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Health Care Fraud Issues

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Letter from the Editor-in-Chief

In this issue, we are pleased to introduce, through our featured interview, the new Chairman of the Attorney General's Advisory Committee, Don Stern. Mr. Stern, the United States Attorney from the District of Massachusetts, has a dynamic message for all Assistant United States Attorneys. He is very interested in using our collective expertise to solve potential criminal problems before they become national crises.

This is the second part of a two part series on Health Care Fraud. From a review of the articles, it is apparent that the variety of schemes and artifices used to attempt to defraud the United States are virtually limitless. The expertise that our Assistant United States Attorneys have quickly developed to stop these crimes is truly remarkable. We thank our contributing authors, who not only have done a great job of prosecuting these cases, but have gone the extra mile to share what they learned from these experiences.

As the quality of our Assistants' articles continues to grow with each issue, we have decided to find a more permanent way of preserving and sharing this information. In 1998 we plan to add the Bulletin to USABook. It is our goal at that time, to add the pleadings (indictments, jury instructions, significant motions) via jumplinks to the computerized version of the Bulletin. When you see an article about a case that is similar to one that you are beginning to develop, you will be able to retrieve key documents that should serve as building blocks for your case.

We hope that you enjoy this issue. Please send me your comments, criticisms, or suggestions to me in St. Croix at (809) 773 3920 or on Email at AVISC01(DNISSMAN).

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Interview with United States Attorney Donald K. Stern, District of Massachusetts

Mr. Stern has been the United States Attorney for the District of Massachusetts since November 1993, and is currently Chair of the Attorney General's Advisory Committee. He has a B.A. degree from Hobart College and a J.D. degree from Georgetown University.

Mr. Stern directs an office of 90 attorneys, whose priorities are violent crime; gun trafficking; drugs; organized crime; and white collar crime, particularly public corruption, health care fraud, securities fraud, and computer crime. On the civil side, he has emphasized affirmative enforcement in such areas as health care and fine collection.

Before becoming United States Attorney, he was a Senior Partner in the Boston law firm of Hale and Dorr, and served as Chief Legal Counsel to Governor Michael S. Dukakis, where his duties included managing the Governor's Anti-Crime Council and the Governor's Alliance Against Drugs.

He also served as an Assistant Attorney General in the Massachusetts Attorney General's office and an assistant professor at Boston College Law School.

United States Attorney Donald Stern (DS) was interviewed by Assistant United States Attorney (AUSA) David Nissman (DN), Editor-in-Chief of the United States Attorneys' Bulletin.

DN: As the new head of the Attorney General's Advisory Committee (AGAC), what are your goals for this year?

*DS: **One of the overriding goals of the AGAC should always be to provide support for line and supervisory Assistant United States Attorneys (AUSAs).** The best way to do this is to get ideas from the field—not just from the United States Attorneys but from the people working on the cases. We want to be the conduit to the Attorney General and the Department. Some of the best things we've done over the last few years have come from line Assistants who are involved in committees or working groups, or who say something to their United States Attorney, which then gets passed along to the AGAC. We should use AGAC subcommittees to initiate things rather than to just respond to Department proposals. Although many very good suggestions come out of Main Justice, I would like for the AGAC to suggest more initiatives that we can work on together.*

DN: I understand that you are interested in having the AGAC take a more proactive role. Could you explain some of your views?

DS: We all must respond to deadlines and crises. At the same time, we need to step back and take a look at issues like Russian organized crime, money laundering, or bankruptcy fraud.

*Thinking systemically is hard for us to do since much of our work is driven by the cases we have in the office. One of the things we're going to do this year is to sit down with agencies and discuss priorities. We recently met with the FBI, and it was one of the best meetings that I've attended with any Federal agency. Some of these relationships have taken a couple of years to develop. You have a group of United States Attorneys who have now been around for three or four years. You have career people in leadership positions in the Department who have been around and who know us. And you have an incredible level of experience at the Assistant United States Attorney level. **Indeed, we've got some of the very best trial lawyers in America in United States Attorneys' offices around the country.** We need to harness that experience and sit down with the FBI, ATF, and DEA to talk candidly about priorities.*

DN: Of course, you want to do this with more than one agency. What do you see as the evolution of this process?

DS: I think we're going to start working with agencies that generate the most business for United States Attorneys' offices. Whether it's through bodies like the White Collar Crime Council or other efforts, we will try to expand beyond that. It happens already at the local level where people get together and talk frequently. I ask Special Agents in Charge all the time what they want to do. I find out what their priorities are, they find out mine, and we generally work it out. I think that also happens at the global budgetary level. But apart from the budget issues, we can still do better in arriving at joint priorities. For example, it doesn't make sense for the Bureau to come up with some elaborate, very appropriate initiative and for us not to be geared up to do it.

DN: What new crime problems do you see on the horizon?

DS: Computer crime is an area where we, as prosecutors, need to prepare ourselves for a flood of business. We need to make sure agents are trained in issues ranging from searches of computers, to computer crime, to child pornography on the Internet. At the last AGAC meeting, we discussed the need for more joint training with agents, not just with the FBI but with other agencies.

DN: One of the most inspiring parts of our job as Assistants is that we can help stop huge potential crime problems, whether they are in the health care fraud industry, the banking industry, or in our pension system. The question is, how can we identify those areas before they become large problems?

DS: The pension fraud initiative is a good example of how one Assistant United States Attorney can make a difference on a national level. Gary Katzman, an Assistant in my office, was working on a couple of pension cases. He knew the Attorney General because he had been on detail to DOJ. One day the Attorney General was in my office—I think she was delivering a speech at Harvard, and she had a couple of hours of down time. She asked Gary what he was working on and he told her. She asked him to give her a memo on it. Gary prepared a proposed National initiative and, ultimately, I presented it to the AGAC and the White Collar Crime Council. Now,

not only are the United States Attorneys' offices stepping up their focus on this problem but, just as importantly, the investigative agencies are gearing up.

DN: Besides substantive crime issues, what else do you want the AGAC to address?

*DS: **One of the things we'd like to do this year, in addition to working on substantive crime areas which change from time to time, is to see if we can improve what might be called the justice infrastructure.** Whether it's to make sure AUSAs have the best computer system, to provide support to the people who are working on USABook, or to provide support to other efforts that help to make our offices function better—we need to improve the infrastructure. We are also going to encourage regional cooperation between United States Attorneys' offices.*

DN: How do you recommend that Assistants bring issues to the attention of the AGAC, and how will the AGAC, in turn, bring the best of those issues to the Attorney General's attention?

DS: One simple way is to walk into the office of the United States Attorney with an idea. Of course, you have to be prepared to do the followup. If someone came in my office, I might tell them to make some calls, see what's happening, and to put it in a short memo. The United States Attorneys have a phone tree that we use before each AGAC meeting. Part of each meeting is devoted to ideas raised by United States Attorneys via the phone tree. We generate some very good ideas through this process. Typically one of the AGAC members will say, United States Attorney so and so came up with an idea, and we'll send it to the appropriate subcommittee for them to work on and come back to us with a recommendation. And what we recommend is taken very seriously not only by the Attorney General but by the components here. We have a significant voice in the Department.

DN: How can AUSAs help you gather information or implement AGAC goals?

DS: One way is to step back and ask, if not while a case is progressing, at least when it is over: Why did this crime happen and is there something that somebody could have done differently, something that would have made it less likely to happen? Or maybe ask, was my life made easier or more difficult by what law enforcement agencies did or didn't do and is there something that can be improved? Or, is there something within either my own office or the Department of Justice which either worked or didn't work?

We have a great reservoir of expertise developed by prosecutors—in some cases career prosecutors like yourself, in other cases someone who may only be doing it for five years but who still has a great deal to offer. Sharing expertise is a challenge. Some expertise is shared by formal, structured committees; other times, expertise is shared by AUSAs simply talking with each other. The irony, as I see, is that we can be very proactive on our individual cases. For example, an AUSA who is doing a long-term drug investigation will typically be very creative about it. Yet, when the case is over, I don't think we fully tap into that expertise. We don't

analyze what we've learned. Harnessing the information AUSAs learn during the investigation and prosecution of a case can be very beneficial to the Department.

DN: What final message do you have for Assistant United States Attorneys?

*DS: **I think the single most efficient component in the Federal Government is the Assistant United States Attorneys.** If they are experienced, aggressive, willing to work long hours, and work well with agents, then the sky is the limit. Whatever the area—pension fraud, health care fraud, or organized crime—there is no more productive, efficient unit in Government.*

United States v. Dr. Ivan Namihas, M.D.: He Never Cried for Us

*Assistant United States Attorney Jonathan S. Shapiro
Central District of California*

The term “abuse of a position of trust” seems to have been coined for Dr. Ivan C. Namihas, M.D. Arrogant, cruel, and greedy, he carried out a particularly cruel form of fraud against his victims.

For approximately 30 years, an Orange County, California, gynecologist sexually assaulted a number of his patients during routine physical examinations at his Santa Ana medical offices. In 1969, several of his victims contacted the state medical board with complaints. Eventually, 160 of them filed official complaints—the largest number ever lodged against a single doctor in California history. Some of the women were raped; others were fondled. A few said that Dr. Namihas performed surgery without giving them sufficient anaesthesia to dull their pain. A former nurse said Namihas seemed to enjoy hurting women. Yet it was not until 1993 that state officials finally sought to strip Namihas of his medical license. Facing a mountain of charges and a ton of negative press, Dr. Namihas voluntarily retired from medicine; destroyed his medical files; and moved to Las Vegas, Nevada.

He might still be there, living in his mansion on the 15th hole of a private golf course, but for the courage and persistence of some of his victims. Outraged that Dr. Namihas had never been charged criminally, a handful of women went public, describing in newspaper accounts what Dr. Namihas did to them. On the television news show *Prime-Time Live*, a number of these women wondered why this man was allowed to get away with causing so much anguish.

I saw the *Prime-Time Live* segment when it aired. As an Assistant United States Attorney in the Santa Ana Branch of the United States Attorney’s office at the time, I received permission to ask the United States Postal Inspection Service to look into whether or not Namihas had committed any Federal crimes. Postal Inspector Susan Watson was assigned the task, a development which, in retrospect, sealed Namihas’s fate; Inspector Watson does not let the guilty get away with anything.

We contacted former patients. Some were eager to talk to us. Others were understandably reluctant: we were asking, as sensitively as we could, for them to discuss gynecological examinations and treatments. We decided to pursue only the cases involving patients who were certain of their recollections; later, we limited our investigation to cases involving patients who were committed to testifying at any future trial—from what we knew of Dr. Namihas, we did not consider a plea likely. We spoke with fired office personnel who feared Namihas would seek revenge against them if they spoke to us, and we spoke with nurses who still liked him, no matter what the newspapers said. Some of Dr. Namihas’s former colleagues spoke with us, but most did not, preferring to honor a code of silence. After months of interviews, we identified a number of

insurance carriers who received claims from Dr. Namihas, as well as a number of hospitals and labs where he practiced. Slowly, we obtained documentary evidence to support what a number of patients told us. We eventually succeeded in recreating, to a great degree, patient histories.

We thought we might have a case, but neither Inspector Watson nor myself understood much of the medical material before us. The meaning of pathology reports and operative notes eluded us. At the University of California's Irvine (UCI) Medical Center Library, I asked for a textbook on gynecologic sciences and was directed to a shelf of books and articles, all written by the same man: Dr. Philip Disaia, a world-renowned expert on gynecologic oncology, author of over 10 books and 200 peer review articles on the subject, and head of the UCI Medical Center. With very little prompting, Dr. Disaia cut his normal consultation fee by 90 percent and, for the first time, agreed to be an expert witness. Like Inspector Watson, Disaia also turned out to be Namihas's worst nightmare.

Reviewing the product of nearly a year and a half of investigation, Dr. Disaia explained what we did not understand. He also left us without a doubt that, in addition to sexually abusing his patients, Dr. Namihas carried out a small-scale, discrete but undeniably heinous, mail fraud scheme.

Beginning in 1988, Namihas leased an expensive laser for performing surgery. When a victim patient came in for an appointment, he would examine her outside of the presence of others. After a brief visual examination, Dr. Namihas wrongfully told the patient that she had cervical cancer. One woman was also wrongfully told she had AIDS. These lies scared the patients and seemed calculated to do so. Dr. Namihas told patients they needed immediate laser surgery and, if the patient hesitated—if the scare was initially insufficient—Namihas would personally telephone the patient at their place of business or home to remind them that they would die without the surgery. Dr. Namihas seemed intent on ensuring that patients would immediately consent to surgery, without first consulting other physicians or seeking other, often cheaper, forms of treatment. Dr. Namihas began to instruct some of his victims to send their husbands or boyfriends in for examinations to determine if the cancer had spread to them. One man submitted to 12 painful laser surgeries; another sought a second opinion and was told that nothing was wrong with him.

