not accept insurance. An email to Dr. Curtiss strongly suggesting that she drug test all patients twice per week was signed with both Palin and Webb's names. Both of their names were signed to an email to Aaron Miller, M.D., another addiction medicine practitioner who briefly worked for MEMC, in which Palin and Webb asked Dr. Miller to drug screen all of his patients weekly.

Based on all of this evidence, I concluded that Webb possessed the requisite criminal intent to be convicted of health care fraud, as a principal or as an aider and abetter, and that he knowingly joined Palin and Wagner in a conspiracy to commit healthcare fraud. He did not merely conduct innocent marketing activities, nor was he simply a bystander to Palin's unlawful conduct. Rather, he was well aware of the fraudulent scheme, likely developed it on his own or with Palin, actively participated in it, and benefitted from it. He can be held liable for Palin's illegal acts both as an aider and abetter and as a coconspirator. There is sufficient evidence of Webb's intent to support his conviction. (footnote 1)

Palin seeks acquittal or a new trial on the ground that after I issued my verdict in this case, the Supreme Court decided *Universal Health Services, Inc. v. United States*, 136 S. Ct. 1989, 195 L. Ed. 2d 348 (2016), in which the Court construed the

materiality element of a civil action brought under the False Claims Act, 31 U.S.C. § 3729. The False Claims Act makes a person civilly liable if she, among other things, knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government. 31 U.S.C. § 3729(a)(1)(G). The False Claims Act defines "material" as "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." 31 U.S.C. § 3729(b)(4).

Universal Health Services concerned a theory of liability known as "implied false certification." According to this theory, when a defendant submits a claim, it impliedly certifies compliance with all conditions of payment. But if that claim fails to disclose the defendant's violation of a material statutory, regulatory, or contractual requirement, so the theory goes, the defendant has made a misrepresentation that renders the claim "false or fraudulent" under § 3729(a)(1)(A). 136 S. Ct. at 1995.

The Court summarized its holdings as follows: We first hold that, at least in certain circumstances, the implied false certification theory can be a basis for liability. Specifically, liability can attach when the defendant submits a claim for payment that makes specific representations about the goods or services provided, but knowingly fails to disclose the

defendant's noncompliance with a statutory, regulatory, or contractual requirement. In these circumstances, liability may attach if the omission renders those representations misleading.

We further hold that False Claims Act liability for failing to disclose violations of legal requirements does not turn upon whether those requirements were expressly designated as conditions of payment. Defendants can be liable for violating requirements even if they were not expressly designated as conditions of payment. Conversely, even when a requirement is expressly designated a condition of payment, not every violation of such a requirement gives rise to liability. What matters is not the label the Government attaches to a requirement, but *whether the defendant knowingly violated a requirement that the defendant knows is material to the Government's payment decision. A misrepresentation about compliance with a statutory, regulatory, or contractual requirement must be material to the Government's payment decision in order to be actionable under the False Claims Act*.

We clarify below how that rigorous materiality requirement should be enforced. *Id.* at 1995-96 (emphasis added). In reaching its conclusions, the Court considered the common law meaning of fraud, which encompasses omissions as well as express falsehoods. *Id.* at 1999.

In *Universal Health Services*, a clinic had submitted claims for counseling services performed by professionals who were not licensed and did not meet licensing requirements. The Court found that the

claims submitted "were clearly misleading in context" because "[a]nyone informed that a social worker at a Massachusetts mental health clinic provided a teenage patient with individual counseling services would probably — but wrongly — conclude that the clinic had complied with core Massachusetts Medicaid requirements" regarding qualifications, training, and experience. *Id.* at 2000.

The Court went on to say that "a misrepresentation about compliance with a statutory, regulatory, or contractual requirement must be material to the Government's payment decision in order to be actionable under the False Claims Act." *Id.* at 2002.

A misrepresentation cannot be deemed material merely because the Government designates compliance with a particular statutory, regulatory, or contractual requirement as a condition of payment. Nor is it sufficient for a finding of materiality that the Government would have the option to decline to pay if it knew of the defendant's noncompliance. Materiality, in addition, cannot be found where noncompliance is minor or insubstantial. *Id.* at 2003. Materiality is determined by '"the effect on the likely or actual behavior of the recipient of the alleged misrepresentation."' *Id.* at 2002 (quoting 26 R. Lord, *Williston on Contracts* § 69:12, p. 549 (4th ed. 2003)).

The criminal health care fraud statute under which Palin and Webb were convicted provides, in relevant part:

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

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

(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both. 18 U.S.C. § 1347(a).

To obtain a conviction for health care fraud, the government must prove that a defendant:

(1) knowingly devised a scheme or artifice to defraud a health care benefit program in connection with the delivery of or payment for health care benefits, items, or services; (2) executed or attempted to execute this scheme or artifice to defraud; and (3) acted with intent to defraud. *United States v. Hunt*, 521 F.3d 636, 645 (6th Cir. 2008) (citation omitted).

A defendant may be convicted of violating the statute only if the government proves beyond a reasonable doubt that the defendant acted "knowingly and willfully" to defraud insurers. 18 U.S.C. § 1347(a); *McLean*, 715 F.3d at 137. In a case like this one, where the government contends that the defendants ordered and billed for medically unnecessary tests, the government must prove that the defendants knew the tests were unnecessary. *See id.*

Unlike the False Claims Act, § 1347 does not use the term "material," and Palin has cited no case holding that § 1347(a) contains a materiality element. (footnote 2) Instead, she argues that "[f]raud is fraud," and therefore if the False Claims Act requires a material misrepresentation, then § 1347(a) must also require a material misrepresentation. (Def. Beth Palin's Mot. for J. of Acquittal or, In the Alternative, New Trial 5, n. 1, ECF No. 338.)

The Fourth Circuit has explained then when interpreting § 1347, "we look to the 'common-law understanding of fraud,' which includes 'acts taken to conceal, create a false impression, mislead, or otherwise deceive.'" *United States v. Witasick*, 443 F. App'x 838, 842 (4th Cir. 2011)(unpublished) (quoting *United States v. Colton*, 231 F.3d 890, 898 (4th Cir. 2000)). "Also important to the analysis of common law fraud is whether the defendant 'fraudulently produc[ed] a false impression upon the mind of the other party; and if the result is accomplished, it is unimportant whether the means of accomplishing it are words or acts of the defendant, or his concealment or suppression of material facts not equally within the knowledge or reach of the plaintiff.'" *United States v. Beverly*, 284 F. App'x 36, 39 (4th Cir. 2008) (unpublished) (quoting *Colton*, 231 F.3d at 899). This explanation implies that at least if the government's case against a defendant is based on concealment of facts, the facts concealed or suppressed by the defendant must be "material" in order for a defendant to be convicted under § 1347.

Assuming, without deciding, that the Supreme Court's statements about materiality under the False Claims Act apply to § 1347, the misrepresentations at issue in this case easily satisfy the standard of materiality set forth in *Universal Health Services*. The health care benefit program representatives who testified stated in no uncertain terms that the benefit programs, as a rule, do not pay for medically unnecessary tests. A Medicare regulation specifically excludes from coverage "[a]ny services that are not reasonable and necessary for one of" the enumerated purposes, the most applicable of which is "[f]or the diagnosis or treatment or illness or injury or to improve the functioning of a malformed body member." 42 C.F.R. § 411.15(k). Another Medicare regulation states:

All diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary (see § 411.15(k)(1) of this chapter). 42 C.F.R. § 410.32(a).

It is clear to me, as fact finder, that none of the affected health care benefit programs would have paid the claims submitted by Bristol Labs had they known that the urine drug screens that had been performed were not medically necessary for patient diagnosis or treatment. Contrary to Palin's assertion, there was no evidence in this case that the

benefit programs had paid claims for tests that they knew were medically unnecessary. *See Univ. Health Servs.*, 136 S. Ct. at 2003-04 (noting that "if the Government pays a particular claim in full despite its actual knowledge that certain requirements were violated, that is very strong evidence that those requirements are not material"). Palin is not entitled to acquittal or a new trial based on the Supreme Court's decision in *Universal Health Services*.

Because the verdicts in this case are supported by substantial evidence and the interests of justice do not require a new trial, I conclude that the defendants are not entitled to post-trial relief.

III.
For the foregoing reasons, it is
hereby **ORDERED** that:

1. Defendant Beth Palin's Motion for Judgment of Acquittal or, In the Alternative, New Trial (ECF No. 338) is DENIED; and

2. The Renewed Motion for Judgment of Acquittal or In the Alternative Motion for New Trial (ECF No. 339) is DENIED.

ENTER: August 2, 2016

/s/ James P. Jones

United States District Judge

Footnotes

1: Webb asserts that I found Dr. Curtiss not guilty of conspiracy to commit health care fraud "because she utilized the lab results." (Renewed Mot. for J. of Acquittal or In the Alternative Mot. for New Trial 5, ECF No. 339.) I did not acquit Dr. Curtiss simply because she used some of the lab results in her treatment of patients. I found that Dr. Curtiss lacked the requisite criminal intent to be convicted of fraud or conspiracy because she believed the tests ordered were appropriate and medically necessary. Contrary to Dr. Curtiss's belief, I found that weekly testing of all patients by Bristol Labs was not medically necessary. (Op. 20-21, Apr. 7, 2016, ECF No. 297.) Webb argues that because Dr. Wagner passed away prior to trial, we cannot know whether Dr. Wagner had legitimate reasons for ordering urine drug screens, implying that the drug screens of Dr. Wagner's patients may have been medically necessary and that he may not have conspired with Palin and Webb. The evidence showed that Dr. Wagner allowed his non-medically trained staff members to write prescriptions upon request without physician oversight and that he failed to even visit his office for lengthy periods of time. In his absence, his staff and the Bristol Labs staff ordered and billed for urine drug screens that he did not use. There is ample evidence to conclude that Dr. Wagner knew the urine drug screens of his patients were not medically necessary and that he knowingly conspired with Palin and Webb to commit health care fraud.