Why did Dr. Namihas do it? Two of his ex-wives, many of his former employees, and several victims were certain that he derived sadistic pleasure from it. He may have. Dr. Namihas billed the patients and their insurance companies for the unnecessary treatment. And, as Inspector Watson was eager to prove in court, Namihas sent those bills and received checks in the United States mail.

Preparing to seek an indictment, we tried to anticipate a defense. Could Dr. Namihas claim that he was merely a bad doctor who misdiagnosed patients with cancer? That would be a hard defense to beat; this was not a medical malpractice case after all, but a mail fraud prosecution. We proceeded anyway. First, we felt confident Namihas would never admit to making a mistake. Second, the evidence suggested fraudulent intent, not mistaken beliefs. Though acknowledging, in retrospect,

that Dr. Namihas was a sexual predator, his colleagues seemed to think he was an excellent doctor who did not make mistakes. (Why these colleagues did not speak out against Dr. Namihas's well-known perversions is the subject of another article.) Finally, Namihas seemed to go out of his way to prevent verification of the accuracy of his diagnoses. He reprimanded employees who disclosed accurate test results to victim patients; performed surgeries before obtaining biopsies; performed biopsies before obtaining test results; lied in preoperative notes about victims' conditions; urged victim patients not to go to hospitals if they hemorrhaged after he performed laser surgery; and failed to obtain operative pathology samples, in violation of standard medical practice and in spite of several letters of warning from hospital peer review committees demanding that he supply samples.

Initially, Dr. Namihas was indicted on 10 counts of mail fraud. The case admittedly had some problems. The court ruled that the Government could neither prove nor mention any sexual assault on the part of the defendant, and that such evidence was irrelevant to whether the defendant committed mail fraud. After almost two years, we found only four victims whose patient files were complete and who were willing to testify. Furthermore, we were able to show only a ludicrously small loss—approximately \$10,000 in billings. Yet we were certain that a jury would see that Namihas stole more than money when he told patients they would die without his help.

At trial, the former patients testified that after Dr. Namihas told them they had cervical cancer, they were treated by other doctors. These second opinion doctors consistently confirmed that Dr. Namihas appeared to have misdiagnosed and mistreated them. Dr. Disaia testified that Namihas's treatment of the victim patients constituted fraudulent, excessive, and unnecessary medical treatment. The Government also offered the testimony of several of the defendant's employees, witnesses, and custodians of records for insurance company and collection agencies. Additional evidence included correspondence and peer review notes between the defendant and two hospital peer review committees where he was a staff member, concerning Namihas's failure to comply with hospital requirements regarding maintaining and keeping postoperative tissue samples from laser surgeries.

The defense called two experts who testified that laser surgery was an appropriate treatment for the removal of **precancerous** growths. Then Namihas took the stand. He proved a terrible witness. Admitting that several of the patients who testified did leave his office weeping, he insisted that he never told them they had cancer or needed surgery. It would have been wrong to tell these patients they had cancer, he conceded, because they did not. The problem was not the diagnosis, he claimed, but was their interpretation. The patients had misunderstood him. They mistook words "precancer to cancer" and "cascade to cancer" as "cancer." They misunderstood the laser surgery; it was not a treatment for cancer but a treatment to stop the progression of precancerous growths. Dr. Namihas said the patients were merely scared and, because of this, they exaggerated what he said and did to them.

It did not sound wholly believable. Things looked promising. Then Juror Number 1 sent a note to the court. During voir dire, Juror 1 (and the other jurors) were asked if they had ever had surgery, ever been treated with a laser, ever been diagnosed with cancer, ever had surgery performed by a gynecologist, or had a reason not to serve on this particular case. Juror 1 answered no to each question but, two weeks into trial, long after the Government rested, she indicated that she forgot to mention that she had been treated with laser surgery for cervical cancer. Over the Government's objections, she was not removed from the panel. The rest of the panel later told us that she proved the hold-out, convincing one other juror that no doctor could be so evil as to do what Dr. Namihas was alleged to have done. The split, from the first day of deliberations until the eighth and last day, never changed—10 to 2 to convict on all counts.

I was beaten. Inspector Watson, usually a stoic, was unnerved. The victims, however, never hesitated. They were ready and willing to go again, right then. The Government's case improved. Notoriety produced a witness who provided probable cause which resulted in a search warrant for a building owned by Dr. Namihas. The search produced what a subpoena to the custodian of records for the doctor's former corporation did not—a small box of patient files that had not been destroyed. As a result, three more patients and five more counts were added to a superseding indictment.

At the second trial, the Government presented a stronger case. The defendant did not take the stand. Instead, he offered an expert witness who proved ineffective. After a two-week trial, the jury took less than two hours to convict Dr. Namihas of all 15 counts of mail fraud.

It had been a long road. Justice, though delayed, was not denied. The case taught me an important lesson about the value of time. Perhaps more than others, health care fraud cases are labor intensive. They require that we spend a great deal of time with witnesses. They require a higher level of patience with witnesses, a greater sense of understanding for their concerns about participating in a trial, and a deeper appreciation of the sensitive nature of the questions that will be asked on the stand. The hours we spent learning about our victim witnesses, often at their homes, created a bond and a level of trust. Ultimately, we relied on that trust through two tough trials. The case also took time to understand. The hours of lectures and readings with Dr. Disaia were key to the success of the case. I could not have cross-examined experts successfully without Dr. Disaia's knowledge. The time, hard work, and commitment of our witnesses made this case possible.

With such a small amount of loss, and before a court that did not find sexual assaults to be relevant conduct in a mail fraud prosecution, the length of Namihas's sentence was 24 months imprisonment, the top end of the applicable guideline. The Government's motion for an upward departure was denied; Inspector Watson wryly noted that we worked on the case longer than the sentence. However, before a packed courtroom, Dr. Namihas, who came so close to avoiding any prosecution, was immediately remanded to begin serving his time. A number of his former patients later expressed great satisfaction in seeing the former doctor led in handcuffs out of the

courtroom, his head down, tears streaming down his face. “He never cried for us,” one of his patients said. Dr. Namihis remains in custody.

Health Care Fraud Hotline

J. Don Foster, United States Attorney, Southern District of Alabama, has developed a new toll-free hotline for people to report instances of health care fraud. The first of its kind in the nation devoted to both private and Government medical abusers, the new telephone system is funded by a Department grant. It is hoped that the system will help stop abuse by private insurers who overcharge patients and by doctors who claim bogus Medicare or Medicaid reimbursements. The hotline number is (888) ABUSEHC. For more information about the hotline, contact Assistant United States Attorney Donna Dobbins, Southern District of Alabama, (334) 441-5845.

Parallel Proceedings in Complex Health Care Fraud Cases: the Blue Shield of California Case

*Assistant United States Attorneys Geoffrey A. Goodman and Benjamin B. Wagner
Eastern District of California;*

*Assistant United States Attorney Gail Killefer, Northern District of California; and
Michael Theis, Civil Division, Commercial Litigation Branch, Fraud Section*

Investigating and prosecuting Government contractors in situations in which criminal, civil, and administrative proceedings may all arise from the same underlying conduct can present Department of Justice attorneys with a variety of legal, ethical, and strategic quandaries. The fact that prosecutors, Government civil attorneys, the victim Government agency, and that agency's investigative arm may all have separate remedies, separate investigative tools, and different responsibilities can complicate the task of investigating and resolving fraud cases. Parallel proceedings are becoming more common in the area of health care fraud, in part due to the increase of employees of Government health care contractors using the False Claims Act. A whistle blower's False Claims Act complaint under seal can spawn simultaneous criminal, civil, and administrative investigations.

The difficulty in obtaining a criminal conviction against a major Government health care contractor under such conditions is evident in the fact that, until recently, no Medicare claims processing contractor had been convicted of fraud, despite numerous investigations and substantial civil settlements. Recently, however, Blue Shield of California (Blue Shield) became the first contractor prosecuted both criminally and civilly for fraud, in connection with its contract to process Medicare claims. In May 1996, Blue Shield pled guilty to one conspiracy count and two substantive counts of obstructing Federal auditors (18 U.S.C. §§ 371 and 1516), and was fined \$1.5 million. In April 1997, Blue Shield agreed to pay \$12 million in damages and penalties to settle a civil False Claims Act case. The criminal case was handled by Assistant United States Attorneys Geoffrey Goodman and Benjamin Wagner in the Eastern District of California—the location of the processing centers where the fraud took place. The civil case was handled in the Northern District of California, the location of Blue Shield's administrative headquarters, and where a qui tam action was filed by Assistant United States Attorneys Gail Killefer and Michael Theis of DOJ's Commercial Litigation Branch.

In the Blue Shield case, we were confronted with many of the coordination issues that typically arise in these cases. In addition, the case demanded a creative approach to evaluating damages.

The Blue Shield Investigation—Who Goes First?

The Government hires private contractors to process Medicare claims. Since 1966, Blue Shield of California held the exclusive contract for processing and paying Medicare Part B claims for northern and central California. The Health Care Financing Administration (HCFA) of the Department of Health and Human Services uses the Contractor Performance Evaluation Program

(CPEP) to measure the contractors' performance. Each year, HCFA auditors review samples of various aspects of claims processing to assess the contractors' timeliness, efficiency, and quality. In addition, contractors are required to conduct ongoing quality reviews of samples of processed claims, and report the number and kind of errors detected to HCFA.

The Government's investigation of Blue Shield began in October 1994, after a former employee filed a False Claims Act complaint under seal. He alleged that Blue Shield employees routinely misled HCFA auditors about Blue Shield's performance by manipulating samples and altering, fabricating, and deleting documents. HHS Office of Inspector General (OIG) Special Agents immediately began an investigation.

The decision as to whether the criminal or civil investigation would go first or proceed together was made quickly. Despite the *qui tam* being under seal, Blue Shield became aware of the investigation quickly. After two employees cooperated in recording some encouraging conversations, another employee who was approached by investigators refused, and promptly advised the company of the investigation. Blue Shield retained counsel, sent letters to current and former employees advising them that they had no obligation to speak with Government investigators, and provided individual counsel for witnesses.

With this turn of events, we determined that it was necessary to issue grand jury subpoenas and offer immunity to most of the knowledgeable, low-level employee witnesses. Because of OIG's policy to not use its subpoena authority once a grand jury investigation commences, further administrative investigation was halted. Since civil discovery would duplicate, and might interfere with, the grand jury investigation, we agreed that the civil investigation would wait while the criminal investigation proceeded.

The Criminal Investigation

The evidence developed through the grand jury investigation was basically testimonial and anecdotal. The actual acts of deception—the manipulation of samples, the cutting and pasting of documents, and other methods used to “clean up” the files prior to review by HCFA—were performed, by and large, by relatively low-level employees who appeared motivated by a desire to save their jobs and to please their superiors. In the area where the service centers were located, Blue Shield was one of the largest employers, and had recently gone through downsizing, resulting in many employees being laid off. Often, management reminded staff that if the company did not pass CPEP, it could lose the Medicare contract which would cost them their jobs.

We started from the bottom up, extending immunity to lower-level employees, many of whom admitted falsifying records to help Blue Shield pass CPEP. As the investigation progressed, it appeared that the fraudulent conduct was not isolated to one or two “bad apple” employees, but had occurred in a number of units. Although we never developed evidence sufficient to prove beyond a reasonable doubt that upper-level management ordered the fabrication of documents, it was apparent that a corporate culture had developed to “pass CPEP at all costs.” Direct orders to

“fix” the files were unnecessary because the fraudulent practice had been going on for so long it became institutionalized. We concluded that because of the nature and extent of the unlawful behavior, and the fact that the fraud was perpetrated primarily to benefit the company, this case was clearly one of corporate criminal liability.

Consideration of Collateral Consequences

Although the evidence convinced us that there was criminal conduct and that the corporation should be held criminally culpable, the decision to seek a criminal conviction was not a simple one. The potential collateral consequences of a criminal prosecution, including debarment from all Government contracts and exclusion from the Medicare program, could have been devastating to Blue Shield, which depended heavily on doing business with the Government. In an effort to dissuade us from proceeding criminally, Blue Shield principally argued that the collateral consequences from a criminal conviction would be disproportionate to the conduct—that the sanction would amount to a corporate “death penalty.” Blue Shield claimed that a criminal conviction would lead to exclusion from the Medicare program, causing deprivation not only of its contract as a Part B carrier, but of the opportunity to offer a risk contract to provide private managed care to Medicare beneficiaries. Blue Shield claimed that this risk contract for which it had applied was critical to its viability in the competitive California health care marketplace.

While as prosecutors we could not control the actions of HHS/OIG or HCFA in connection with their exclusion and contracting authority, we wanted to get a sense of their likely course of action to better understand the full impact of our decision before we instituted criminal charges. We contacted HHS/OIG and HCFA representatives in an attempt to verify Blue Shield’s claim that a criminal conviction would result in the loss of its Part B contract and bar it from receiving a Medicare risk contract, but determining the agencies’ future intentions was tough. Although they were aware of the general nature of the investigation due to the pre-grand jury investigation by HHS/OIG, we could not share with them the additional facts revealed in the grand jury investigation. Understandably, they were reluctant to commit to a course of action without knowing all the facts.

For two reasons, we elected to press ahead with a criminal resolution of the investigation, despite Blue Shield’s arguments. First, based upon our and Blue Shield’s discussions with HHS/OIG and HCFA, we determined that a likely administrative consequence was that Blue Shield would lose its Part B contract under which the fraud was committed, but that it was not likely to be excluded from all Government contracts. In fact under certain conditions Blue Shield would be permitted to receive the risk contract it was seeking to offer managed care services to Medicare beneficiaries. (The new contract would involve divisions of the company, separate from those which were the subject of our investigation.) Accordingly, while a conviction and the loss of the huge Medicare Part B contract would be major setbacks to Blue Shield, it did not appear that they would be fatal to the company. Second, during the period we were investigating the collateral consequences of a criminal conviction and other dire predictions that Blue Shield’s attorneys made, the criminal case got stronger. As we uncovered more evidence of fraud within Blue Shield, the potential collateral

consequences of a criminal conviction seemed less and less disproportionate to the criminal conduct. At this point, we firmly decided to proceed criminally and sent an offer of a pre-indictment plea to Blue Shield.

(The administrative consequences of a criminal conviction for a company are more predictable—and severe—under the Health Insurance Portability and Accountability Act. A broader class of convictions now triggers mandatory exclusions. Ironically, these mandatory provisions, intended to toughen health care fraud enforcement, may cause prosecutors to refrain from criminally prosecuting established companies in otherwise appropriate cases because of the perceived disproportionate collateral consequences of a conviction.)

Resolving the Criminal Case

During case settlement discussions, coordination between the Department's civil and criminal attorneys was very important. Blue Shield initially expressed a desire to resolve the matter globally. We indicated that we would discuss a global resolution but that we were also willing to resolve the criminal matter independently. Rather than a single, global negotiation, Blue Shield elected to pursue simultaneous but separate discussions with the prosecutors and civil attorneys. When it appeared to us that Blue Shield was taking advantage of this arrangement by stalling negotiations on the criminal side in order to battle the damages issue on the civil side, we insisted on a resolution of the criminal case, put firm deadlines on the company, and prepared to indict.

Because of the civil case and the difficulty of quantifying the loss to the Government caused by Blue Shield's conduct, we realized that we could not reach an agreement on restitution in the criminal case without compromising the civil proceeding. Accordingly, we agreed to defer the determination of loss and restitution issues to the civil case. However, we insisted that the plea agreement contain a *Halper* waiver, so that Blue Shield could not use the criminal conviction to defend against the civil case and avoid paying compensatory damages in either proceeding. This point was almost a deal breaker but we held firm. While we felt strongly about the need for a criminal conviction, we were not willing to prejudice the civil case in the course of obtaining a criminal conviction.

Pursuant to the plea agreement, Blue Shield pled guilty to three felony counts and paid a \$1.5 million fine. Restitution was specifically deferred. In a matter separately negotiated between Blue Shield and HCFA prior to the entry of the plea, HCFA declined to renew Blue Shield's Medicare Part B claims processing contract, and Blue Shield signed an agreement to implement a special compliance program.

Resolving the Civil Case

Results of the grand jury investigation were shared with the civil attorneys pursuant to Rule 6(e). Blue Shield had no objection, since it hoped to resolve the case civilly without criminal prosecution, or at least to reach a global settlement if criminal charges were forthcoming. Blue

Shield realized that the Government’s civil attorneys would not recommend a settlement figure without conducting an independent investigation or learning the results of the grand jury investigation.

The challenges presented in negotiating the civil settlement came from several sources. First, surprisingly, was the criminal plea. The momentum in the case shifted in Blue Shield’s favor after, as their lawyer said, the company “fell on its sword” in the criminal case. Blue Shield had no incentive to pay a substantial civil settlement when there was no hope of forestalling a criminal plea. Moreover, they asserted that a strong defense could be asserted to the civil case because there were “no damages” suffered by the United States. With the criminal case resolved and with HCFA’s agreement that Blue Shield would keep its Medicare managed care contract, the company dug in for a fight.

Blue Shield’s position on damages was essentially this: As a cost-reimbursement contractor, Blue Shield is paid all of its costs of administration of the Medicare claims-processing function regardless of its performance rating under CPEP. Because payments of Blue Shield’s administrative costs were not triggered, augmented, or reduced by the submissions made to HCFA for performance evaluation purposes, claims for reimbursement of those costs were neither false claims nor false statements in support of a false claim.

The criminal plea was not dispositive on this issue. Indeed, the plea itself—conspiracy to obstruct and obstruction of Government audits—established only that Blue Shield cheated on CPEP, not that the contractor submitted false claims. Blue Shield believed that because payment to a Medicare contractor is not tied to the quality of its work, they could concede that the company obstructed CPEP audits and still assert that the company was entitled to reimbursement of all of its costs. Blue Shield asserted that the only remedy for poor performance by a contractor, or for falsifying documents in the CPEP process, was termination of the contract.

Our response was two-fold: First, a Medicare contractor is permitted to claim only “allowable costs” that are “necessary and proper for carrying out the functions covered by the contract.” [See 42 U.S.C. § 1395u(c)(1)(A).] We argued that the time spent by Blue Shield employees falsifying records, destroying documents, “whiting out” information, and defeating the entire purpose of the contractor’s quality assurance program, translated into costs that were neither “allowable” nor “necessary and proper” under the carrier contract. We viewed these damages no differently than the testing or quality assurance costs paid to a defense contractor—even one paid on a cost basis—who falsifies test results for fasteners or relays.

That component of damages was fairly limited since there were only a handful of employees who dedicated their time to the contractor’s quality assurance program. Our broader theory of damages encompassed all of the contractor’s claims processing costs. We asserted that by manipulating the CPEP process and misrepresenting its performance under the carrier contract to HCFA, Blue Shield was able to retain its contract under false pretenses; i.e., HCFA reawarded Blue Shield’s contract from year to year because of a mistaken belief that Blue Shield was a high

quality contractor. In fact, Blue Shield was a poor performer who cheated on the tests. We argued that, like the student who cheats on the final exam, Blue Shield was entitled to no credit for the course, despite its protestations that it did the course work.

Our position was bolstered by the Blue Shield employees. When interviewed, they all said they cheated on CPEP in order to keep the Medicare contract. The watershed in the negotiations of the civil case came when we obtained court permission to disclose the grand jury testimony to Blue Shield. Then the company saw what its employees would be saying about how they had gone about doing their work. Rather than facing a steady parade of witnesses who would testify in depositions about the culture inside the company that fostered falsification of records submitted to the Federal Government for audit, the company got serious about settling the case.

In the end, the civil settlement of \$12 million was based on several factors. We identified all of the administrative costs incurred in the company's quality assurance function during the relevant period—an amount of about \$2 million—as damages for which we had “hard evidence.” We believed we could demonstrate that Blue Shield's quality assurance cheating had so corrupted their work that it was valueless to HCFA. Additionally, we agreed with a Blue Shield analysis that showed that unallowable labor costs and overhead associated with the periodic HCFA audits in other functional units at the company, totaled approximately \$278,000. For purposes of the settlement, these amounts were trebled and penalties of \$1 million (\$10,000 for each claim for administrative reimbursement submitted by the contractor) were added. We arrived at the other component of damages by taking a percentage of Blue Shield's claims processing costs, contending that diminished claims processing was directly related to the contractor's misconduct in quality assurance. We argued that such an approach was justified on the grounds that, although the Government bears the burden to prove damages, it need not prove them with scientific exactitude, *see United States v. Killough*, 848 F. 2d 1523, 1531 (11th Cir. 1988) (“damages need not be calculated by mathematical precision”), and that Congress intended that the damages assessment in a False Claims Act suit be “liberally measured to effectuate the remedial purposes of the Act.” (S.Rep. No. 615, 96th Cong., 2d Sess. at 4.)

Conclusion

Effective coordination of parallel proceedings in the health care area is often difficult, sometimes frustrating, but always important. The players on the Government side must attempt to understand the roles and goals of one another, and work together to accommodate varying interests if the best results are to be achieved.

Multidistrict Health Care Fraud Cases

On April 17, 1997, EOUSA Director Carol DiBattiste forwarded to United States Attorneys, First Assistant United States Attorneys, Criminal Chiefs, and Civil Chiefs new guidelines on multidistrict health care fraud cases. These guidelines were approved on April 2, 1997, by Attorney General Reno. She recognizes that efficient and effective law enforcement requires cooperation and communication with the Department as well as with other law enforcement

agencies. The guidelines were developed with the input and advice of the Chairs of the Attorney General's Advisory Committee and its Health Care Fraud Subcommittee, and the Criminal and Civil Divisions. Questions should be directed to Assistant United States Attorney Robert Liles, EOUSA's Legal Programs staff, (202) 616-6444. For personnel in USAOs, your office should have a copy of this memo. If not, you may call (202) 616-1681.

Authorized Investigative Demand Status

On May 16, 1997, EOUSA Director Carol DiBattiste forwarded to United States Attorneys, First Assistant United States Attorneys, and Criminal and Civil Division Chiefs, a copy of the bluesheet covering the issuance of authorized investigative demands. Under 18 U.S.C. Sec. 3486, a provision of the Health Insurance Portability and Accountability Act, P.L. 104-191, the Attorney General or the Attorney General's designee is authorized to issue investigative demands to obtain records for criminal investigations relating to Federal criminal health care fraud offenses. These records are not subject to the constraints applicable to grand jury matters set forth in Fed.R.Crim.P. 6(e), and thus enhance the ability of United States Attorneys' offices to conduct parallel criminal and civil investigations. Pursuant to 28 U.S.C. Sec. 510 and 18 U.S.C. Sec. 3486, on April 23, 1997, Attorney General Reno delegated the authority to issue investigative demands to all United States Attorneys and to the Assistant Attorney General for the Criminal Division. The Attorney General further authorized United States Attorneys and the Assistant Attorney General for the Criminal Division to redelegate this authority, should they desire, to Assistant United States Attorneys (AUSAs) and Criminal Division Trial Attorneys. Delegations of authority are not automatic and must be affirmatively made before an AUSA or a Criminal Division Trial Attorney will be authorized to issue investigative demands. Any questions regarding the issuance of authorized investigative demands should be directed to Assistant United States Attorney Robert Liles, EOUSA's Legal Programs staff, (202) 616-6444.

Treatment from the Tropics*

Assistant United States Attorneys Debra P. Kanof and Stephen G. Garcia

Western District of Texas

El Paso Division

Dr. Loring Arden Gifford is a psychiatrist who forayed into the pain management field of medical practice, primarily for its lucrative aspect. A jury convicted him and his associate, an unlicensed foreign medical school graduate, Samarjeet Sidhu, of mail fraud; upcoding; double billing; billing for services not rendered; billing for services other than those provided; false representations in billings, claiming that he delivered services under physician specific Current Procedural Terminology (CPT) codes, when he delegated the duties to employees; and money laundering, among other things. While the doctor launched a shotgun-like defense, the largest pellet by far was his position that, by the advice of his experienced, board-certified lawyer, he was legally permitted not only to provide services in a manner in which the Government was objecting, but to bill precisely in the mode for which he was criminally accused.

Ace Pickens, attorney-at-law, testified that since 1992, he had been licensed to practice law in Texas, was board certified in Administrative Law, and concentrated his practice “. . . with a special emphasis on insurance and health law, administrative matters, matters dealing with hospitals, medical staff privileges, peer review-type situations, reimbursement for issues before varying third-party payers, professional liability suits or health care liability suits.”

Pickens claimed that Gifford sought legal advice prior to opening his private medical office for the practice of psychiatry and pain management. Gifford’s inquiry included “how he should do this and what would be the proper way to bill this. Varying degrees of just general questions that a physician would have in relationship to how he should operate his practice and be within the confines of the Medical Practice Act and other laws related to the practice of medicine.”