2: Palin points to jury instructions I gave in 2012 in another criminal case charging health care fraud under § 1347. *United States v. Louthian*, No. 1:12CR00002, Jury Instr. No. 19, ECF No. 187. In that case, I instructed the jury that the government was required to prove that "[a] false statement, misrepresentation, or concealment in furtherance of the scheme was material." *Id.* I also instructed the jury that "[a] statement is 'material' if it has a natural tendency to influence, or is capable of influencing, the health care benefit program to which it is directed." *Id.* The source of this instruction is unclear. In the present case, my discussion of the requirements for a conviction under § 1347 did not include any reference to a materiality element. (*See* Op. 27-28, Apr. 7, 2016, ECF No. 297.)

United States v. Palin

United States District Court for the Western District of Virginia, Abingdon Division

April 7, 2016, Decided; April 7, 2016, Filed

Case No. 1:14CR00023

Reporter
2016 U.S. Dist. LEXIS 46939 *

UNITED STATES OF AMERICA
v.
BETH PALIN, ET AL., Defendants.

Subsequent History: As Corrected October 14, 2016.

Prior History: United States v. Palin, 2015 U.S. Dist. LEXIS 127417 (W.D. Va., Sept. 23, 2015)

Counsel: Janine M. Myatt, Special Assistant United States Attorney, and Zachary T. Lee, Assistant United States Attorney, Abingdon, Virginia, for United States. Michael J. Khouri, Khouri Law Firm, Irvine, California, for Defendant Beth Palin. Nancy C. Dickenson, Assistant Federal Public Defender, Abingdon, Virginia, for Defendant Joseph D. Webb. Edward G. Stout, Curcio & Stout, Bristol, Virginia, for Defendant Mary Elizabeth Curtiss.

By: James P. Jones, United States District Judge

In this criminal case, in which the defendants are accused of health care fraud and paying and receiving kickbacks, the defendants waived their right to a jury trial and with the consent of the government, the case was tried before the court. This opinion sets forth the findings of fact and conclusions of law supporting my verdicts. (Footnote 1)

I. BACKGROUND AND CHARGES.

The Indictment in this case charges the defendants with participating in a conspiracy between May 1, 2009, to April 30, 2012, to defraud Medicare, TennCare, (footnote 2) Virginia Medicaid, and private insurance companies by ordering, completing, and billing for medically unnecessary urine drug screens in violation of 18 U.S.C. § 1347, and paying and receiving illegal remunerations, or kickbacks, in violation of 42 U.S.C. § 1320a-7b(b)(1)(A) and (b)(2)(A). The Indictment's key allegations are described in detail in my earlier opinion denying the defendants' Motion to Dismiss. *United States v. Palin*, No. 1:14CR00023, 2015 U.S. Dist. LEXIS 140870, 2015 WL 6134128, at *1-4 (W.D. Va. Oct. 16, 2015). Count One charges all three defendants, as principals, aiders, and abetters, with health care fraud under 18 U.S.C. §§ 2, 1347. Count Two charges all three defendants with conspiracy to commit health care fraud under 18 U.S.C. § 1349. Count Three charges defendant Mary Elizabeth Curtiss, a physician, with receiving illegal remunerations under 42 U.S.C. § 1320a-7b(b)(1)(A), and Count Four charges defendants Beth Palin and Joseph D. Webb with paying illegal remunerations under 42 U.S.C. § 1320a-7b(b)(2)(A).

The nonjury trial began on Monday, February 1, 2016, and lasted approximately six and a half days. The government called 36 witnesses and introduced 161 exhibits. On April 7, 2016, I reconvened the parties for the purpose of announcing my verdict in open court.

II. FINDINGS OF FACT.

The following are the court's findings of fact. In determining the credibility of the witnesses, I have taken into account the rationality and internal consistency of the witnesses' testimony, the extent of detail and coherent nature of the testimony, the manner of testifying by the witnesses, and the degree to which the subject testimony is consistent or inconsistent with the other evidence in the case. Moreover, I have drawn such reasonable inferences from the credible direct and circumstantial evidence as is permitted by reason and common sense.

1. Ownership of Bristol Laboratories, LLC ("Bristol Labs") was in Palin's name, but Webb, her husband, was directly involved in its operation. The ostensible business of Bristol Labs was to conduct drug screens of patient urine samples ordered by physicians. Most of the physicians who ordered urine drug screens from Bristol Labs were addiction medicine practitioners.

2. Palin made the final business decisions for Bristol Labs. Webb performed marketing tasks and served as a liaison between employees and Palin.

3. Charles K. Wagner, M.D., was an addiction medicine practitioner who opened an office in 2009

next to Bristol Labs in Bristol, Virginia. The Indictment charges Dr. Wagner as a coconspirator, but he died before the Indictment was returned and is not a defendant.

4. In his practice, Dr. Wagner prescribed Subutex (buprenorphine hydrochloride) and Suboxone (buprenorphine hydrochloride and naloxone hydrochloride) for treatment of opioid dependency.

5. Buprenorphine hydrochloride ("buprenorphine") treats withdrawal from opioids by occupying receptors in the brain. A normal non-drug user's brain has relatively few of these receptors, and approximately 50-75% of the receptors are ordinarily occupied by endorphins produced by the human body. The brain of a person who is using opioids has many more receptors, and the receptors are occupied by those drugs. The full occupation of all of the receptors can cause the person to stop breathing, often resulting in death by overdose. Once a person has become physically dependent on opioids, the body cannot make enough endorphins to occupy the receptors. If the person stops taking the opiates or opioids, the receptors become unoccupied, causing the patient to experience physical withdrawal effects. When experiencing withdrawal, a person can suffer from flu-like symptoms, diarrhea, and other unpleasant effects. Buprenorphine occupies the receptors and stops or prevents the physical withdrawal symptoms without creating the kind of high caused by opioid use. As a patient's treatment progresses, the goal is to eventually taper the use of buprenorphine and, ultimately, to wean the patient from buprenorphine entirely.

6. The naloxone hydrochloride ("naloxone") contained in Suboxone is a reversal agent that prevents users from experiencing a high if they take the medication other than as prescribed. Because Subutex does not contain naloxone, it is more subject to diversion and abuse than Suboxone. Therefore, prescription of Subutex is generally appropriate only if the patient is pregnant or allergic to naloxone.

7. Dr. Wagner required his patients to submit to weekly urine drug screens. The purpose of these tests was to make sure that the patients were taking the prescribed Suboxone or Subutex, rather than diverting it, and were not taking other commonly abused drugs.

8. Initially, Dr. Wagner ordered that all of his patients' urine samples be tested at Bristol Labs on a machine called an analyzer. After about six months, Palin informed Dr. Wagner that Bristol Labs would no longer test uninsured patients' samples on the analyzer because Bristol Labs was not likely to receive payment for those tests.

9. Bristol Labs began administering so-called "quick-cup" urine tests to self-pay patients, for which the patients were required to pay $25 in cash at the time of the test. The quick-cup consisted of a plastic cup with a built-in indicator that, when the cup was filled with urine, immediately showed whether the patient's urine contained metabolites of certain drugs. The quick-cup test was a qualitative test that showed only the presence or absence of a drug in the urine. The quick-cup test did not indicate the

quantity of a substance in the urine; in other words, it was not a quantitative test.

10. Dr. Wagner's patients would go to Bristol Labs with an order form for a urine drug screen, go into the bathroom and pass urine into a cup, and give it to a Bristol Labs employee. If the patient had health insurance, the Bristol Labs employee would test the sample on the analyzer machine. If the patient did not have health insurance, the patient would be required to pay $25, and the patient's sample would be subjected to the quick-cup test.

11. Dr. Wagner's patients could write on the order form any prescription medications they were taking. Many of the patients wrote that they were taking benzodiazepines, which could interact dangerously with the Suboxone or Subutex that Dr. Wagner was prescribing to them.

12. Bristol Labs used the analyzer to test the samples of insured patients for 15 drugs of abuse.

13. Bristol Labs then sent the remainder of the insured patient's urine sample to Forensic Laboratories ("Forensic Labs"), a high complexity laboratory located in Denver, Colorado, for confirmation testing. The testing done at Forensic Labs was more sophisticated than the testing performed by Bristol Labs. Both tests were quantitative tests, but the Forensic Labs test employed a different methodology.

14. The confirmation testing by Forensic Labs was done regardless of whether the results obtained at

Bristol Labs were positive or negative for any banned substances. If the initial Bristol Labs analyzer test was positive for a substance, and the insured patient admitted to having taken that substance, the sample was still sent for confirmation testing, even though the patient did not dispute the results of the analyzer test.

15. Patients were expected to test positive for buprenorphine, the active ingredient in Suboxone and Subutex, which had been prescribed to them for their addiction treatment. Even when the analyzer test was positive for buprenorphine, the insured patient's sample was still sent to Forensic Labs for confirmation testing.

16. Bristol Labs would send the patient's remaining urine sample to Forensic Labs by overnight delivery.

17. The defendants in this case were not affiliated in any way with Forensic Labs and did not receive any payment for tests performed by Forensic Labs.

18. Forensic Labs billed patients' insurers directly for the confirmation testing. Bristol Labs did not bill insurers for tests performed at Forensic Labs.

19. Bristol Labs was a moderate complexity clinical testing laboratory and could not perform the kind of confirmation testing done by Forensic Labs. (footnote 3) Bristol Labs eventually purchased a machine that would allow it to qualify as a high complexity laboratory and to perform its own confirmation testing. However, it never began doing its own confirmation testing because it lost most of its

business after the execution of a federal search warrant, before it had obtained a high complexity certification.

20. Dr. Wagner's referral of urine drug tests was the top source of income for Bristol Labs.

21. Dr. Wagner eventually moved to Louisiana. There was a period of time during which he was not living in the Bristol area but his practice was still open and operating. During that time, he initially came to the practice weekly, but he visited less and less as time went on. Dr. Wagner eventually moved his Bristol, Virginia, practice to a different location in adjacent Bristol, Tennessee, not in the immediate vicinity of Bristol Labs. Dr. Wagner's practice ultimately closed, and he is now deceased.

22. Palin and Webb were interested in purchasing Dr. Wagner's practice, but he decided not to sell it.

23. Palin and Webb then decided to establish a medical practice to generate business for Bristol Labs. Initially, Palin and Webb opened an addiction treatment clinic called MedPath, which was located in Bristol, Virginia, but it was short-lived due to licensing or permitting issues. Shortly thereafter, Palin and Webb founded Mtn. Empire Medical Care LLC ("MEMC"), an addiction medicine clinic located in Gate City, Virginia.