Fortunately, Gifford had a penchant for vacations—the beach in Jamaica, the opera in New York, a casino or two in Las Vegas. However, his absence from his medical practice was not reflected in his billing practices, either to private insurance companies or to Government health care benefit programs such as Medicaid. While taking in tropical rays, Gifford’s Health Care Financing Administration (HCFA) 1500 billing forms reflected Physician’s CPT code charges like 90844—an approximately 45- to 50-minute, face-to-face physician administered psychotherapy session; 90843—an approximately 20- to 30-minute, face-to-face physician conducted

*This case was initially investigated and indicted by Assistant United States Attorney Sol Weisenberg of the San Antonio Division of the Western District of Texas. It was then assigned to Assistant United States Attorney Debra P. Kanof for additional investigation and indictment, and prosecuted by Assistant United States Attorneys Kanof and Stephen G. Garcia of the El Paso Division of the Western District of Texas. The civil case was prepared and tried by Assistant United States Attorney Stan Luke, and the collection and search for offshore funds is being conducted by Assistant United States Attorney Harold Brown, both of the San Antonio Division of the Western District of Texas. The case was investigated by FBI Agents David Hamilton and James Griego, and Defense Criminal Investigative Service Agent Scott Parker.

psychotherapy session; 99214—typically a 25-minute, face-to-face “evaluation and management” physician visit with an established patient; controlled substance, physician signed and distributed prescriptions, such as morphine and demerol; and other physician-driven billing codes.

Attorney Pickens provided his expert opinion in support of Gifford’s defense that the continued billing for physician specific CPT codes for services provided by his designated, delegated non-physician support staff, was not only legal but expressly authorized by the Texas Medical Practice Act.

Pickens’ advice to Gifford—based on the statute he testified that he drafted—was, “that a physician, such as himself, could delegate to a non-physician any medical act that was reasonable to be delegated if the act is carried out in a customary manner and the physician assumes responsibility for that act.” Gifford’s office support staff testified that before going on a trip to Jamaica, he left instructions with them to call him on his cellular telephone in Jamaica if they needed to. Point by point, defense counsel elicited Pickens’ approval of the doctor/defendant’s delegation of each duty for which he billed, as if he provided the services. While Pickens admitted that under the statute the physician was to reasonably supervise the delegate, he further explained that, “where the physician has made a diagnosis and this is the process of treatment, [the] Medical Practice Act does not require over-the-shoulder supervision. It does not require even that the person be in attendance at the office.” Pickens testified that the physician could be in another country and, more important to the litigation, that he advised Gifford in that regard.

Pickens acknowledged familiarity with the CPT code system and the fact that each Government and private benefit provider had their own rules for billing, and that those rules were not always uniform. His position, however, went so far as an assertion that he knew “no law that any doctor has to comply with an insurance company’s request to comply with their billing format.”

In addition to the allegations that Gifford billed for services he provided when he was not present physically, the Government charged the doctor with over one million dollars in fraudulent billings for services rendered when he **was** present physically in his office, but could not have performed all of the services or treatments billed. FBI Financial Analyst Ivonne O. Stephenson calculated the number of hours the doctor would have had to spend seeing patients each day, then, for the total period of the conduct charged in the indictment, the number of hours Gifford would have had to spend to truthfully bill for his services.

Using Gifford’s own accountant’s work papers and computer billing program (seized by warrant early in the investigation), Financial Analyst Stephenson selected the three most frequently billed CPT codes: 990843, 90844, and 99214—all three codes with time-specific criteria that would have required attendance to the patient. Giving Gifford the benefit of the doubt—a 9-hour work day, 5 days per week, and a 5-hour work day on Saturdays, for a total of a 50-hour work week—the analyst multiplied the work hours by 52 weeks per year, and subtracted only those days for which proof existed that Gifford was out of town. The calculation showed that he had 2,017 reasonably available work hours to not only see patients but to do whatever was necessary

to run his practice. Gifford's records demonstrated that he actually billed 5,845 hours under the three example, time-driven CPT codes only. He also billed under other codes but to a lesser degree. Even if Gifford worked 9 hours a day, 7 days a week, with no vacation, the hours he billed for reflected approximately 650 work days, or almost 2 years packed into 1, with holidays and weekends. For the first year of the fraud, the total number of fraudulently billed hours, by this analysis, was 3,829.

Based on Pickens' testimony, the defense insisted that since the Medical Practice Act permitted a Texas licensed physician to delegate medical treatment that the doctor deems reasonable—to anyone the doctor feels qualified—those figures merely demonstrated the permissible work of Gifford's employees and himself.

Gifford's staff comprised co-defendant Sidhu, an unlicensed foreign medical school graduate, allegedly for the purpose of performing biofeedback therapy; a part-time chiropractor who administered physical therapy; an assistant who gave injections; and office clerks. He claimed his biofeedback technician and physician's assistant were qualified to do psychotherapy. Using Medicaid as an example in cross examination, and using the applicable Medicaid provider manual seized from Gifford's office, Pickens was asked to explain his position when juxtaposed against the Medicaid requirement that physicians' services include only those "reasonable and medically necessary that are ordered and performed by a physician under the personal supervision of the physician." Pickens was asked, based on the provider manual, if Medicaid would pay a claim if a physician billed for a service performed by someone other than himself when he was not personally supervising the service provider in the office or the building at the time of the treatment, if Medicaid knew the truth about the circumstances under which the treatment was provided. After some dancing and avoidance, Pickens testified, "Well, like I say, everybody—all of these systems they got little idiosyncrasies. All of them have little differences, 'we pay for this, but we won't pay for that; we'll pay for this, but we won't pay for that.' So if that is one of them—you represented to me that is true—then they would not reimburse for that. **That does not mean that the physician has done anything wrong in his practice.**" (emphasis added).

Much to the jury's credit, they understood the difference between a state statute that provides medical practice guidelines for licensed physicians and the necessity of a physician to follow the billing rules prescribed by third-party payors.

In most cases, prosecutors do not cross into the "medical necessity" area of the defendant's practice because of the quagmire leading to a battle of the experts. But this was a particularly egregious fact situation, where Gifford would direct even his psychiatric patients to the pain management aspect of his practice, identify that they had some kind of pain, then prescribe addictive substances like morphine by injection. The patient had to come to the office everyday for their prescription and injection. If Gifford saw them at all—if he was in town—it was for five to ten minutes, "wave therapy," then he billed for a 45-minute psychotherapy session or a 25-minute medical visit. Many patients became addicts and families were destroyed as a result of his greed. The case is pending appeal before the Fifth Circuit Court of Appeals.

Settlement in *United States v. Bruce Erickson, M.D., the Great Falls Eye Surgery Center and Gary Andregg*

*Assistant United States Attorney Leif M. Johnson
District of Montana*

In a Consent Decree dated December 10, 1996, the United States Attorney for the District of Montana settled a civil False Claims Act suit against a Great Falls eye surgeon, Dr. Erickson; his ambulatory eye surgery center; and one of its Certified Registered Nurse Anesthetists, Gary Andregg. In a related matter, the Department of Health and Human Services (HHS) settled its pending exclusion action against two of the defendants within days of the announcement of the False Claims Act settlement. In all, the defendants agreed to pay an aggregate amount of \$475,000 payable over 5 years, \$200,000 of which was due immediately. In the exclusion settlement, Dr. Erickson and the Surgery Center agreed to a 7½-year exclusion. Gary Andregg was not a party to the exclusion action.

The False Claims Act case was filed after the criminal trial and convictions of Dr. Erickson and the Surgery Center for overbilling of nurse-administered anesthesia services. The criminal trial disclosed that Medicare was paying for concurrent anesthesia for up to five patients at a time. After dissecting the defendants' Medicare claims and comparing them to patient records, HHS Special Agent Al Gomez was able to graphically display how overlapping anesthesia claims resulted in a windfall to the defendants. On some of the busier days, the defendants billed Medicare for more than 25 hours of anesthesia treatment per day. Under Medicare regulations, a provider may only bill for the personal anesthesia treatment of one patient at a time.

The criminal trial, however, resulted only in partial convictions of the defendants on some of the lesser overbilling conduct. The indictment charged that the defendants began billing Medicare for concurrent treatment in 1990 and continued the practice until June 1993. Although evidence was presented that this violation of Medicare regulations was widely known in the eye surgery community, the jury was unable to convict on the first two years of overbilling, which amounted to the lion's share of loss to the Medicare program, approximately \$160,000.

The third year of overbilling was greeted with more skepticism by the jury in the criminal trial. After the second year, Agent Gomez contacted the Surgery Center and informed them that they were violating the law by billing for concurrent services. He testified that while the defendants changed their pattern of billing they were still billing for more time each day than treatment was rendered. His testimony brought about the partial convictions. The amount of loss to Medicare for this limited period was approximately \$22,000.

In the civil case, we were presented with the problem of re-trying the first two years of overbilling conduct. In order to ensure that we would prevail on this issue, we developed additional evidence that proved that the defendants knew, or should have known, that they were violating Medicare regulations prior to the time Agent Gomez told them. So we hired Agent Gomez, who by that

time had retired from HHS, to take a second look at the case and see if he could unearth additional evidence of intent to defraud during the first two years. His findings were startling. Payments received by the Surgery Center plotted against payments by the Center to its Certified Nurse Anesthetists showed that the defendants were receiving an average profit of more than \$1,000 per day from anesthesia treatment.

In addition, we were able to identify a witness who could testify that Dr. Erickson admitted that he was making a healthy profit from anesthesia treatment. This new evidence, combined with the prospect of a lower burden of proof and potentially draconian civil penalties, quickly brought the defendants to the negotiating table after an initial flurry of discovery. After two days of judicial settlement conferences, we were able to agree on a settlement figure approaching treble damages. After the criminal and civil actions, the defendants paid \$275,000 in criminal fines, \$22,000 in criminal restitution, and \$475,000 in civil damages, all relating to an aggregate loss to the Medicare trust fund of between \$170,000 and \$190,000. In addition, Dr. Erickson received a 6-month home detention/work release split sentence. The Surgery Center has since dissolved.

A Qui Tam Action on an End Stage Renal Disease Lab

Assistant United States Attorney Gail Killefer, Northern District of California, and Trial Attorney James E. Ward IV, Commercial Litigation Branch, Civil Division

In 1993, Al Aviles, a former Spectra Laboratories, Inc., employee, filed a *qui tam* action against the independent clinical laboratory that specializes in testing for patients suffering from End Stage Renal Disease (ESRD). This complaint, *United States ex rel. Almario Aviles v. Spectra Laboratories, Inc.*, C 93-3492 CW (N.D. Cal.), launched what may have been the Department of Health and Human Services Office of Inspector General's (HHS-OIG) first full-scale investigation of an ESRD specialty laboratory and resulted in a \$10.1 million settlement.

Medicare Coverage of the ESRD Program

ESRD is permanent kidney failure that can result in death without a transplant or long-term (maintenance) kidney dialysis. Because of the high cost of transplants and long-term dialysis, many patients were unable to afford treatment prior to 1972. That year, Congress amended the Social Security Act to provide Medicare coverage for all patients with ESRD.

The ESRD program is the only entitlement covered by Medicare that is based on the diagnosis of a specific medical condition and, unlike most Medicare beneficiaries, ESRD patients do not need to be 65 to qualify. These patients are susceptible to many other illnesses related to their renal failure and as Medicare beneficiaries they obtain treatment for a wide range of conditions at Government expense. Today Medicare spends more than \$7 billion a year to treat only about 270,000 ESRD patients, a per-beneficiary expenditure well in excess of that for the typical Medicare beneficiary. The number of ESRD patients is increasing. With the growth of the ESRD program and the current structure of the Medicare payment system for ESRD laboratory tests, there is significant potential for abuse in billing practices by ESRD laboratories and others who provide services to ESRD patients.

Medicare reimbursement is provided for ESRD patients through a combination of Part A and Part B coverage. Standard services required by ESRD beneficiaries, including many laboratory tests, are covered by a "composite rate" that Medicare Part A pays to the beneficiaries' dialysis facility per dialysis session. The composite rate is intended to cover most supplies, nursing services, and routine laboratory tests required as part of routine outpatient maintenance dialysis.

Nephrologists who treat ESRD patients need to monitor the condition of patients and the effectiveness of dialysis carefully, and frequent laboratory blood testing is a part of this regimen. Typically, dialysis facilities obtain the laboratory tests included in the composite rate from independent clinical laboratories like Spectra, who charge a "capitation rate" for performing composite rate tests.

Medicare recognizes that ESRD patients may need laboratory tests beyond those included in the composite rate, and Medicare Part B supplements the composite rate by reimbursing independent

clinical laboratories directly for additional medically necessary tests. Medicare has frequency guidelines for certain “routine” tests beyond those included in the composite rate. Medicare Part B will pay for these tests at certain frequencies without a diagnosis more specific than ESRD, and will also pay for other “non-routine” tests when accompanied by a specific diagnosis beyond ESRD, such as hepatitis or iron deficiency anemia.

Whereas claims for non-composite rate lab tests performed by independent clinical laboratories are submitted to the Medicare Part B carrier, when the tests are performed by hospitals, the claims are submitted to the Medicare Part A fiscal intermediary for processing as outpatient claims. Although hospital-based units initially provided the majority of dialysis treatments, the number of independent dialysis units, particularly those for profit, have increased substantially.