24. Palin was listed as the sole owner of MEMC, but Webb was heavily involved in its operations, primarily seeking to obtain new patients.

25. MEMC hired Dr. Curtiss and Aaron Miller, M.D., both on a part-time basis, to provide addiction medicine services to patients at MEMC.

26. Dr. Miller began working for MEMC near the end of MEMC's operations and worked there for a short period of time. Dr. Miller saw only four patients and worked a total of only 17.5 hours for MEMC.

27. Like Dr. Wagner's patients, the patients of MEMC were required to submit to weekly urine drug tests.

28. Palin and Webb decided that drug screens of MEMC patients would be tested by Bristol Labs. Palin owned both MEMC and Bristol Labs. Dr. Curtiss and Dr. Miller did not control where urine drug screens were sent for testing.

29. All of the patients of MEMC were given a quick-cup test every week, regardless of whether the patients were insured or uninsured.

30. Rather than sending patients to Bristol Labs, urine samples were collected and quick-cup tests were performed on site at MEMC. The samples were then sent to Bristol Labs.

31. Most of the uninsured patients' samples were simply kept at Bristol Labs and not subjected to further testing, while most of the insured patients' samples were subjected to further testing. In general, an uninsured patient's urine sample was tested only once, via the quick-cup test, while an

insured patient's sample was tested three times, first the quick-cup test, then the Bristol Labs analyzer, and finally confirmation testing at Forensic Labs. (footnote 4)

32. Dr. Curtiss and Dr. Miller signed their names to blank Physician's Order forms and allowed Bristol Labs employees to complete the forms ordering the laboratory tests. Palin and a Bristol Labs technician trained Bristol Labs employees on how to complete the pre-signed order forms. By signing the blank order form, Dr. Miller assumed the clinic and Bristol Labs would follow their ordinary procedures for drug screening patients.

33. If an uninsured patient disputed the results of the quick-cup test, the sample could be tested on the analyzer and then sent to Forensic Labs for confirmation testing. On approximately five occasions, a sample from one of Dr. Wagner's uninsured patients was sent for confirmation testing because the patient disputed the results of the Bristol Labs analyzer test. If the confirmation test results showed that the analyzer test had been wrong, Bristol Labs paid for the confirmation testing. If the confirmation test results were the same as the Bristol Labs analyzer test, the uninsured patient was responsible for the cost of the confirmation test. On approximately three occasions, Dr. Curtiss requested that a sample of an uninsured patient be sent for confirmation testing, either because the patient disputed the results of the quick-cup test or there was something unusual about the sample.

34. There were a few insured patients who refused the analyzer test because they did not want to use their insurance, for fear of alerting their employer that they had a substance abuse problem. Those patients elected to be tested with the quick-cup test only.

35. The turnaround time for testing done at Bristol Labs was 24 hours. The turnaround time for testing done at Forensic Labs was 48 hours after shipment by Bristol Labs.

36. Most patients of MEMC were seen weekly. The results of the quick-cup test were available immediately for use by the doctor at the same appointment at which the urine sample was provided by the patient. The results of the Bristol Labs and Forensic Labs tests were both available for use by the physician at the following week's appointment.

37. Confirmation testing is fully accurate. Analyzer testing is about 96-98% accurate. Quick-cup testing is 90% or less accurate.

38. Unlike the quick-cup test, the analyzer and confirmation tests are quantitative tests that reveal how much of a substance is present in the urine sample.

39. Quick-cup tests can produce false negatives for Xanax, Fentanyl, and Klonopin. A quick-cup test can produce a false positive if the patient has taken Robitussin, Nyquil, Paxil, or Clarinex, among other substances.

40. A quick-cup test does not test for alcohol. The analyzer does test for alcohol. Alcohol and buprenorphine can interact dangerously.

41. There are ways for people to cheat on a urine test, and the quick-cup test is the easiest test to cheat.

42. If a patient had not been taking the prescribed Suboxone or Subutex regularly, but took it just the day before the urine test, the quick-cup test would indicate that the patient had taken the Suboxone or Subutex. However, the analyzer would show that the patient had taken only one dose of the Suboxone or Subutex, which would suggest that the patient might be diverting or selling the remainder of the prescribed medicine.

43. A Bristol Labs employee was always present at MEMC to collect urine samples, perform quick-cup tests, collect money, and schedule appointments.

44. MEMC did not accept insurance, but a Bristol Labs employee located at MEMC would collect patients' insurance information and give it to the laboratory technician at Bristol Labs.

45. When MEMC first opened, the Bristol Labs laboratory technician stated in an email to a Forensic Labs employee that all of the MEMC patients whose samples would be sent for confirmation testing would have health insurance. In other words, before MEMC began treating patients, Bristol Labs determined that it would not submit

uninsured patients' urine samples for confirmation testing.

46. Bristol Labs was required by law to have a laboratory director. Carina Cartelli, M.D., was the laboratory director for Bristol Labs. She lived in Vermont and was available by phone, but she only visited Bristol Labs about every six months. Her primary job was to ensure that Bristol Labs was compliant with the requirements of the Clinical Laboratory Improvement Amendments ("CLIA"), the federal regulations that govern all clinical laboratory testing. Dr. Cartelli was not familiar with the day-to-day operations of the lab and did not know that Bristol Labs was performing quick-cup tests.

47. A drug counselor named Sandra Morgan had worked with Dr. Wagner in his earlier practice in Johnson City, Tennessee. Webb had visited that practice and told Morgan that he would pay her a per-patient referral fee if she could persuade the doctors in her practice to use Bristol Labs for analysis of urine drug tests. She told him that she was not interested and he did not pay her anything, but he left a refrigerator at the practice.

48. Bristol Labs performed advertising and marketing for Dr. Wagner's Bristol, Virginia, practice.

49. On a TennCare prior authorization form, the fax number listed for Dr. Wagner was the Bristol Labs fax number.

50. In an email to Dr. Wagner, Palin wrote, "I saw the first of your patients today~thank you!!" and stated that she was "very happy to start on our new adventure with you." (Gov't Ex. 54.)

51. Dr. Wagner initially ordered drug tests of his patients randomly, but about two months after opening his clinic in Bristol, he began ordering drug tests of all patients weekly.

52. An email discovered pursuant to a search warrant, sent from the Bristol Labs email address to the same email address, and which appears to be a list of tasks, states, "ask Charlie to first bring in new patients with insurance, then 2nd tier is those without." (Gov't Ex. 51.) Dr. Wagner's first name was Charles. I find that this email was likely written by Palin or Webb or at their direction.

53. Dr. Wagner's patients were often given prescriptions without seeing the doctor. After he moved to Louisiana, an office worker with no medical training or even a high school education was tasked with reviewing drug screen results and handing out prescriptions. She sometimes gave prescriptions to people who had tested positive for a drug of abuse.

54. In general, tests whose results are not used in treating a patient are medically unnecessary.

55. Dr. Wagner's patient files reveal that he was not using the results of urine drug screen tests to direct his treatment of patients.

56. Dr. Wagner's office had none of the usual medical office equipment, such as a stethoscope or blood pressure cuff.

57. Bristol Labs employees were present at Dr. Wagner's office during times when Dr. Wagner was not there.

58. Bristol Labs purchased and placed signs advertising MEMC. The phone number on the signs was the number of a cell phone purchased by Bristol Labs.

59. Webb and other Bristol Labs employees worked closely with Dr. Curtiss's husband to market MEMC and recruit new patients.

60. Dr. Curtiss's paychecks were picked up at Bristol Labs, and the Bristol Labs bookkeeper issued the checks.

61. Between January, 2011, when MEMC began operations, and November, 2011, when MEMC ceased operations, Bristol Labs paid approximately $22,000 into MEMC to ensure MEMC's financial viability.

62. Uninsured patients of MEMC signed a form stating:

Mtn. Empire Medical Care, LLC ("Mtn. Empire Medical Care Physician") orders automated laboratory toxicology testing for all of its patients. Most insurances are accepted for the laboratory testing. If a patient does not have health insurance

benefits which pay for these ancillary services, Mtn. Empire Medical Care Physician will order less sophisticated and therefore less expensive toxicology testing if the patient so requests. By signing below, the patient indicates his/her request for the less expensive toxicology testing and that he/she is aware of the lower standard of medical care which they will be receiving by way of the non-automated testing and assent to same.

(Palin Ex. 4.) The signing of these consent forms was not preceded by any doctor-patient discussion about the comparative benefits and drawbacks of the different kinds of tests. I find that these forms do not represent the patients' informed consent and that the forms were used merely to give the appearance that the patient had knowingly requested quick-cup testing only.

63. Insured patients were not given the option of having the quick-cup tests billed to their insurance provider. I infer from this fact that the coconspirators did not want insurers to know that patients were routinely receiving both quick-cup and analyzer tests, as that knowledge may have alerted insurers that the analyzer tests were unnecessary.

64. Dr. Miller did not see his patients weekly, but he still ordered weekly drug tests for all patients. Dr. Miller did not personally decide which type of tests would be performed. He does not know who made that decision.

65. Palin asked Dr. Miller to start ordering weekly drug screens for all his patients. Without her

request, he would not have required weekly drug screens for every patient. Typically, he would reduce the frequency of drug screens over time unless the patient tested positive for a banned substance, in which case the frequency might be increased. Dr. Miller does not order weekly drug testing of all patients at his current practice in Illinois. However, according to Dr. Miller, a number of similar clinics do drug test every patient weekly.

66. Dr. Curtiss was aware that MEMC patients were required to submit to weekly drug tests, and she was aware that many samples were sent to Bristol Labs for more detailed analysis. She did not know how much patients or insurers were charged for the testing.

67. Dr. Curtiss believed that requiring all patients to submit to weekly drug screens was an important and medically necessary component of addiction treatment. She further believed that weekly quantitative testing on the analyzer was appropriate because it provided more thorough and accurate results than the quick-cup test, and a patient's willingness to have his or her sample tested on the analyzer showed a greater commitment to staying sober and complying with the treatment plan. She believed that the confirmation tests done by Forensic Labs were appropriate because they provided even greater accuracy.

68. Dr. Curtiss believed that all patients were offered quantitative testing and that some patients chose to opt out of those tests, possibly due to a lower level of commitment to the treatment program. She

was not aware that the patients' insurance status was the primary determinant of which patients received which kind of test.