Most fraudulent schemes concocted by laboratories performing tests for ESRD patients are designed to maximize reimbursement from Medicare by generating as many orders for non-composite rate tests as possible from dialysis facilities, often without regard to medical necessity. The Spectra case provides an illustration of several of these schemes.

Government Investigation

Our investigation, conducted with the assistance of HHS-OIG, began with interviews by HHS-OIG analysts of former Spectra employees, nephrologists, and others to learn about Medicare reimbursement of ESRD services and Spectra’s operations. We then issued an Inspector General subpoena to Spectra, requesting documents related primarily to its marketing and billing practices. After wading through scores of boxes of documents that Spectra produced, we located approximately 100 “hot documents.” During this time frame, the Attorney General issued Civil Investigative Demands to six individuals connected with Spectra, and we deposed these individuals, confronting them with a number of the “hot documents.” Following these depositions, Spectra’s attorneys indicated an interest in exploring settlement of the Government’s claims.

With the assistance of the Part B carrier, we analyzed the claims Spectra submitted for 100 sample beneficiaries that were finalized during the last half of 1992 and then, using the findings, extrapolated damage estimates for the various issues covered by our investigation.

Our investigation focused primarily on three practices that resulted in Spectra submitting false claims: (1) billing Medicare Part B for tests already reimbursed by the Part A composite rate payment; (2) billing Medicare Part B for chemistry tests not covered because of the “50/50 rule”; and (3) using a test ordering system, including a “Master Annual Prescription Form,” designed to induce orders for medically unnecessary tests.

Double-Billing for Composite Rate Tests

Our investigation revealed that Spectra submitted false claims to Medicare Part B by billing for tests already included in the composite rate—tests for which Medicare Part A had already paid the

dialysis unit. Specifically, Spectra billed for hematocrits, hemoglobins, blood urea nitrogens (BUNs), creatinines, magnesiums, hemograms, platelets, differentials, and certain chemistry panels—tests that should not have been billed separately from the composite rate. For example, although the composite rate includes all hematocrit and hemoglobin tests furnished incident to each dialysis treatment, Spectra systematically billed Medicare Part B for these tests. On the hematocrit and hemoglobin issue alone, we estimated that Spectra billed 24,738 false claims during the six-month sample period.

Our settlement negotiations were significantly easier because Spectra billed Medicare Part B using claim forms stamped with the statement, “**Test not part of composite rate.**” For services Spectra billed to Medicare which were included in the composite rate, the false statement was obvious. The 24,738 hematocrit and hemoglobin false claims alone amounted to damages and civil penalty exposure under the False Claims Act that exceeded Spectra’s ability to pay.

Violations of the “50/50 Rule”

A specific ESRD coverage rule known as the “50/50 Rule” applies to laboratory tests performed as part of a panel—a group of tests commonly performed on the same automated machine at the same time. The 50/50 Rule requires the laboratory to consider tests included in a panel and to determine if any of them have already been included in the ESRD composite rate. If 50 percent or more of the covered tests in a panel are included in the composite rate, the laboratory cannot receive further reimbursement for the panel, even though it may contain some non-composite rate tests. On the other hand, if fewer than 50 percent of the tests in the panel are included in the composite rate, then the laboratory can bill Medicare Part B, using the appropriate codes (CPT codes 80002-80019) for the entire panel, including the composite rate tests.

To beat the 50/50 Rule, when Spectra performed a single panel of tests that included both composite and non-composite rate tests, it billed Medicare Part B as if no composite rate tests had been performed, submitting a claim only for the non-composite rate tests in the panel. Thus, for example, if Spectra performed a 20-test panel and 12 of those tests were included in the composite rate, the 50/50 Rule dictates that they are not entitled to Medicare reimbursement for the panel. To get around the Rule, Spectra billed and obtained reimbursement for an 8-test panel composed exclusively of non-composite rate tests.

During our negotiations, Spectra argued that the 50/50 Rule was incomprehensible and unfair. As part of our settlement, however, Spectra accepted the Government’s interpretation of the Rule and agreed to comply with it. HHS-OIG’s subsequent analysis indicated that Spectra’s billing in compliance with the 50/50 Rule will save Medicare approximately \$2.5 million per year.

Ordering of Medically Unnecessary Tests

Spectra used a three-tier system for obtaining test orders from dialysis facility clients, which resulted in the performance and billing of a large number of tests that were medically unnecessary.

The first step in the test ordering system was the “Master Annual Prescription Form,” which listed all the tests that Spectra offered, with a menu of frequency options and possible diagnosis codes for each test. The dialysis unit’s nephrologist completed and signed this form, sometimes in the presence of a Spectra salesperson. The form covered all patients “presently treated in the unit and future admissions.” The test, frequency, and diagnosis choices selected on the form were carried through without regard to the patients’ needs; at large dialysis facilities, the form covered 200 or more patients.

The Master Form could be supplemented by an “Individual Prescription Form,” which was patient-specific and allowed the facility to add tests but not delete them from the list of tests specified on the Master Form. Our investigation revealed that Spectra’s clients used this form infrequently and often when they did, it was not authorized with a physician’s signature. Spectra used these two forms to create a third form, a computer-generated “requisition” form, which Spectra sent to the dialysis facility with test tubes and pre-printed labels for every blood draw. According to Spectra, its clients could add to or delete tests listed on the requisition, but our investigation indicated that tests were rarely deleted.

In practice, the Master Form served as the primary test ordering form. Dialysis facilities rarely altered the computer-generated requisition forms and, therefore, all patients, regardless of individual medical necessity, received all the tests at the frequencies listed on the Master Form. In addition, Medicare claims for all patients at a facility listed the same diagnosis to support the medical necessity of a test, which might differ from that of all patients at another facility. For example, we uncovered two Master Forms at two facilities requesting monthly uric acid tests for all patients. According to the diagnoses on the forms, all patients at the first facility required this test because they suffered from “gout,” while all patients at the second facility required the test because they suffered from “joint pain.” As part of the settlement, Spectra agreed to use a patient specific test ordering form.

Settlement

After extensive negotiations, Spectra agreed to pay \$10.1 million, cease marketing and billing practices we identified as problematic, and enter into a Corporate Integrity Program with HHS-OIG to resolve the case. Although our extrapolations indicated that Medicare overpaid Spectra by many times the amount of the settlement, we reached this figure based on Spectra’s ability to pay, particularly because its revenues would decrease drastically as a result of the billing and test ordering changes in the settlement agreement. Relator Almario Aviles will receive a 15-percent share of our recoveries.

Although the settlement amount included recoveries for CHAMPUS, Railroad Retirement Medicare, and the Federal Employees Health Benefits Program, the amount of damages to each of these programs was very small compared to Medicare’s damages. This was due primarily to the fact that Medicare provides coverage to all ESRD patients after a short waiting period, and most payments by other programs were made during this waiting period. In a separate negotiation,

Spectra agreed to a small settlement with the Medicaid programs in most of the states in which it did business for the same pro rata share as the Federal settlement.

Conclusion

At the time of our investigation, Spectra was the second largest exclusive ESRD testing laboratory in the United States, behind Lifechem, but a small operation compared to large nationwide laboratories. Large independent clinical laboratories and many hospital laboratories perform ESRD tests and bill Medicare for them, and recent LABSCAM settlements have included monies recovered on ESRD issues similar to those in the Spectra case.

As for lessons learned from the case, there were several crucial parts of the process. First, the documents we obtained through the Inspector General subpoena were invaluable and made it difficult for Spectra to refute certain important facts. Second, our Civil Investigative Demand depositions constituted a turning point in the case, particularly since we obtained sworn testimony concerning the “hot documents” we got through the subpoena. Third, as is true with any laboratory billing case, the thorough analysis of sample claims that we conducted with the carrier’s assistance was extremely helpful. Finally, we cannot over stress the importance of smart, hardworking HHS-OIG analysts, which we were fortunate to have.

Successful LabCorp Settlement a Result of Operation LABSCAM

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Introduction

On November 21, 1996, Laboratory Corporation of America Holdings (LabCorp), Burlington, North Carolina, agreed to pay \$182,000,000 to resolve civil allegations associated with submitting false claims for medically unnecessary laboratory tests to Federal and state health care programs. On that same day, LabCorp's subsidiary, San Diego Regional Laboratory of Allied Clinical Laboratories, Inc. (Allied), pled guilty to a similar charge and was fined \$5,000,000 in Federal court in Greensboro, North Carolina. LabCorp entered into a Pre-Trial Diversion Agreement with the United States Attorney's office (USAO) for the Middle District of North Carolina (MDNC) and a Corporate Integrity Agreement with the Department of Health and Human Services (HHS) to preclude reoccurrence. Because LabCorp's corporate headquarters is located in Burlington, the USAO for the MDNC was assigned to investigate and prosecute the LabCorp criminal case. The civil investigations were focused in the Southern District of New York (SDNY) and the MDNC. The settlement was a team effort, negotiated by the Assistants in the Southern District of California (SDCA), the SDNY, and the MDNC, and the Civil and Criminal Divisions of the Department of Justice (DOJ). The criminal guilty plea, pretrial diversion, and civil settlement with LabCorp are recent developments in a nationwide crackdown by DOJ on fraudulent conduct by independent clinical laboratories.

The LabCorp settlement is significant not only because it was one of the goals of the National Operation LABSCAM seven-member task force to restore millions of dollars to Medicare and other Federal and state health care programs, but because it provided important lessons for Assistant United States Attorneys using parallel civil and criminal investigations as part of DOJ's affirmative civil enforcement (ACE) program in the fight against health care fraud. The authors acknowledge the importance and incalculable assistance received throughout the investigations from the SDCA, the SDNY, and both the Civil and Criminal Divisions of the Department. The USAOs in the Eastern District of Virginia, Middle District of Pennsylvania, District of Columbia, and the District of New Mexico played an instrumental role in the LabCorp resolution. The USAO for the District of Columbia and the Office of Personnel Management provided invaluable assistance on issues pertaining to the administration of the Federal Employees Health Benefits Program and the Railroad Retirement Board.

Background

This article is limited to the MDNC's investigation of Roche Biomedical Laboratories, Inc. (RBL). The criminal investigation was instituted in the MDNC. Two *qui tam* actions were filed,

one in the Eastern District of Louisiana and the other in the SDNY. The *qui tam* from Louisiana was transferred to the MDNC at the beginning of the investigation, and the SDNY *qui tam* was transferred after the settlement was concluded in principal. Through a series of mergers, Allied; National Health Laboratories, Inc. (NHL); and RBL were combined to establish LabCorp.

The lessons shared in this article will provide insight for criminal and civil assistants handling parallel cases. This article focuses on MDNC’s investigations of RBL from the perspective of a USAO with limited resources employing parallel civil and criminal investigations in an efficient and effective manner by using a joint health care task force and investigative techniques to facilitate both investigations of a major health care corporation.

Criminal-Civil Health Care Task Force

RBL’s billing and marketing scheme included aspects of criminal and civil fraud and implicated several state and Federal programs. The USAO tailored an existing MDNC Health Care Task Force (HCTF) to pursue the full range of the fraud by including the following representatives:*

<u>MDNC Health Care Task Force</u>	
<u>Agency</u>	<u>Focus</u>
Federal Bureau of Investigation (FBI)	Health Care Fraud
Health & Human Services/Office of Inspector General, Office of Investigation and Office of Audit	Medicare
Defense Criminal Investigative Service	Civilian Health and Medical Program for the Uniformed Services (CHAMPUS)
Defense Contract Audit Agency	Audit Support for CHAMPUS
U.S. Postal Service	Mail Fraud
Internal Revenue Service	Money Laundering
N.C. Medicaid Fraud Control Unit	Medicaid
N.C. Department of Insurance	Private Insurance Health Care Fraud

A joint HCTF office adjoining the FBI office in Greensboro was established close to the USAO for records storage, meetings, interviews, and other investigative work. The FBI purchased

* Although not a part of the HCTF, the USAO for the District of Columbia and the Office of Personnel Management played an active role in issues pertaining to the administration of the Federal Employees Health Benefit Program and the Railroad Retirement Board.

furniture and equipment, including a computer and software. A central document repository and database of non-grand jury documents were established. The United States Attorney, as well as criminal and civil AUSAs, chaired HCTF meetings, often on a weekly basis, directing agents in investigative work, and coordinating criminal and civil investigations consistent with the requirements of Fed. R. Crim. P. 6(e). The Criminal Chief and civil Assistant United States Attorney maintained daily contact.

Investigative Techniques in Parallel Investigations

Task force agents maximized the use of non-grand jury documents. A database containing over 90,000 pages of documents was established, allowing the agents to search for “hot documents” by key word. These searches revealed the corporate scheme for implementing the fraudulent billings and allowed the HCTF to establish timelines and a chronology of key documents organized in notebooks pertaining to the addition of the particular tests.**

Initially, both criminal and civil investigations focused on how RBL billed for its profiles (i.e., groups of tests) on a theory that they were “bundling” (i.e., adding) tests to their basic profiles, leading doctors to believe that the tests were added at little or no additional charge. Then, unbeknownst to the doctors, RBL “unbundled” these added, medically unnecessary tests to bill the Government, resulting in excessive revenues. We requested from the HHS/OIG a computer run of all Medicare payments to RBL for targeted tests for the years 1988 through 1993 to determine if RBL’s claim volume for those tests increased substantially during that period. They provided printouts of test volume and reimbursement but did not furnish bundling data. The information was transferred to spread sheets to detect “spikes” in billing which revealed that RBL’s billings for certain tests spiked during the targeted period. These spikes provided a clue as to when billing practices changed, and which tests were affected. Agents were then able to identify the profiles from which the tests were unbundled and billed separately.

HCTF agents used non-grand jury witnesses to the maximum extent possible. They met with the carrier’s (CIGNA’s) Medical Director to determine when certain tests would be medically necessary for elderly patients and others. The Medical Director indicated that generally the test for high-density lipoprotein (HDL), a measure of cholesterol, should not be performed more than once a year. Based on the Medical Director’s advice, a computer printout was requested from CIGNA of RBL’s claims from three laboratory locations in North Carolina and South Carolina for Medicare patients who received three or more HDL tests bundled in a basic RBL profile. As a result of this search, 44,000 patients were identified and then the field was narrowed to 201 patients that had seven or more HDL tests in 1991. Individual billing histories for those patients and the names of their treating physicians were obtained.

** Additionally, HCTF agents reviewed boxes of records of physician complaints to determine whether physicians complained of the RBL billing practices. The RBL HCTF also requested provider files from the carrier, CIGNA. The provider files revealed fee schedules, correspondence, minutes of meetings, carrier bulletins, complaints, and policy statements.

HCTF agents interviewed over 70 treating physicians regarding multiple HDL and other targeted tests. They learned that in most cases, the tests were not medically necessary; that physicians did not know RBL was billing Medicare separately for the tests added to the profiles; and that when physicians were invoiced by RBL for their private-pay patients, the profiles were charged as one fee. After establishing that medically unnecessary tests were unbundled and billed to Medicare, records of claims submitted to the North Carolina Medicaid and CHAMPUS programs were obtained and analyzed for similar billing schemes. As a result, doctors who treated Medicaid and CHAMPUS patients were interviewed and stated essentially the same facts as the Medicare doctors: that unbundled tests like HDL were medically unnecessary and they had no knowledge of how Medicaid/CHAMPUS was billed for those unbundled tests.

Interview techniques that promoted information for both the criminal and civil investigations were used to the maximum extent possible. Current RBL employees were interviewed with corporate counsel present, which significantly benefitted the civil investigation but slowed the criminal investigation because it revealed our tactics to corporate counsel. As with many investigative techniques, open interviews had to be used in a pragmatic manner and, while they were helpful initially, later during the grand jury process information was no longer shared with the civil case.

Over 20 former RBL employees were interviewed without corporate counsel present, and the information was freely shared between the criminal and civil investigations. These employees included sales representatives, division sales managers, operations managers, a Vice President of Sales and Marketing, a Credit Manager, a Lab System Manager, a Marketing Manager, and an Assistant Vice President of Pricing. The interviews focused on RBL's billing practices, the marketing and pricing of tests to physicians, the addition of certain tests to profiles, and RBL's billing of Government programs for tests. Additional documents were obtained from the former employees and reviewed for relevancy.

To determine the percentage of targeted tests bundled with RBL profile tests, a match of those tests billed to Medicare on CIGNA's history tape was requested from the Computer Specialist, HHS/OIG. The run included claims containing a combination of the targeted tests. The amount of the fraud was then calculable. To determine how RBL billed the Government, HCTF agents met with the carrier, CIGNA, and determined that most of RBL's claims were billed electronically.

As the investigation developed, it was obvious that open interviews of current employees and informal discovery with RBL would not adequately serve the needs of the criminal investigation, and that Government strategy was being revealed needlessly. Furthermore, RBL did not voluntarily disclose all documents that were requested. Therefore, grand jury proceedings were initiated and the criminal and civil investigations separated, but they continued on parallel tracks. In some investigations it has been a practice for a civil attorney to be involved in the criminal investigation,[†] MDNC took a cautious approach by establishing bright line procedures between

[†]See *United States v. John Doe, Inc.* 481 U.S. 102 (1987).

the civil and criminal investigations. Care was exercised to ensure that HCTF agents scrupulously complied with Fed. R. Crim. P. 6(e).

In May 1996, RBL approached the criminal Assistant United States Attorney regarding global resolution, and meetings were scheduled along three parallel tracks: (1) negotiations of criminal matters only, in which the civil Assistant United States Attorneys were excluded; (2) negotiation of civil matters only, in which the criminal Assistant United States Attorneys would not take part; although on occasion they attended at the request of the defense counsel; and (3) global meetings involving both civil and criminal matters. As is discussed in the introduction, these settlement negotiations were conducted by a team of lawyers from the SDCA, the SDNY, the MDNC, and DOJ. This structure maintained the integrity of the criminal and civil processes while producing valuable information to further both investigations.

To ensure that civil negotiations fully cover all issues, including facts developed during the grand jury investigation, the Government obtained an order under Fed. R. Crim. P. 6(e), authorizing disclosure to all Civil Assistants and DOJ lawyers of matters occurring before the grand jury. RBL consented to the order, a significant move since the grand jury investigation was ongoing. Additionally, the 6(e) application was tailored to request that the court specifically find that documentary evidence preexisting the paneling of the grand jury was not a “matter occurring before the grand jury”; thereby ensuring that if there were challenges to the 6(e) order, the use or derivative use of the documents would not become an issue. Finally, even though a disclosure order existed, discretion was exercised by the Criminal Chief to limit disclosure of grand jury testimony.

Because of the volume of claims and data involved, substantial computer analysis was a critical element of the investigations. A key to success was the use of RBL’s data to establish damages. DCAA obtained RBL’s computer data, ran programs to determine the precise number of tests that were included in the billing and marketing scheme, and reviewed RBL microfiche records for monthly and annual volume of pertinent profiles. The HCTF used RBL’s data to calculate single damages for the civil case, leaving RBL hard pressed to argue that its own data was inaccurate.

Conclusion

The success of the parallel investigations in the RBL case, in particular, and in the LabCorp case, in general, is testament to the power that Federal prosecutors possess in health care fraud cases. As was apparent in the RBL investigations, issues arising in parallel investigations are often complex, with no single answer applicable to all districts and all cases. These issues must be resolved through professional and moral judgment guided by applicable law, ethical standards, and an abiding sense of justice and fairness. The MDNC found that close coordination of the criminal and civil investigations through joint HCTF and investigative techniques that promoted the communication of information between the criminal and civil cases produced a synergistic effect, allowing both investigations to accomplish more than either could have achieved independently.

United States v. Charles M. Parrot, M.D.: A Case Study

*Assistant United States Attorney Barbara Bailey Jongbloed, Deputy Chief, Criminal Division,
and Assistant United States Attorney Karen L. Peck*

District of Connecticut

After jury selection and the day before trial was scheduled to begin, Charles M. Parrot, M.D., entered guilty pleas to charges of false claims against the Government. Dr. Parrot, a well-known family practice physician in southeastern Connecticut, was charged with executing a complex and lengthy scheme to defraud public and private insurers and his own patients by systematically billing for services and procedures he did not perform, services that he fraudulently “upcoded,” and services and procedures that were not medically necessary. To further his scheme and escape detection, he altered claims to add false diagnoses and falsified patients’ medical records, fabricating symptoms, test results, and entire office visits.

This significant case in the District of Connecticut was one of the first prosecutions of a family medicine physician. It involved an array of fraudulent practices designed to cheat both the public and private sectors. It attracted media attention, and they publicized all aspects of the case, hopefully contributing to the deterrence of this kind of fraud. The success of the case was a result of the joint efforts of the District’s Health Care Fraud Task Force, with representatives from the FBI, the Defense Criminal Investigative Service, and the United States Attorney’s office.

The Investigation

For several years, Dr. Parrot owned and operated walk-in medical clinics in the New London-Groton, Connecticut, area. His operation included an in-house laboratory and x-ray facility, and he employed numerous medical assistants and doctors. He had a computerized billing and claims system with a full-time billing department. He was an active businessman, recruiting several corporations to use his clinics for corporate physicals and drug screens, and contracting with a number of insurance companies and HMOs to act as a participating or preferred provider. He had provider numbers from Medicare and CHAMPUS, and he solicited patients among employees of General Dynamics, Electric Boat Division, a large defense contractor in Groton.*

In the early 1990s, Medicare and CHAMPUS informed Federal law enforcement agencies of alleged billing fraud perpetrated by Dr. Parrot. Both programs were alerted to his conduct by Parrot’s patients, employees, and co-workers, the latter deemed particularly significant by the insurers. In turn, pursuant to their policies, both public programs alerted law enforcement of the allegations of fraud once they received notice from his employees.

Probably the single most important development in the investigation was the recruitment of Parrot’s billing supervisor and other billing employees as confidential, cooperating witnesses.

*The United States Department of Defense ultimately paid for the medical benefits of Electric Boat employees.

They were an invaluable resource. First, they had daily contact with Parrot and watched him alter claims and medical records, and heard him make incriminating statements. Second, Parrot asked them to assist in altering claims and they were directed by him to upcode office visits, add false diagnoses, and mislead patients who questioned their bills. Third, they knew the computerized billing system intimately and could identify the computer reports that showed when, how, and by whom insurance claims were altered. Finally, they recruited other employees, such as medical assistants and receptionists, to talk to agents and assist in the investigation.

The CCTV Camera

As a result of information from the confidential witnesses, the United States Attorney's office obtained a court order authorizing the installation and use of a concealed video camera in Parrot's office to document him altering health care claims on his computer. The order, obtained pursuant to Rule 41(b), Fed. R. Crim. P., and the All Writs Act, 28 U.S.C. § 1651, authorized agents to monitor and record visual, non-verbal activity for a 30-day period, which was later extended pursuant to the court order. Agents minimized the intrusion by turning off the camera when Dr. Parrot was not at his desk. The primary value of the videotape evidence was its corroboration of the testimony of billing employees. It showed Dr. Parrot, typically late at night or on weekends, at his desk reviewing stacks of health care claims and accessing his computer. It established that he did **not** review medical records or laboratory log books, or consult with other doctors or medical assistants when he systematically added and upcoded services on claims. The videotapes were important evidence, as Dr. Parrot asserted that he legitimately changed claims after his detailed review of the patients' charts revealed errors in medical judgments by the doctors he employed.

The Searches

Through the information provided by Dr. Parrot's employees and the camera, search warrants were obtained for Dr. Parrot's clinics and home. The investigation revealed that the doctor used his computer and modem at home to access the clinics' computer and change claim forms from there.

The agents seized the computers and computer reports, certain patient files, clinic manuals, laboratory logs, and billing office files from the clinics, including, among other things, patient complaints. They also found "draft" claim forms—claims printed at Dr. Parrot's direction with notations of upcodes and added procedures, and diagnoses in the defendant's handwriting. These changes were entered into the computer by the doctor or his billing employees, and the claims reprinted and submitted with the fraudulent changes. Among the most potent evidence seized were printed computer reports called Transaction Register reports. Dr. Parrot's clinics used a billing software called ProMed. This software generated a report each day showing all computer activity from the day before and noting the computer identification of the user. The Transaction Register reports reflected, therefore, that someone using "chuck" or "cparrot," Dr. Parrot's user IDs, altered dozens of patients' claims on a particular day. Through these reports, we determined that Dr. Parrot changed claims, or directed others to do so, on more than 100 separate days in

1992 and on more than 70 days in 1993. The reports also showed, for example, that, on a single day, Dr. Parrot doubled his billings, adding more than \$16,000 in fraudulent charges. These Transaction Register reports, with the videotape evidence, demonstrated precisely what Dr. Parrot was doing on his computer.

The laboratory logs also were significant evidence. Medical assistants were directed to record tests and test results in the patient charts and in laboratory log books. Indeed, Federal and state regulations require that some of these logs be maintained. Thus, the absence of log entries, along with employee testimony, showed that certain tests were billed that had not been performed.

One revealing piece of evidence seized at Parrot's clinic was a law enforcement and military equipment catalogue showing that he ordered, among other things, the "Encyclopedia of Revenge" and a telephone voice changer. This evidence indicated that the concerns of Parrot's co-workers and employees may have had a basis in fact. Several potential witnesses hesitated to cooperate with the investigation because they feared Parrot.