69. Palin, Webb, and their agents, rather than Dr. Curtiss, determined which patients would receive the more expensive analyzer and confirmation tests, and that decision was in almost all cases based solely on the patient's insurance status.

70. On July 26, 2011, Palin and Webb emailed Dr. Curtiss, through Dr. Curtiss's husband's email address, "urging Mary to start ordering toxicology labs on all patients 2/x a week." (Gov't Ex. 167 at 3.) "Exceptions would only be a really long-term patient~I think we may have (1) person in this category." (*Id.*) Later in the same email, Palin and Webb wrote, "I would prefer to wait to order chem labs on our patients until we can do it in our lab." (*Id.*) That email was followed by one from Bristol Labs to the Curtisses emphasizing the need for "fiscal responsibility" and "positive cash flow." (*Id.*)

71. When no second drug screens were ordered immediately, Bristol Labs again emailed Dr. Curtiss and her husband to "be super-clear with Mary about the second drug screen for each patient, each week." (*Id.* at 1.) The email stated, "I suppose it will work out better if Dr. Mary tells them it[']s necessary and then our staff can follow up with an Order, directions to the lab, etc." (*Id.* at 2.)

72. Dr. Curtiss's husband replied, "Mary is in agreement that two drug screens per week are a good idea, and should be part of the program with

the emphasis on people resisting temptation in their initial stage of treatment." (*Id.* at 1.) He later noted the burden this might place on patients who live far from Bristol Labs, however, suggesting that "[p]erhaps a short term solution might be for patients more than a certain distance from Bristol or Gate City to get a screen from a local lab." (*Id.*)

73. Despite this exchange, the twice-weekly testing policy was not implemented.

74. When a patient could only come to MEMC or Bristol Labs after hours, a Bristol Labs employee would verify that the patient met all the criteria on a checklist that Dr. Curtiss had developed, including a satisfactory urine drug screen. The Bristol Labs employee would then give the patient a prescription for Suboxone, signed in advance by Dr. Curtiss.

75. One of the Bristol Labs employees who collected urine samples at MEMC was an addiction recovery patient of Dr. Curtiss and received Suboxone prescriptions from her the entire time he worked there.

76. One of Dr. Curtiss's patients asked to reduce the frequency of her MEMC visits to every two weeks. Dr. Curtiss eventually allowed her to do this, but MEMC required the patient to pay $200 per visit rather than the usual $100 per visit. In other words, she was essentially required to pay for doctor's visits she did not attend.

77. Dr. Curtiss was not involved in billing for services on behalf of either MEMC or Bristol Labs.

78. Based on the testimony of the government's expert witness, Samuel Hughes Melton, M.D., I find that the standard of care in addiction medicine requires urine drug screens to be ordered at a frequency that is determined by the need to monitor the individual patient for compliance. Frequent testing by quickcup meets the standard of care. Further automated testing of urine drug screens is warranted when the doctor is randomly spot-checking samples to ensure accuracy of the quick-cup tests, or when the results of the quick-cup are questioned in some way, either by the patient or by the doctor based on the patient's behavior or history. But it is not medically necessary to send every single sample for quantitative or confirmatory testing.

79. In his own addiction medicine practice, Dr. Melton requires every patient to take a quick-cup test at every visit. Initially, he sees his patients three times a week; the frequency eventually drops to twice a week, then weekly, then every other week, assuming the patient remains compliant with the rules and progresses favorably in treatment.

80. Dr. Melton estimated that approximately 40% of his patients' quickcup samples are sent for further quantitative testing.

81. Based on the testimony of healthcare consultant Mark Lowe, who assisted in contract negotiations between Palin and Dr. Curtiss, and his experience working with approximately ten other addiction medicine clinics, I find that a physician prescribing Suboxone and Subutex can earn from $1,000 to $3,000 per day.

82. Dr. Curtiss was paid $1,400 per day she worked at MEMC. If Dr. Curtiss worked an eight-hour workday, her pay rate was the equivalent of $175 per hour. Dr. Miller was compensated at a rate of $175 per hour.

83. Dr. Curtiss's salary of $1,400 per day represents the fair market value of the medical services she provided.

84. In an email to Palin dated August 9, 2011, an accountant doing work for Bristol Labs informed Palin that MEMC had experienced a large financial loss in July of that year. In response, Palin wrote, "no kidding! thanks! can't wait to see the statement for the lab! Thanks!" (Gov't Ex. 266.)

85. While it is not unusual for a business to lose money in its first year of operation, I find that the establishment and operation of MEMC had as its primary purpose the production of revenue for Bristol Labs.

86. For patients of both Dr. Wagner and MEMC, the primary factor that determined whether a patient's urine drug screen was tested on the analyzer and sent for confirmation testing was whether the patient had insurance. The primary factor was not the patient's progress in treatment, or whether anything about the quick-cup test or the patient's condition indicated a need for further analysis of the sample. The driving force behind Palin and Webb's insistence that every insured patient receive weekly quantitative testing was a desire to generate revenue for Bristol Labs.

87. In a recorded telephone conversation between Palin and Webb, which took place while Webb was in custody pending trial, Palin expressly stated that she had refused to test the samples of uninsured patients on the analyzer because she knew she would not receive payment for those tests.

88. Although Webb was not technically an owner of MEMC or Bristol Labs, he was involved in the management of both businesses and directly benefited from the profits generated by Bristol Labs.

89. Bristol Labs billed third-party payors $1,875 for each analyzer test. Medicare would only pay $117 per analyzer test, and Medicaid would only pay $121, although non-governmental health insurers paid more.

90. Bristol Labs did not regularly charge patients the co-pay and coinsurance amounts that were required by the patients' insurance policies. I find that they decided not to bill patients these required amounts so that the patients would not question the need for the expensive testing.

91. Between February, 2009, and April, 2012, (footnote 5) Bristol Labs billed various health care benefit programs, including Medicare, Virginia Medicaid, TennCare, and non-governmental health insurers, $12,474,147 for analyzer tests for patients of Dr. Wagner, Dr. Curtiss, and Dr. Miller. The various health care benefit programs paid Bristol Labs a total of $1,142,942 for those claims.

92. During the same time period, Forensic Labs billed various health care benefit programs $1,804,193 for confirmation tests for patients of Dr. Wagner, Dr. Curtiss, and Dr. Miller. The various health care benefit programs paid Forensic Labs a total of $293,945 for those claims.

93. During the relevant time period, Bristol Labs submitted 2,563 individual claims to Medicare for patients of Dr. Wagner and 846 claims to Medicare for patients of Dr. Curtiss. Forensic Labs submitted 948 claims to Medicare for patients of Dr. Wagner and 196 claims to Medicare for patients of Dr. Curtiss.

94. During the relevant time period, Bristol Labs submitted 920 claims to Blue Cross Blue Shield of Tennessee for patients of Dr. Wagner and 84 claims to Blue Cross Blue Shield of Tennessee for patients of Dr. Curtiss. Forensic Labs submitted two claims to Blue Cross Blue Shield of Tennessee for patients of Dr. Wagner. In addition to providing private insurance, Blue Cross Blue Shield of Tennessee also manages portions of the TennCare governmental insurance program, and many of these claims were for patients insured through TennCare.

95. During the relevant time period, Bristol Labs submitted 5,056 claims to UHC Optum Commercial for patients of Dr. Wagner. Forensic Labs submitted 2,863 claims to UHC Optum Commercial for patients of Dr. Wagner.

96. During the relevant time period, Bristol Labs submitted 8,963 claims to TennCare MCO UHC

Optum for patients of Dr. Wagner and 561 claims to TennCare MCO UHC Optum for patients of Dr. Curtiss. Forensic Labs submitted 3,087 claims to TennCare MCO UHC Optum for patients of Dr. Wagner and seven claims to TennCare MCO UHC Optum for patients of Dr. Curtiss.

97. During the relevant time period, Bristol Labs submitted 1,303 claims to Anthem Blue Cross Blue Shield of Virginia, for patients of Dr. Wagner and 909 claims to Anthem Blue Cross Blue Shield of Virginia for patients of Dr. Curtiss.

98. During the relevant time period, Bristol Labs submitted 12 claims to Aetna Insurance for patients of Dr. Wagner and 16 claims to Aetna Insurance for patients of Dr. Curtiss. Forensic Labs submitted eight claims to Aetna Insurance for patients of Dr. Wagner and seven claims to Aetna Insurance for patients of Dr. Curtiss.

99. During the relevant time period, Bristol Labs submitted 227 claims to Cigna Insurance for patients of Dr. Wagner, and Forensic Labs submitted 216 claims to Cigna Insurance for patients of Dr. Wagner.

100. During the relevant time period, Bristol Labs submitted to Virginia Medicaid 12,386 claims for patients of Dr. Wagner, 2,784 claims for patients of Dr. Curtiss, and six claims for patients of Dr. Miller. Forensic Labs submitted to Virginia Medicaid 9,802 claims for patients of Dr. Wagner and 910 claims for patients of Dr. Curtiss.

101. The above-referenced health care benefit programs have rules prohibiting providers from submitting claims for medically unnecessary services.

102. Palin, Webb, and Dr. Wagner knowingly joined in a conspiracy to defraud health care benefit programs by devising and executing a scheme to bill these programs for tests that were not medically necessary.

103. Dr. Curtiss did not join in the conspiracy. Although Dr. Curtiss failed to more properly supervise the testing process, she did not knowingly and willfully execute the scheme to defraud the health care benefit programs.

104. Dr. Curtiss's salary was not contingent on the volume of urine drug screens she ordered.

105. Dr. Curtiss's salary was compensation for services she rendered in good faith. Dr. Curtiss did not accept her salary in exchange for referring urine drug screens to Bristol Labs. The payment and receipt of Dr. Curtiss' salary was not a kickback for referral of drug testing to Bristol Labs.

III. ANALYSIS.

In order for me to find any of the defendants guilty of any of the crimes charged, I must be convinced beyond a reasonable doubt that the defendant committed the specific crime as charged. If the government has not proven beyond a reasonable doubt that the defendant committed the crime as

charged, I must find him or her not guilty of that crime.

A.
The criminal health care fraud statute provides, in relevant part:
(a) Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice—
(1) to defraud any health care benefit program; or
(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program,
in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both. 18 U.S.C. § 1347(a).

To obtain a conviction for health care fraud, the government must prove that a defendant:
(1) knowingly devised a scheme or artifice to defraud a health care benefit program in connection with the delivery of or payment for health care benefits, items, or services; (2) executed or attempted to execute this scheme or artifice to defraud; and (3) acted with intent to defraud. *United States v. Hunt*, 521 F.3d 636, 645 (6th Cir. 2008) (citation omitted).

The Fourth Circuit has explained that "[t]he health care fraud statute is not a medical malpractice statute, it is a simple fraud statute." *United States v. McLean*, 715 F.3d 129, 136 (4th Cir. 2013). A defendant cannot be convicted of violating the statute unless the government proves beyond a reasonable doubt that the defendant acted

"knowingly and willfully" to defraud insurers. 18 U.S.C. § 1347(a); *McLean*, 715 F.3d at 137. In a case like this one, where the government contends that the defendants ordered and billed for medically unnecessary tests, the government must prove that the defendants knew the tests were unnecessary. *See Id.* "[T]he specific intent to defraud may be inferred from the totality of the circumstances and need not be proven by direct evidence." *Id.* at 138 (quoting *United States v. Harvey*, 532 F.3d 326, 334 (4th Cir. 2008)).

The statute regarding conspiracy to commit health care fraud states, "Any person who attempts or conspires to commit any offense under this chapter shall be subject to the same penalties as those prescribed for the offense, the commission of which was the object of the attempt or conspiracy." 18 U.S.C. § 1349. The elements of conspiracy to commit health care fraud are: "(1) two or more persons made an agreement to commit an unlawful act; (2) the defendant knew the unlawful purpose of the agreement; and (3) the defendant joined in the agreement willfully, with the intent to further the unlawful purpose." *United States v. Simpson*, 741 F.3d 539, 547 (5th Cir.), *cert. denied*, 134 S. Ct. 2318, 189 L. Ed. 2d 195 (2014) and *cert. denied sub nom. Shafer v. United States*, 134 S. Ct. 2320, 189 L. Ed. 2d 195 (2014) (stating elements of conspiracy under 18 U.S.C. § 1349 as applicable in mail and wire fraud case) (cited favorably in *United States v. Lewis*, 612 F. App'x 172, 175 (4th Cir. 2015) (unpublished), as providing elements of conspiracy to commit health care fraud). Circumstantial evidence of participation in a

common plan is sufficient proof of an agreement. *Hunt*, 521 F.3d at 647.

I find that Palin and Webb, along with Dr. Wagner, knowingly and willfully executed a scheme to defraud health care benefit programs by submitting bills for tests that they knew were not medically necessary. They devised the drug testing plan and they directed their non-medically-trained staff to order expensive analyzer tests for every insured patient, knowing that the insurers would pay Bristol Labs for the tests. The coconspirators decided that uninsured patients would be tested by the quick-cup only, while insured patients would receive the quantitative testing by Bristol Labs and Forensic Labs. Their influence went beyond mere marketing; they made the decisions regarding testing, and they knew that these decisions were not based on the needs of the individual patients. They also knew that they were not regularly charging patients the required co-pays and co-insurance amounts, in order to hide from the patients the costs of the testing.

It was argued at trial that Palin, Webb, and Bristol Labs were simply following the doctors' orders for the analyzer and confirmation tests, but the evidence does not support that assertion. Rather, it is clear that the coconspirators determined which tests would be performed, and those determinations were made without regard to whether the tests were medically relevant.

It was also argued that it did not constitute fraud for the defendants to treat insured and uninsured patients differently. It was contended that a medical

provider is not normally required to provide free services, and because uninsured patients were unlikely to be able to pay for the expensive analyzer test, the defendants were justified in limiting those patients to the inexpensive quick-cup urine testing. I find, however, that the fraud here consisted of requiring the expensive tests only because they would be paid for by insurance, rather than because they were medically indicated. The government has shown beyond a reasonable doubt that, with rare exceptions, insured patients were automatically tested by the analyzer. While not subjecting uninsured patients to the expensive tests may not be fraudulent by itself, it is further evidence of the real purpose of the scheme. As with insured patients, the type of test performed on uninsured patients was not based on the patient's treatment needs.

On Webb's behalf, it was argued that he was only an employee of Bristol Labs, with limited duties, and that the evidence does not show that he devised or participated in the scheme to defraud. However, while there is no doubt that Palin and Wagner were more heavily involved in the conspiracy, a defendant "need not . . . comprehend the reach of the conspiracy [or] participate in all the enterprises of the conspiracy" in order to be found guilty. *United States v. Burgos*, 94 F.3d 849, 861 (4th Cir. 1996). Indeed, participation by a coconspirator on only one occasion may be sufficient to show guilt. *Id.* at 858. The government has proved beyond a reasonable doubt that Webb joined the conspiracy understanding its nature, even though he may have played only a minor role. Moreover, as to the substantive charge of health care fraud, a

conspirator may be convicted of an offense committed by a coconspirator if the crime was committed during the course of and in furtherance of the conspiracy. *See Pinkerton v. United States*, 328 U.S. 640, 646-47, 66 S. Ct. 1180, 90 L. Ed. 1489 (1946). At the least, Webb is guilty of Count One under the *Pinkerton* doctrine based upon the commission of this offense by Palin and Wagner during the course of and in furtherance of the conspiracy.

Based on these facts, I find that Palin and Webb are guilty of committing health care fraud and conspiracy to commit health care fraud as charged in the Indictment.

B.

The Anti-Kickback Statute prohibits both the offering and acceptance of illegal remunerations in exchange for referrals. Regarding the acceptance of kickbacks, the statute states:

(1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—
(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, ...shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both. 42 U.S.C. § 1320a-7b(b)(1)(A).

Regarding the offering of kickbacks, the statute provides:

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

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, ...shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both. 42 U.S.C. § 1320a-7b(b)(2)(A).

"This statute criminalizes the payment of any funds or benefits designed to encourage an individual to refer another party to a Medicare provider for services to be paid for by the Medicare program." *United States v. Miles*, 360 F.3d 472, 479 (5th Cir. 2004). For a defendant to be convicted of offering or paying kickbacks, the government must prove that the defendant: "(1) knowingly and willfully made a payment or offer of payment, (2) as an inducement to the payee, (3) to refer an individual, (4) to another for the furnishing of an item or service that could be paid for by a federal health care program." *Id.* at 479-80. The payment element "includes not only sums for which no actual service was performed but also those amounts for which some professional time was expended." *United States v. Greber*, 760 F.2d 68, 71 (3rd Cir. 1985). The

words "to induce" require "an intent to exercise influence over the reason or judgment of another in an effort to cause the referral of program-related business." *Hanlester Network v. Shalala*, 51 F.3d 1390, 1398 (9th Cir. 1995). "Giving a person an opportunity to earn money may well be an inducement to that person to channel potential Medicare payments towards a particular recipient." *United States v. Bay State Ambulance & Hosp. Rental Serv., Inc.*, 874 F.2d 20, 29 (1st Cir. 1989). The fact that the payment is consistent with the fair market value of the services rendered does not necessarily render the payment lawful. *See id.* at 31. "The language of the statute makes no distinction on the basis of control or extent of participation." *Id.* at 35.

While I find that Palin and Webb established MEMC with the intent that it would generate business for Bristol Labs, I conclude that Dr. Curtiss was employed to provide legitimate medical services and that she was paid a fair market salary for providing those services. Her job was not contingent upon referring a certain number of tests, nor did her salary fluctuate based on the number of tests she ordered. Dr. Curtiss did not believe she would lose her job if she did not refer as many tests as possible to Bristol Labs. Based on the evidence presented and the legal precedent under the Anti-Kickback Statute, I find that the government did not prove beyond a reasonable doubt the crimes charged in Counts Three and Four of the Indictment.

IV. CONCLUSION.

Based upon my factual findings and the applicable law, I find defendants Palin and Webb guilty of Counts One and Two of the Indictment, but not guilty of Count Four. I find defendant Curtiss not guilty of all charges.

DATED: April 7, 2016

/s/ James P. Jones

United States District Judge

Footnotes

1: While no party has requested specific findings of fact, *see* Fed. R. Crim. P. 23(c), I nevertheless in my discretion find it appropriate to set forth such findings.

2: TennCare is the name of the Tennessee Medicaid program.

3: Laboratory tests are categorized as waived, moderate complexity, or high complexity. 42 C.F.R. § 493.5. The categories and certificate application process are explained at 42 C.F.R. §§ 493.17, 493.20, 493.25, 493.43, and 493.45.

4: While the testimony was that nearly all of the insured patients' samples were sent to Forensic Labs for confirmation testing, the claims data introduced by the government contradicts that assertion. (*See infra* ¶¶ 91-100.)

5: This time period is several months longer than the period of time charged in the Indictment.

FILED: November 28, 2017

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 16-4522(L)
(1:14-cr-00023-JPJ-PMS-1)

UNITED STATES OF AMERICA

Plaintiff-Appellee

v.

BETH PALIN

Defendant-Appellant

No. 16-4540
(1:14-cr-00023-JPJ-PMS-2)

UNITED STATES OF AMERICA

Plaintiff-Appellee

v.

JOSEPH D. WEBB

Defendant-Appellant

ORDER

The court denies the petition for rehearing and rehearing en banc. No judge requested a poll under Fed. R. App. P. 35 on the petition for rehearing en banc.

Entered at the direction of the panel: Judge Motz, Judge Duncan and Judge Wynn.

For the Court

/s/ Patricia S. Connor, Clerk

28 U.S.C. §1254(1)

Current through PL 115-117, approved 1/12/18

§ 1254. Courts of appeals; certiorari; certified questions

Cases in the courts of appeals may be reviewed by the Supreme Court by the following methods:

(1) By writ of certiorari granted upon the petition of any party to any civil or criminal case, before or after rendition of judgment or decree;

(2) By certification at any time by a court of appeals of any question of law in any civil or criminal case as to which instructions are desired, and upon such certification the Supreme Court may give binding instructions or require the entire record to be sent up for decision of the entire matter in controversy.

18 U.S.C. §1347

Current through PL 115-117, approved 1/12/18

§ 1347. Health care fraud

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

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

(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title [18 USCS § 1365]), such person shall be fined under this title or imprisoned not more than 20 years, or both; and if the violation results in death, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.