The search warrants authorized seizure of only the records of patients with certain insurance coverage who were seen in the clinics in the preceding six months. Although this limitation was based on a desire to keep the case manageable, the scope of the warrant ultimately proved to be too limited. After the search, the computer data and information from insurers revealed substantial fraud in connection with patient files which were not seized. Some of the records were obtained through "forthwith" grand jury subpoenas *duces tecum*, but some were never produced. As an unintended benefit to using a forthwith subpoena months after the search, we discovered alterations to charts that Dr. Parrot made after the execution of the search warrants.

A second problem with only seizing charts for insured patients was that we lacked medical charts for cash-paying patients. We learned from medical assistants that Dr. Parrot tended to prescribe many more tests for insured patients than for cash-paying patients, and that he defrauded insured patients more often. The charts for patients who paid cash would provide a useful comparison. While we obtained some of these charts by forthwith subpoena, others were undoubtedly lost or destroyed after the execution of the search warrants.

The search of the defendant's home yielded one piece of particularly valuable evidence—a "burn box." Agents found a wooden box next to Dr. Parrot's fireplace. In addition to matches and a fire starter log, it also contained hundreds of draft claim forms. Several of the forms had alterations, such as the addition of tests, diagnoses, or upcodes, made in Dr. Parrot's handwriting. This was direct evidence that the defendant was making and directing these changes, and it rebutted his defense that he was altering claims based on his review of medical records. Patient files for the altered claims were not found at Parrot's home. Agents also found nearly \$140,000 in cash at his home, including approximately \$10,000 in his pocket. This money was seized and ultimately turned over to the Internal Revenue Service.

The Prosecution

Deciding What to Charge

In charging the case, we focused on two private insurers: Blue Cross and Blue Shield of Connecticut, and M.D. Health Plan, an HMO, and on three public programs: Medicare, CHAMPUS, and the defense contractor, Electric Boat. Mail fraud, 18 U.S.C. § 1341, was charged as to the private companies, and violations of the false claims provision, 18 U.S.C. § 287, were charged as to the public programs. The allegations describing the defendant's fraudulent scheme were incorporated in all counts, including the false claims counts.

We decided to charge a sufficient number of counts to show a pattern of fraud as to each insurer. We did this for two reasons. First, proof of a pattern of fraud would rebut any claim that the charged counts were isolated instances or the result of inadvertence or mistake. Second, we wanted to ensure that evidence of numerous instances of fraud would be presented to the jury, even if the court was inclined to interpret Federal Rule of Evidence 404(b) narrowly and limit our ability to present evidence of uncharged conduct. Also, because the indictment would be given to the jury, a sizable list of examples of fraud would help impress upon jurors the magnitude of the crime.

We also decided to charge the full range of the defendant's fraudulent conduct—his charging for services not performed, for “upcoded” services, and for services not medically necessary. Certainly the charges relating to the defendant's charging for services he did not provide were the cleanest to prove. But what the witnesses talked about most was the litany of tests Dr. Parrot prescribed for insured patients, at times before he had examined or even spoken to the patient, and his routine upcoding of office visit charges for his own patients and those of other doctors. Even though cases involving medical necessity and upcoding can become a battle of the experts,** we were confident, given our evidence, that the jury would not believe the defendant's actions were justified, at least in most instances. Proof that he also charged for services he did not provide could bolster our evidence as to the other types of charges.

The Expert Witness

For our expert, we chose a well-credentialed, local, board-certified family practice doctor, who had a busy practice in a lower-income area, somewhat similar to the locale of the defendant's clinics. We looked for a practicing physician with a practice sufficiently similar to the defendant's, to avoid a defense attack on our expert for a lack of experience with the problems particular to a family practice doctor in lower-income Connecticut.

The expert offered certain insights that were particularly useful to us and would have been compelling to the jury. For example, the defendant prescribed a somatosensory test (“NDX”) for which he charged \$215.00. His medical assistants performed the test themselves and were told simply to connect monitors to patients and have them breathe to music. According to our expert,

** Parrot, however, never disclosed an expert witness on either billing matters or medical necessity.

the NDX test is highly sophisticated and primarily used in places like the Mayo Clinic to diagnose conditions such as advanced neuropathy. Our expert stated that many neurologists are not qualified to conduct the test and evaluate the results, much less family doctors or medical assistants, and that the test was never conducted appropriately in walk-in clinics like the defendant's.

Numerous other tests were prescribed unnecessarily including an Epstein-Barr Virus test which he billed as a four-test series for more than \$100. The test simply showed whether the patient had ever been exposed to certain viruses. Some doctors who worked with Dr. Parrot and our expert stated that this unsophisticated test had little utility at best. Yet, many patients who complained of fatigue or flu-like symptoms received this test, at times even on subsequent visits after initial positive results confirmed the exposure. A number of patients were subjected to three thyroid tests together—T-3, T-4, and TSH tests—for a total charge of \$270. Our expert opined that these tests were often prescribed unnecessarily, and, in particular, that all three tests were usually unnecessary. Thyroid tests also were among those added to claims by Dr. Parrot when they had not been performed.

The expert also pointed out that, on several patient charts that insurers requested before they paid the corresponding claim, Dr. Parrot's notes were disjointed, indicating numerous symptoms that normally would not occur together. The expert opined that the notes may have been inaccurate and written solely to justify the numerous tests that were run. This testimony would have dovetailed with that of a patient whose insurance company refused to pay for hundreds of dollars in tests Dr. Parrot prescribed. The defendant wrote a letter of protest to the company, claiming that the patient was one of the sickest he'd ever seen and that she suffered from a number of very serious symptoms. When shown the letter, the patient denied this, saying that she had neither complained of nor suffered from many of the symptoms the defendant described.

The Patients

We were prepared to present testimony from a number of patients, two of whom had conversations with the defendant during the investigation in which he tried to persuade them that they had not been defrauded. Several of the patients had difficulty speaking English and some lacked financial resources or sophistication. Their testimony would have provided the jury with a picture of the type of people victimized and used by the defendant as unwitting instrumentalities of his fraud. Their testimony also would have contrasted starkly with that of the patients on the defendant's witness list who, no doubt, would have extolled his virtue as a doctor.

Summary Exhibits

One challenge was to organize and present the voluminous documentary evidence so that it was meaningful to the jury. To accomplish this, we prepared summary exhibits for each patient in the indictment. We planned to present these exhibits at the end of our case through the case agent.

The exhibits consisted of a folder for each patient. At the front of each folder was a summary sheet which listed the date of the relevant visit to the defendant's clinic; the date the patient's claim was altered; the services and procedures that were added, upcoded, or prescribed unnecessarily; the date the claim was submitted to the insurer; and, for the mail fraud counts, the date the insurance company mailed the check. Behind the summary sheet was (1) a copy of the patient chart for the visit at issue; (2) a highlighted copy of the transaction register computer report showing the charges entered into the billing system on the date of the visit; (3) a highlighted copy of the report showing when and what charges were added or altered and by whom; (4) a copy of the claim with the fraudulent charges highlighted; and (5) for the mail fraud counts, a copy of the check. The originals of all these documents would have been in evidence by the time the summary exhibits were introduced.

The summary exhibits were road maps through the relevant documents for each count, showing that each element of the charged offense had been met. They also would have relieved the jury of the need to shuffle through piles of paper to determine what claim, medical chart, or check applied to a particular count.

In our trial memorandum, we alerted the court and defense counsel that we intended to present these summary exhibits, and provided them with copies. As expected, the defense objected, arguing that, among other things, the summary sheets stated the ultimate issue for the jury to decide and emphasized the Government's theory of the fraud. The court rejected these arguments and ruled the exhibits admissible.

Suggestions

From our experiences in this case, we offer the following suggestions:

Get a Computer Expert

To fully analyze and exploit all the information in the defendant's computer system, use a consultant with expertise in the specific system and software used by the defendant. In this case, members of the Department's Computer Crimes Section assisted the agents with the searches, seized the computers, and conducted a preliminary review of the hard drive; however, they did not have experience with the ProMed software or its interaction with Parrot's system. The one local consultant who had this expertise was employed by ProMed and was reluctant to participate in the prosecution. Fortunately, the case agent gained some expertise with the software, and we got valuable information off of the computer. We would have liked to do more, and could have, if a consultant was available.

The Loss

Under the Sentencing Guidelines, the loss amount is crucial. It is also crucial to communicate with the insurers early in the case concerning how loss calculations should be done and what

information is needed. This will allow them to select a sampling of claims, preferably a random statistical sampling from those the defendant submitted during the relevant time period, and to audit the corresponding patient records to determine the total extrapolated loss. (This is another reason to seize **all** patient records for those covered by the target insurers.) Getting a reasonable estimate of the loss early in the case makes sense; it gives the insurers time to perform a reasonable audit, shows you the financial magnitude of the case up front, and prepares you for the sentencing, whether after a guilty plea or trial.

Dr. Parrot was sentenced May 20 to fifteen months in prison; a term of supervised release; and a restitution order covering all counts in the superseding indictment—not merely the counts of conviction. His medical license is suspended indefinitely.

Medicare Kickback Case Nets \$2 Million Settlement

Assistant U.S. Attorney Daniel A. Caldwell, Northern District of Georgia, and Trial Attorney Laurie A. Oberembt, Civil Division, Commercial Litigation Branch

In January 1997, the Office of the United States Attorney for the Northern District of Georgia and the Commercial Litigation Branch of the Civil Division of the Justice Department reached a civil settlement in excess of \$2 million, to resolve the False Claims *qui tam* case, *U.S. ex rel. Parker v. Apria Healthcare Group Inc., et al.* (Civil Action No. 1:95-cv-2142-FMH)(USDC N.D. Ga.)

In August 1995, relator Mark Parker filed suit under the *qui tam* provisions of the False Claims Act, 31 U.S.C. §§ 3729, et seq., against nine defendants. Parker primarily alleged that the defendants participated in kickback arrangements designed to influence the referral of Medicare patients. As in any *qui tam* suit, the civil action remained under seal while the United States determined whether to intervene in the case. Throughout the investigation, we were assisted by FBI Special Agent James Eckel; FBI Special Agent Joyce Dean; and Dana James, a Special Agent with the U.S. Department of Health and Human Services, Office of the Inspector General (HHS-OIG), in evaluating relator's allegations.

After the investigation of the relator's charges, the United States elected to intervene in the *qui tam* suit with regard to the relator's claims that defendants Apria Healthcare Group, Inc. (Apria); Georgia Lung Associates, P.C. (GLA); and Edward Swartz, M.D., entered into a sham consulting agreement as a means of paying kickbacks for the referral of patients. The United States did not elect to intervene with regard to the relator's other claims against Apria, GLA, Swartz, or the six other defendants.

In the Amended Complaint that was subsequently filed by the United States, we alleged that Apria, one of the largest suppliers of durable medical equipment in the country, through its corporate predecessor, Homedco, Inc., entered into a sham medical consultant agreement with GLA, a group of physicians that included defendant Swartz. Apria allegedly made payments under that agreement in order to secure referrals of Medicare patients. The United States alleged that the consultant payments violated the anti-kickback provisions of the Social Security Act, 42 U.S.C. § 1320a-7b(b), and that claims for services provided to patients referred pursuant to this scheme violated the False Claims Act.

This False Claims Act case was unusual because the sole basis for alleging fraudulent claims was the presence of a kickback—there was no allegation that the services were not provided to patients referred pursuant to the kickback scheme, or that any portion of the kickback was added to the Medicare invoices. Only three district courts have specifically addressed this scenario,* and

* See *United States ex rel. Pogue v. American Healthcorp, Inc.*, 914 F. Supp. 1507 (M.D. Tenn.), appeal denied, No.96-8518 (6th Cir. Apr. 19, 1996); *United States ex rel. Roy v. Anthony*, No. C-1-93-0559, 1994 WL 376271 (S.D. Ohio) Jul. 14, 1994)(court denied motion to dismiss and permitted plaintiff to proceed in False Claims Act case based

no court of appeals has definitively resolved whether the conduct the defendants were charged with violates the False Claims Act. The United States asserts that prohibitions upon kickbacks and other improper referral practices are a central part of the statutory scheme for the Medicare program, with which providers must comply to receive payment under Medicare.

However, in the recent case of *U.S. ex rel. Thompson v. Columbia/HCA Healthcare*, 938 F. Supp. 399 (S.D. Tex. 1996), a district court held that the rendering of medical services in violation of the Medicare anti-kickback statute does not, standing alone, state a claim that submission of claims for payment for those services violate the False Claims Act. That decision—the basis for dismissal of a *qui tam* suit in which the United States did not elect to intervene—is on appeal to the Fifth Circuit. The United States has filed an *amicus* brief with the Fifth Circuit.

The uncertainty of the claims in which the United States elected to intervene and the relator's pursuit of the remaining defendants and claims increased the potential for protracted and unwieldy litigation. To avoid this, the district court required the parties to adhere to a strict discovery schedule and to seek a good faith resolution of the case.

The district court accomplished this by holding several lengthy conferences, pursuant to Rule 16 of the Federal Rules of Civil Procedure, in order to establish firm time frames for the completion of discovery. The district court also held one conference to resolve expeditiously disputes arising from the initial production of records in this document intensive case.