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

18 U.S.C. §1349

Current through PL 115-117, approved 1/12/18

§ 1349. Attempt and conspiracy

Any person who attempts or conspires to commit any offense under this chapter [18 USCS §§ 1341 et seq.] shall be subject to the same penalties as those prescribed for the offense, the commission of which was the object of the attempt or conspiracy.

31 U.S.C. §3729

Current through PL 115-117, approved 1/12/18

§ 3729. False claims

(a) Liability for certain acts.

(1) In general. Subject to paragraph (2), any person who--

(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

(C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);

(D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;

(E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of

the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or

(G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government,

is liable to the United States Government for a civil penalty of not less than $ 5,000 and not more than $ 10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104-410), plus 3 times the amount of damages which the Government sustains because of the act of that person.

(2) Reduced damages. If the court finds that--

(A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;

(B) such person fully cooperated with any Government investigation of such violation; and

(C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation,

the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of that person.

(3) Costs of civil actions. A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

(b) Definitions. For purposes of this section--

(1) the terms "knowing" and "knowingly"-

(A) mean that a person, with respect to information--

(i) has actual knowledge of the information;

(ii) acts in deliberate ignorance of the truth or falsity of the information; or

(iii) acts in reckless disregard of the truth or falsity of the information; and

(B) require no proof of specific intent to defraud;

(2) the term "claim"--

(A) means any request or demand, whether under a contract or

otherwise, for money or property and whether or not the United States has title to the money or property, that--

(i) is presented to an officer, employee, or agent of the United States; or

(ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government--

(I) provides or has provided any portion of the money or property requested or demanded; or

(II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and

(B) does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property;

(3) the term "obligation" means an established duty, whether or not fixed, arising from an express or implied

contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and

(4) the term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

(c) Exemption from disclosure. Any information furnished pursuant to subsection (a)(2) shall be exempt from disclosure under section 552 of title 5.

(d) Exclusion. This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1986 [26 USCS §§ 1 et seq.].

(e) [Redesignated]

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
ABINGDON DIVISION

UNITED STATES OF AMERICA

Case No. 1:14:CR23

v.

BETH PALIN
JOSEPH D. WEBB
And
MARY ELIZABETH CURTISS

INDICTMENT

INTRODUCTION

THE GRAND JURY CHARGES THAT:

1. At all times relevant to this indictment, Medicare, Virginia Medicaid, and TennCare were health care benefit programs funded and administered by the United States Government. A health care benefit program is defined in Title 18, United States Code, Section 24(b) as any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item or service for which payment may be made under the plan or contract. Medicare, Virginia Medicaid, and TennCare provided health care benefits to eligible recipients, including payment for laboratory services, such as urine drug screens, and for prescription drugs.

2. The Medicare program was established to provide medical services to elderly, blind, and disabled beneficiaries pursuant to the provisions of the Social Security Act (Title 42, United States Code, Section 301 et seq.). Medicare is administered by the Federal government through the Centers for Medicare and Medicaid Services (CMS) and is funded through a portion of the payroll taxes paid by workers and employers; and, by premiums deducted from monthly social security checks.
3. Medicare will only pay for treatments and services, such as laboratory tests and prescription drugs, which are considered medically necessary, performed within accepted medical standards, and are rendered for a legitimate medical purpose.
4. Medicare services are divided into distinct parts. Medicare Part B (outpatient insurance) includes benefits for doctor and other non-hospital health care provider services, such as laboratory services and urine drug screens. Medicare Part D is a prescription drug benefit. Medicare will only pay for treatments and services which are considered reasonable and medically necessary, performed within accepted medical standards, and are rendered for a legitimate medical purpose.
5. All providers enter into a Medicare provider enrollment agreement, which outlines the rules and regulations that are to be followed to ensure that limited Medicare funds are expended appropriately. Upon CMS certification of the provider enrollment agreement, a provider number is issued. Bristol Laboratories became a Medicare provider on or about January 1, 2009 and was assigned the National Provider Index (NPI) number #1447410642.
6. Medicare providers electronically submit billings

for medical treatments and services rendered to recipients via a health insurance claim form ("CMS-1500") to the Medicare Administrative Contractor or "MAC". The MAC is a regional private company that contracts with CMS to administer Medicare benefits. The MAC reviews and processes the claim, and then generates an electronic funds transfer to the provider's designated bank account. The MAC that serviced Virginia from May 2009 through March 18, 2011 was Trailblazer Health Enterprises, LLC, headquartered in Dallas, Texas. The MAC that replaced Trailblazer in March 19, 2011 through April 30, 2012 is Palmetto GBA, headquartered in Columbia, South Carolina.

7. 42 Code of Federal Regulations Section 410.32 states that all diagnostic x-ray and laboratory tests, and other diagnostic tests billed to Medicare must be ordered by the physician who is treating the beneficiary. That is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary.

8. Chapter 1, Section 30.1.3 of the Medicare Claims Processing Manual - General Billing Requirements states that a provider cannot impose any limitations with respect to care and treatment of Medicare beneficiaries that it does not impose on all other persons seeking treatment. A provider may not refuse to furnish a treatment for certain illnesses or conditions to Medicare beneficiaries, if it furnishes such treatment to others. Failure to abide by this rule is a cause for termination of the provider's

agreement to participate in the Medicare program.
9. Virginia Medicaid is a health care benefit program that was established by Title 19 of the Social Security Act of 1965 designed to provide medical assistance services to indigent persons. The U.S. Department of Health and Human Services ("HHS") and the Commonwealth of Virginia, Department of Medical Assistance Services ("DMAS") administer and supervise the Medicaid program in Virginia, which is called the Virginia Medical Assistance Program ("VMAP"). In Virginia, Medicaid is funded by both federal and state dollars at approximately a 50% - 50% ratio during the years 2009-2011.
10. DMAS has established procedures in accordance with the regulations of HHS to compensate doctors, laboratories and other health care providers for services provided to Medicaid recipients. A participating provider is a person, organization, or institution with a valid participation agreement who or which will (1) provide the service, (2) submit the claim, and, (3) accept as payment in full the amount paid by VMAP. One of the ways a provider receives reimbursement for Medicaid services is to submit, by mail or wire, a Health Insurance Claim Form ("CMS 1500") to the Medicaid fiscal intermediary. The fiscal intermediary, under contract with DMAS, receives, processes, and authorizes payment to providers of services under the Medicaid program First Health Services Corporation, of Richmond, Virginia, was the fiscal intermediary until July 2010. Xerox (originally ACS State Health, which was bought by Xerox) was the fiscal intermediary after July 2010.
11. Providers sign Medicaid participation agreements that require them to keep such records as are necessary to fully disclose the services

provided to Medicaid patients, and to furnish such information, upon request, to the Medicaid program. Providers agree to render and perform services that are in accordance with federal and state law, as well as all VMAP administrative policies and procedures.
12. Medicaid will only pay for services and items (such as laboratory tests and prescription medications) which are considered medically necessary, performed within accepted medical standards, and are rendered for a legitimate medical purpose.
13. Virginia Administrative Code §12 VAC 30-80-30 covers Medicaid fee-for-service payments and states that providers are prohibited from chargipg Medicaid-insured patients a higher fee-for-service than they would charge a non-Medicaid, uninsured patient. Section A states: "Payment for the following services, except for physician services, shall be the lower of the state agency fee Schedule or actual charge (charge to the general public). " Section A (8) specifically addresses laboratory services (other than inpatient hospitals).
14. The TennCare program was implemented as a five-year demonstration program approved by the federal Health Care Financing Administration ("HCF A"), which is now known as the Centers for Medicare and Medicaid Services ("CMS"). The program received several extensions after the original expiration date of December 30, 1999 and is in place today. TennCare is considered a health care benefit program as established by Title 19 of the Social Security Act of 1965. TennCare is funded by both federal and state dollars. The Federal portion ofTennCare's costs was 64.3% in 2009; 65.57% in 2010; and, 65.8% in 2011.

15. TennCare essentially replaced and enhanced the Medicaid program in Tennessee by offering coverage to some uninsured and uninsurable persons who were not eligible for traditional Medicaid. TennCare services are offered through several managed care entities. Each enrollee has a Managed Care Organization ("MCO") for his primary care and medical/surgical services.
16. Healthcare providers submit a "CMS 1500" form to the proper TennCare Managed Care Contractor ("MCC") for payment of services performed by the provider. Provider billing submissions and subsequent TennCare payments to the providers can either be in paper or electronic format.
17. Providers complete a binding provider enrollment agreement, which states they will abide by TennCare standards, rules, and regulations. TennCare will only pay for services and items (such as laboratory tests and prescription medications) which are considered medically necessary, performed within accepted medical standards, and are rendered for a legitimate medical purpose. In Section F of the TennCare provider enrollment agreement, providers agree "to make Covered Services available to (TennCare) Members in the same manner that such services are provided or made to all other patients of Supplier; " and "not to differentiate or discriminate in the treatment of TennCare Members on the basis of race, color, veteran status, sex, age, religion, national origin, handicap, disability, state of health, or source of payment. "
18. At all times relevant to this indictment, Anthem Blue Cross Blue Shield of Virginia based in Richmond, Virginia; Blue Cross Blue Shield of Tennessee based in Chattanooga, Tennessee; CIGNA

Insurance based in Hartford, Connecticut; and, AETNA insurance based in Hartford, Connecticut (collectively the "private insurance companies"), were health care benefit programs. A health care benefit program is defined in Title 18, United States Code, Section 24(b) as any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item or service for which payment may be made under the plan or contract. Anthem Blue Cross Blue Shield (of Virginia), Blue Cross Blue Shield of Tennessee, CIGNA Insurance, and AETNA insurance ("the private insurance companies") provided health care benefits to eligible recipients, including payment for laboratory services, such as urine drug screens, and for prescription drugs.

19. Each of the private insurance companies, as with Medicare and Medicaid, have provider agreements in which they only will pay for treatments and services which are considered reasonable and medically necessary, performed within accepted medical standards, and are rendered for a legitimate medical purpose.

20. At all times relevant to this indictment, Bristol Laboratories, LLC, was a participating provider for Medicare, Virginia Medicaid, and TennCare, as well as for each of the private insurance companies. Provider participation in all of these health care benefit programs is voluntary.

21. Subutex (buprenorphine hydrochloride) and Suboxone (buprenorphine hydrochloride and naloxone hydrochloride) were approved by the U.S. Food and Drug Administration ("FDA") in 2002 for

the treatment of opiate/opioid dependence. Subutex and Suboxone treat opiate addiction in patients by preventing the symptoms of withdrawal from heroin, oxycodone, and other opiates/opioids.

22. Subutex contains only buprenorphine hydrochloride and is intended for use at the beginning of treatment for drug abuse (also called "induction"). Suboxone is a combination of two proven medications, buprenorphine and naloxone. Naloxone is added to buprenorphine to decrease the likelihood of diversion and abuse of the combination product. Both drugs are supplied in 2 mg and 8 mg tablets, as well as sublingual film sheets. Subutex is also indicated when a patient cannot take Suboxone due to pregnancy or documented allergy to naloxone.

23. Due to its opioid agonist effects, buprenorphine can be abused, particularly by those not physically dependent on opioids. Based on the potential for abuse of Subutex and Suboxone, the FDA and its parent Department of Health and Human Services ("HHS") recommended that the Drug Enforcement Administration ("DEA") place the active ingredient, buprenorphine, in Schedule III under the Controlled Substances Act ("CSA"). The DEA has, in fact, classified buprenorphine as a Schedule III controlled substance.

24. Suboxone, Subutex and buprenorphine diversion and abuse have become common in Southwest Virginia and Northeast Tennessee. Warrants and indictments for their diversion and/or illegal distribution are frequent in many jurisdictions, including Washington County, Virginia; Bristol, Virginia; Scott County, Virginia; and, Sullivan County, Tennessee.

25. In order to prescribe Suboxone, Subutex, and

buprenorphine in an office based setting for treatment of drug addiction, a physician must complete additional training and apply for a separate DEA number called an "X number." The X number is the same as the physician's regular DEA number with an X in front of it. This training is eight hours and can be completed on-line.

26. An X number allows a physician to treat 30 patients with Suboxone, Subutex and buprenorphine for the first year. The physician can apply to the DEA to treat up to 100 patients after the first year.

27. Dr. CKW, MD ("CKW") was an anesthesiologist who obtained his X number and began prescribing Suboxone, Subutex and buprenorphine in 2009, and initially worked at a Johnson City, Tennessee facility. In approximately July or August of 2009, he left that facility and opened his own practice in Bristol, Virginia, where he continued to prescribe Suboxone and Subutex and buprenorphine. That practice, CKW, M.D., PLLC, was originally located at 1009 West State Street, Suite 2-C, Bristol, Virginia. From January 2011 until its closure in April 2012, the practice was located at 337 Bluff City Highway, Unit 101, Bristol, Tennessee. CKW died on March 14, 2013, a little less than one year after he closed this office.

28. Bristol Laboratories, LLC, ("Bristol Labs") located at 1009 West State Street, Suite 2B, Bristol, Virginia, is a medical laboratory owned by BETH PALIN ("PALIN"), who is a nonpracticing attorney licensed in South Carolina. Palin's husband, JOSEPH D. WEBB ("WEBB"), although not an owner according to corporate filings, is heavily involved in running the business. WEBB handles the marketing part of the business and is also involved

with hiring and firing employees.
29. Mtn. Empire Medical Care, Inc., LLC ("MEMC"), was a business incorporated in Virginia and in Tennessee and owned by PALIN. MEMC was located at 138 Antique Street, Gate City, Virginia. Dr. MARY ELIZABETH CURTISS ("CURTISS"), an otolaryngologist (ear, nose and throat doctor) who has a practice in Marion, Virginia, was an employee of MEMC. CURTISS, like CKW, has an X number that allows her to prescribe Suboxone, Subutex and buprenorphine. In fact, CURTISS was employed by CKW for a short time in 2010 before she became employed by MEMC.
30. Both CKW and CURTISS purported to be operating substance abuse treatment programs, prescribing Suboxone, Subutex and buprenorphine for the treatment of opiate addiction. CURTISS ultimately had an X number allowing her to treat up to 100 patients. CKW's X number only permitted him to see up to 30 patients.
31. Both CKW and CURTISS operated on a cash only basis and did not accept Medicare, Medicaid or insurance of any kind for office visits. Patients paid as much as $250 for an initial visit and up to $110 for each subsequent weekly visit.
32. CKW and CURTISS both filled out and sent in pre-authorization forms so that insured patients could have their prescriptions covered by their plans.
33. Both CKW and CURTISS required every patient to undergo a urine drug screen at every weekly appointment. Both doctors referred all of their urine drug screens to Bristol Labs.
34. Unlike MEMC and CKW's office, Bristol Labs did accept insurance, Medicare and Medicaid. Both MEMC and CKW would collect patients' insurance

information so Bristol Labs could bill insurance for any testing done.

35. Bristol Labs, CKW, and MEMC treated insured patients with two different expensive automated drug screens: a qualitative test that measures the presence or absence of a drug or its metabolites, followed by a quantitative test that measures how much of a drug or its metabolite is present in the urine. Uninsured patients were treated using one much cheaper, dip-stick type drug screen called a "quick cup."

36. When a patient was insured, Bristol Labs would do qualitative testing in-house, and then send the specimen out to another lab, "FL", in Denver, Colorado, for quantitative testing.

37. Medicare, Medicaid and the insurance companies would be billed up to $2,000.00 per urine drug screen for the in-house qualitative testing. Medicare would pay up to $321.76; Virginia Medicaid would pay up to $118.53; TennCare would pay up to $256.72; and, insurance companies paid up to $1218.75 for the in-house qualitative testing by Bristol Labs.

38. Medicare, Medicaid and the private insurance companies would be billed an average of $1,125.00 per urine drug screen for the additional quantitative testing by FL. Medicare would pay up to $321.76; Virginia Medicaid would pay up to $112.59; TennCare would pay up to $209.74; and, insurance companies paid up to $582.35 for the quantitative testing.

39. Patients without insurance, Medicare or Medicaid would not get any automated urine drug screen testing. Uninsured patients would have a "point of care" or "quick cup" test, for which they were charged between $10 and $25.

40. Insured patients were not given the option of taking the cheaper quick cup test, and uninsured patients were not given the option of taking the more expensive automated tests.
41. The type of urine drug screen ordered depended only on method of payment and had nothing to do with the particulars of each patient's individual treatment.
42. At MEMC, CURTISS insisted that every patient have an instant, point of care "quick cup" urine drug screen. Patients with Medicare, Medicaid or insurance would have additional automated qualitative testing and automated quantitative testing, while uninsured patients had no further testing. Uninsured patients paid an extra $25 cash for the quick cup test. Insured patients paid nothing extra, and their insurance was billed for the two automated tests - they paid nothing out of pocket for the lab testing.
43. For an insured patient, the government or private insurance companies were billed 125 times as much as the cash patient, and they paid 25 times as much as a cash patient, for weekly drug screening.

DR, CKW, MD

44. From approximately August 2009 through December 2010, CKW's office was located in the same building as Bristol Labs. Patients could easily register with the doctor, go to the lab for a urine drug screen, and return to the doctor's office. Staff from both businesses went back and forth freely between CKW's office and the lab.
45. CKW moved his practice to Bristol, Tennessee in January 2011, and remained there until its closure in April 2012. Since the lab was no longer physically close by, Bristol Labs placed a "collector" at CKW's

office every day it was open. The collector would collect insurance information or cash for uninsured patients, and the urine specimen from each CKW patient, and bring them back to the lab for processing and analysis. The collector was an employee of, and was paid by, Bristol Labs.

46. When a patient tested positive for something they should not have been taking, or tested negative for Suboxone or another drug that they should be taking, CKW seldom took action or imposed consequences. Occasionally, treatment notes stated that a patient was "counseled" or the test would be noted in the file. Rarely was a patient dismissed, even for repeated bad drug screens. Patients were never required to attend counseling or Narcotics Anonymous meetings when they had bad drug screens. In fact, no patients were ever required to go to counseling or meetings of any kind for any reason.

47. A patient's initial visit consisted of a cursory interview and no physical exam or testing other than the urine drug screen, and the patient paid $250 cash for that visit. Patients did see CKW during an initial visit.

48. CKW did not get records from patients' other medical providers and relied simply on what patients told him in terms of medical history and physical condition.

49. Subsequent visits were required weekly, and patients had to have a urine drug screen each time. The patient did not always see CKW during the subsequent visits, which cost $110, often having their drug screen and getting a prescription from the office staff.

50. Subutex, should only be used for patients who have a documented allergy to naloxone, or for

patients who are pregnant, or during induction. Subutex has a higher street value and is more prone to abuse and diversion than Suboxone.

51. CKW prescribed Subutex or generic buprenorphine to many patients who did not have a documented allergy to naloxone and who were not pregnant.

52. Suboxone, Subutex and buprenorphine are central nervous system ("CNS") depressants, and combining those drugs with other CNS depressants, such as alcohol or benzodiazepines can be very dangerous and cause respiratory failure. CKW often prescribed benzodiazepines along with Suboxone, Subutex or buprenorphine.

53. Induction is the process a patient should go through on his or her first visit to a Suboxone clinic. Induction occurs when the patient presents for the first treatment appointment in moderate withdrawal. The doctor administers a dose, monitors the patient, and adjusts the dose as needed.

54. CKW did not perform any inductions at his practice. After a cursory first appointment, typically lasting less than fifteen minutes, a patient was given a prescription to fill at the pharmacy. Other than the urine drug screen, no other medical tests or exams occurred.

55. MCRW was hired by CKW to be his office manager. She was employed by another office-based addiction treatment physician in Kingsport, Tennessee, prior to being hired by CKW.

56. Once hired, MCRW took a very active role in determining how the practice would operate. MCRW was involved with nearly every significant decision concerning CKW's practice.

57. Although no counseling or meetings occurred,

MCRW held herself out to be a counselor and group leader/facilitator for Narcotics Anonymous-type meetings, thereby giving the illusion that legitimate counseling and meetings were being offered at CK W's practice. This part of the practice was called "Bristol Recovery." Counseling and/or meetings were not required to remain a patient of CKW' s.

58. CKW and MCRW began to have a romantic relationship, and MCRW became pregnant with CKW's child, born in approximately December 2010.

59. During the summer of 2010, CKW and MCRW moved to Louisiana, but kept his practice open in Bristol, Tennessee, despite living a driving distance of over twelve hours and 800 miles away.

60. When he moved to Louisiana, CKW would come up to his office in Bristol, Tennessee, once or twice a month, yet his office was open two days a week, every week. There were times that five weeks went by without CKW appearing at his practice or seeing his patients. His patients, however, continued to pay for appointments, have drug screens, and receive pre-written prescriptions in his absence from CKW's non-medically trained staff.

61. During December 2010, CKW's office was closed for one week over the holidays. Patients were required to pay double ($220) at their appointment prior to the holiday week in order to receive an extra week's prescription. Patients were told if they only brought the usual office visit fee ($110), they would only receive one week's prescription and they would "feel like crap" over the holidays.

62. CKW left his new office manager, JP, in charge of his practice when he was not there. JP had no medical training. JP was hired initially to be a housekeeper for CKW and MCRW. JP was assisted

by her sister, HB, who had a high school diploma and had taken some classes at a community college but who had no medical training either.

63. The atmosphere at CKW's office was unlike most doctors' offices: smoking in the waiting room was sometimes permitted; CKW brought his dog with him to the office at times; there were no stethoscopes, thermometers or other kinds of medical equipment (other than urine screen cups); and, some patients seemed impaired by alcohol and drugs while there for appointments.

64. CKW wrote prescriptions for Suboxone, Subutex, buprenorphine, and benzodiazepines, not for legitimate medical purposes and outside the usual course of a professional medical practice.

65. CKW ordered excessive, medically unnecessary quantitative and qualitative urine drug screens from Bristol Labs, and failed to use the results of these tests to guide treatment of his patients.

66. CKW treated cash patients differently than insured patients by giving them different laboratory tests based only on their method of payment, and for reasons that had nothing to do with their treatment. Insurance patients were not given the choice of having a quick cup test, and cash patients were not given the choice of automated testing.

MTN. EMPIRE MEDICAL CARE, LLC - DR. MARY ELIZABETH CURTISS

67. In October 2010, PALIN and WEBB attempted to open an office-based addiction treatment clinic in Bristol, Virginia, which they called "Medpath." This business was closed shortly after it opened due to their failure to get an appropriate business license.

68. The clinic re-opened as Mtn. Empire Medical

Care, LLC ("MEMC") in December 2010, at a new location in Gate City, Virginia.

69. MEMC's primary physician was CURTISS, whom PALIN and WEBB had met while she worked with CKW for about 3 months during the summer of 2010 Gust before CKW moved to Louisiana). CURTISS was an independent contractor and was paid $1400 per day to work at MEMC, regardless of the number of patients she saw or the amount of work she did.

70. CURTISS' salary exceeded fair market value for the work she performed. Her salary was excessive for the time she spent and the work she did, and was not viable commercially. The only reason MEMC could afford to pay her that salary was the large income generated by lab testing she ordered that was completed and billed by Bristol Labs.

71. CURTISS referred every patient she saw at MEMC to Bristol Labs for urine drug screening.

72. For most of the time that MEMC was open, there was no counselor working there. In approximately June 2011, ML was hired to be a counselor there. Counseling or "group" was never a requirement to remain a patient at MEMC.

73. Although CURTISS did spend more time with her patients than CKW, she did not do inductions of new patients either. She just gave them a prescription to fill at the pharmacy at their first appointment.

74. CURTISS was paid by MEMC, however, she or her husband would pick up her paycheck at Bristol Labs.

75. There was always a Bristol Labs employee working at MEMC. This person would act as receptionist, office manager, and urine drug screen

sample collector at MEMC. That person would also be involved with marketing MEMC by putting up yard signs in Southwest Virginia and Northeast Tennessee.

76. PALIN and WEBB decided that they wanted to hire additional physicians to work at MEMC, as CURTISS was only working one or two days per week.

77. A management consulting firm introduced them to another physician who had his X number from DEA and was able to prescribe Suboxone, Subutex and buprenorphine. He began working there during the summer of 2011 and only saw four patients.

78. The same management consulting firm introduced WEBB and PALIN to two other physicians who were interested in obtaining their X numbers and working for MEMC. Both of those doctors took an on-line course at Bristol Labs to get their X number, and the course was paid for by Bristol Labs. MEMC closed before these doctors officially began employment.

79. Although they signed the orders authorizing the screenings, the physicians at MEMC did not choose the type of urine drug screens that would be done. Bristol Labs created the drug screen order forms which the doctors pre-signed. The MEMC office manager, also a Bristol Labs employee, would check off the tests to be performed depending on whether the patient had insurance or not: automated qualitative and quantitative testing for insured patients, or quick cup for non-insured patients.

80. PALIN and WEBB required the physicians they employed at MEMC, and in particular CURTISS, to order excessive, medically unnecessary quantitative and qualitative urine drug screens from Bristol Labs,

and the physicians did not use the results of those tests to guide treatment of MEMC's patients.
81. At PALIN and WEBB's instruction, MEMC treated cash patients differently than insured patients by giving them different laboratory tests based only on their method of payment, and for reasons having nothing to do with their treatment. Insurance patients were not given the choice of having a quick cup test, and cash patients were not given the choice of automated testing.

COUNT ONE
The Grand Jury charges that:
1. The Introduction is re-alleged and incorporated by reference into this count of the indictment.
2. On or about and between May 1, 2009 and April 30, 2012, in the Western District of Virginia and elsewhere, CKW, MCRW, BETH PALIN, JOSEPH D. WEBB, and MARY ELIZABETH CURTISS, as principals and aiders and abettors, knowingly and willfully executed and attempted to execute a scheme and artifice to (a) defraud any health care benefit program and (b) obtain by means of false and fraudulent pretenses, representations, and promises, money under the custody or control of Virginia Medicaid, TennCare, Medicare, and the private insurance companies, which are health care benefit programs as defined by Title 18, United States Code §24(b), in connection with the delivery of and payment for health care benefits, items and services.
3. It was the object of the scheme and artifice to defraud that CKW, MCRW, BETH PALIN, JOSEPH D. WEBB, and MARY ELIZABETH CURTISS would gain compensation from Virginia Medicaid, TennCare, Medicare, and the private insurance

companies, to which they were not entitled, by fraudulently ordering, completing, and billing for urine drug screens that were medically unnecessary, and the results of which were not used in directing the care of the patient.

4. In furtherance of the scheme and artifice to defraud, CKW, MCRW, BETH PALIN, JOSEPH D. WEBB, and MARY ELIZABETH CURTISS knowingly submitted and caused billing in the amount of $12,459,211 to be submitted to Virginia Medicaid, TennCare, Medicare, and the private insurance companies, and received over $1,203,000 to which they were not entitled.

5. In furtherance of the scheme and artifice to defraud, both CKW and MARY ELIZABETH CURTISS made a urine drug screen by Bristol Laboratories, LLC, a precondition for obtaining a weekly Suboxone, Subutex or generic buprenorphine prescription for opiate addicted patients.

6. All in violation of Title 18, United States Code, Sections 2 and 1347.

COUNT TWO

The Grand Jury charges that:

1. The Introduction is re-alleged and incorporated by reference into this count of the indictment.

2. On or about and between May 1, 2009 and April 30, 2012, in the Western District of Virginia and elsewhere, CKW, MCRW, BETH PALIN, JOSEPH D. WEBB, and MARY ELIZABETH CURTISS conspired to knowingly and willfully execute and attempt to execute a scheme and artifice to (a) defraud a health care benefit program and (b) obtain by means of false and fraudulent pretenses, representations, and promises, money under the

custody and control of Virginia Medicaid, TennCare, Medicare, and the private insurance companies, which are health care benefit programs as defined by Title 18, United States Code Section 24(b), in connection with the delivery of and payment for health care benefits, items and services, in violation of Title 18, United States Code,§ 1347.

3. It was the object of the conspiracy that CKW, MCRW, BETH PALIN, JOSEPH D. WEBB, and MARY ELIZABETH CURTISS would gain compensation from Virginia Medicaid, TennCare, Medicare, and the private insurance companies, to which they were not entitled by fraudulently ordering, completing, and billing for urine drug screens that were medically unnecessary, and the results of which were not used in directing the care of the patient.

4. In furtherance of the conspiracy, and to effect its object, CKW, MCRW, BETH PALIN, JOSEPH D. WEBB, and MARY ELIZABETH CURTISS knowingly submitted and caused billing in the amount of $12,459,211 to be submitted to Virginia Medicaid, TennCare, Medicare, and the private insurance companies and received over $1,203,000 to which they were not entitled.

5. In furtherance of the conspiracy, and to effect its object, both CKW and MARY ELIZABETH CURTISS made a urine drug screen by Bristol Laboratories, LLC, a precondition for obtaining a weekly Suboxone, Subutex or generic buprenorphine prescription for opiate addicted patients.

6. All in violation of Title 18, United States Code, Section 1349.

COUNT THREE

The Grand Jury charges that:

1. The Introduction is re-alleged and incorporated by reference into this count of the indictment.

2. On or about and between December 1, 2010 and November 16, 2011, in the Western District of Virginia and elsewhere, MARY ELIZABETH CURTISS, as principal and aider and abettor, knowingly and willfully received remuneration, specifically, directly and indirectly, overtly and covertly, in return for referring individuals for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole or in part by Medicaid or Medicare, both of which are Federal health care programs.

3. All in violation of Title 42, United States Code Section 1320a-7b(b)(l)(A).

COUNT FOUR

The Grand Jury charges that:

1. The Introduction is re-alleged and incorporated by reference into this count of the indictment.

2. On or about and between December 1, 2010 and November 16, 2011, in the Western District of Virginia and elsewhere, BETH PALIN and JOSEPH D. WEBB, as principals and aiders and abettors, knowingly and willfully paid remuneration, directly and indirectly, overtly and covertly, in return for referring individuals for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole or in part by Medicaid or by Medicare, both of which are Federal health care programs.

3. All in violation of Title 42, United States Code Section 1320a-7b(b)(2)(A).

A TRUE BULL, this 23rd day of September, 2014.

James D. Sheen
Grand Jury

Foreperson

Timothy J. Heaphy
Timothy J. Heaphy
United States Attorney