In accordance with guidelines established under the Local Rules for the United States District Court for the Northern District of Georgia, the court strongly encouraged the parties to seek non-binding mediation. Through a convergence of the defendant physicians' interest in reaching a settlement prior to their scheduled depositions and all parties' recognition of their respective litigation risks, the parties resolved a portion of the case amongst themselves prior to mediation. Following mediation of the remaining claims, tentative resolution of the case was reached in early December 1996. Under the terms of the settlement, Apria agreed to pay \$1.65 million to resolve claims relating to alleged kickback payments and providing in kind services to physicians in Georgia and Florida; GLA and the four defendant physicians in GLA agreed to pay approximately \$346,000 to resolve pending claims against them; the other defendants named in relator Parker's *qui tam* action agreed to pay smaller sums to resolve claims against them; and, finally, the defendants agreed to reimburse Parker for his attorneys' fees.

Apria, GLA, and the physicians affiliated with GLA were concerned about potential debarment or suspension actions that HHS might take against them; therefore, at the time those defendants were seeking to resolve civil claims brought against them, HHS-OIG attorney Larry Goldberg negotiated compliance programs with those defendants.

on tainted patient referrals); *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 938 F. Supp. 399 (S.D. Tex. 1996), [appeal docketed](#), No. 96-40868 (5th Cir. 1996).

Pursuant to the settlement, the United States received payments in excess of \$2 million. Of this amount, relator Mark Parker received a relator's share of approximately \$450,000.

In this case, through the coordinated efforts of HHS-OIG, the FBI, the Commercial Litigation Branch of the Civil Division, and the United States Attorney's office in Atlanta, the United States achieved a successful settlement based primarily upon claims arising from an unsettled area of law. While the coordinated use of limited resources was a major factor in resolving the case, the prompt settlement was a result of the district court establishing a manageable discovery schedule at the outset of litigation and the parties' interest in using the mediation process to resolve differences. In this case, DOJ guidelines for the utilization of alternative dispute resolution procedures in civil litigation assisted the achievement of a favorable outcome for the United States.

United States v. Dr. Fred Paul Norman

Assistant United States Attorney Lee E. Berlinsky

Civil Division

District of South Carolina

On December 31, 1996, the United States Attorney's office for the District of South Carolina and Dr. Fred Paul Norman, M.D., entered into an Affirmative Civil Enforcement (ACE) Settlement Agreement relating to Dr. Norman's violation of numerous record keeping provisions of the Controlled Substances Act, 21 U.S.C. 801, *et seq.*

Dr. Norman is a medical doctor practicing in Myrtle Beach, South Carolina, specializing in bariatric medicine, the treatment of patients for weight control.

During 1994 and 1995, DEA Diversion Group-Columbia, South Carolina, and the South Carolina Department of Health and Environmental Control, Bureau of Drug Control, conducted several inspection audits and drug accountability investigations regarding Dr. Norman, and found that his record keeping and controlled substances inventory control were not in compliance with state and Federal regulations. His violations included the omission from dispensing log books of patients' home addresses, dates on which controlled substances were dispensed, dosage amounts of controlled substances dispensed, and inaccurate inventory records of controlled substances.

As a result, DEA seized his books and records covering a two-year period (the statutory period during which the records must be maintained for inspection), and turned them over to our office. Upon our review, it was clear that we had a *prima facie* case.

The first step taken was to notify Dr. Norman by letter of the civil violations he committed, the potential monetary exposure he faced for the penalties, and the demand that he tender that amount to our office. (AUSAs must refamiliarize themselves with the provisions under EAJA as well as DOJ policies prior to sending "demand" letters). I asked him to contact me within 10 days to set up a meeting to discuss a resolution or I would file the Summons and Complaint which I already prepared. Needless to say, he called.

Since the monetary amount of Dr. Norman's potential penalty exceeded our office's delegated settlement authority, we had to obtain approval from Assistant Attorney General Frank Hunger, Civil Division, pursuant to 28 C.F.R. Part O, Subpart Y, which took only three days.

At the initial meeting at DEA headquarters with Dr. Norman and his attorney, I explained that strict liability could be imposed for civil violations of the record keeping provisions of the Comprehensive Drug Abuse Prevention and Control Act. I displayed his books with the violations highlighted, and it became clear that Norman was willing to accept responsibility for the violations, leaving only the penalty to be negotiated.

This office was, therefore, able to use Executive Order No. 12988, *Civil Justice Reform*, 61 Fed. Reg. 4729 (1996) WL 46665, Section 1(a), to enter into unassisted settlement negotiations with Norman and his attorney without filing suit.

Negotiating this case without filing a lawsuit presented several problems which I would like to share.

First, this was a single issue negotiation focusing only on penalties since Dr. Norman already conceded liability. That issue alone put the United States Attorney's office in an incredibly powerful position, and remaining objective during the negotiations was very difficult. I had Dr. Norman right where all Assistant United States Attorneys want their defendants. I wanted the penalty assessed to be substantial since his exposure was; yet, I wanted to avoid any challenge of being unreasonable or abusing the discretion of the office, which defendants are so eager to allege these days.

In order to remove any appearances of a one-sided negotiation between the Government and Dr. Norman, I asked the other side to assist in developing a formula for settlement, which I hoped would make them feel involved in fostering justice. I hoped their involvement in the process would quell any illegitimate settlement environment.

I reviewed judicial decisions from our circuit that were factually related to our case and, based on my findings, developed a **subjective** formula for recovery that could be used not only in this case, but in similar cases. The other side accepted the formula without controversy.

The formula took into consideration the willfulness of the violations, the extent to which Dr. Norman profited from the alleged violations, the harm caused to the public, and his ability to pay the agreed amount [*United States v. Queen Village Pharmacy*, 1990 WL 165907 (E.D. Pa.)].

Second, without filing the lawsuit, the parties were not subjected to formal discovery or court rules. Instead, documents were provided through informal interrogatories and requests. As a result, I had little confidence in the reliability of Dr. Norman's personal financial statements and business financial records, but I still had to rely on them to make the formula work. I did, however, have full confidence in the integrity of his attorneys which helped chill my suspicions.

Third, there were periods of time when Dr. Norman would not provide documents as promised and we had no way to compel delivery.

In the settlement, Dr. Norman agreed to (1) pay the Government a civil penalty of \$225,678; (2) a 30-day suspension from administering and dispensing controlled substances; and (3) allow Government personnel access to his business for 2 years to verify compliance with the regulations, without the Government obtaining an administrative warrant or giving notice. The Drug Enforcement Agency administered the 30-day suspension according to administrative regulations

and, pursuant to agency regulations, arranged for the Government to have access to Dr. Norman's business for 2 years, without obtaining a warrant or giving notice.

The intent of the Settlement Agreement was not to deprive Dr. Norman of his livelihood, rather, to see that he accepted responsibility for his actions and took the affirmative steps to comply with regulations.

In looking back, this unassisted negotiation was probably successful because the two sides built a problem solving environment from the very beginning. Rather than dwelling on Dr. Norman's past violations, we set out to determine how Dr. Norman could regain compliance with the regulations.

Of equal importance during the negotiations was the role that DEA played—not only in our initial meeting with Dr. Norman, when we explained his violations and the steps he needed to take to conform with state and Federal regulations, but throughout the process until the final terms of the agreement were reached. Once the hostile environment caused by the demand letter was diffused, we were able to move expeditiously and economically towards resolution.

The Settlement Agreement represents the largest civil penalty imposed on an individual physician in the DEA-Atlanta Region, which includes North Carolina, Georgia, Tennessee, and South Carolina.

Failure to Repay Credit Balances: West Jersey Health Systems

*Assistant United States Attorney Janet S. Nolan
District of New Jersey*

Based on the number of ongoing nationwide enforcement projects involving hospitals, it appears that they are being subjected to the same scrutiny that Part B providers have been subjected to for some time. While trying to trace fraud on a Part A cost report is much harder than on a straightforward Part B overbilling case, the results garnered by districts such as the Eastern and Middle Districts of Pennsylvania, the Northern and Southern Districts of Ohio, and Massachusetts in several different hospital cases, illustrate that the efforts can be extremely fruitful.

Recently, our office entered into a civil settlement with West Jersey Health Systems (West Jersey), a fairly large hospital chain in southern New Jersey. While the final settlement amount (\$875,000) pales in comparison to the multi-million dollar settlements in laboratory and other hospital cases, the issues involved were somewhat novel. The case also may be a rarity in the health care arena in that, while the methodology used by the Department of Health and Human Services (HHS) and Part A auditors to determine damages was very sophisticated, the underlying fraud would have been fairly easy to explain to a jury.

What is a Credit Balance?

In short, West Jersey failed to refund to Medicare certain credit balances it accrued for hundreds of Medicare patients beginning in approximately 1985. Although credit balances can occur in a variety of ways, they often fall into one of three categories. A hospital may submit duplicate bills for the same service, and they may not be detected by the intermediary because different codes or different dates of service were used. In another example, a hospital may bill for a service that is not rendered, such as a diagnostic test that is later canceled by the doctor. Finally, credit balances occur when the hospital bills Medicare as the primary insurer when, in fact, another insurance company is primary. In this instance, Medicare and the other insurer pay the full allowable amount, resulting in a surplus for that particular patient. In our case, the vast majority of the credit balances occurred because Medicare was the secondary payer but was billed as the primary.

The Medicare rules governing which insurer is primary are referred to as Medicare Secondary Payer (MSP) rules and are set forth in section 1862(b) of the Social Security Act, 42 U.S.C. § 1395(y)b. Generally, they provide that Medicare will be a secondary payer in cases where other coverage is available to a beneficiary, such as automobile accident insurance, liability insurance, no fault insurance, Employer Group Health Plan, or worker's compensation benefits. HHS published regulations implementing the MSP provision which are codified at 42 CFR Part 411. Obligations a provider assumes when participating in the Medicare program are to identify primary payers other than Medicare and to bill other primary payers before billing Medicare.

I have been told by HHS that now there is a central database which makes it easier for hospitals to determine a patient's primary insurer. Prior to the existence of this database, hospitals relied on a comprehensive form which every patient was required to complete to identify their primary insurer. (See Sections 300 and 301 of the *Medicare Hospital Manual*.)

Credit balances themselves are not suspicious; in fact, Medicare assumes that hospitals will generate credit balances routinely. Since 1992, Medicare has required hospitals to submit quarterly reports to the Part A intermediary, specifically identifying outstanding credit balances. This report is referred to as HCFA Form 838, and it requires the provider to identify every credit balance due to Medicare as of the last day of that quarter. The very first Form 838 that a provider submits to Medicare requires the provider to identify every credit balance that the provider had accrued since their participation in the Medicare program. Form 838 also requires the provider to sign a certification verifying that the credit balance report submitted was true, correct, and complete.

The Investigation

In our case, West Jersey submitted all the required Form 838s, and certified on each one that it had identified all credit balances. HHS Special Agent James McDonald and our Part A auditors, however, found that West Jersey "wrote off" a substantial number of Medicare patient balances, beginning as early as 1986. During the course of a routine audit by the intermediary, Part A auditors saw that West Jersey maintained separate general ledger accounts for the written off credit balances. West Jersey only refunded the money if the insurance company specifically requested a refund.

Based on our analysis of interviews and hospital documents, we determined that officials at West Jersey knew about the problem but decided it would be too costly to research and identify past credit balances. Moreover, based on our interpretation of the records, we found that hospital officials believed that many of the credit balances were attributable to computer error and that some error rate was permissible. In 1992, it appeared that the hospital decided to make a concentrated effort to correct or at least minimize the problem in the future, but not to refund past credit balances unless refunds were requested. Thus, even though West Jersey was required to identify all pending credit balances on its August 1992 HCFA Form 838, it listed only a few credit balances pre-dating that quarter.

Making a False Claims Act Case

From the beginning, West Jersey's actions constituted a violation of the False Claims Act, 31 U.S.C. §§ 3729-3733, not mere negligence. I equated the problem as similar to that of a large clinical laboratory that could not perform certain lab tests because of a tainted sample or insufficient specimens. While no one would dispute that these errors could occur, a technician's negligence does not excuse the lab for submitting the bills to Medicare, or for not refunding the money to Medicare once the "mistake" was discovered. Similarly, in this case we were more

concerned with West Jersey's avowed intention to ignore certain credit balances, than the fact that the misbillings occurred. (However, as part of the corporate compliance agreement, HHS required the hospital to take more steps to determine the primary insurer before submitting the bill to Medicare.) West Jersey's error rate for billing Medicare as the primary insurer was in excess of other neighboring hospitals and certain hospital officials knew it, which bolstered our False Claims Act case.

In fact, we told attorneys for the hospital that we thought the case presented almost an ideal False Claims Act case. For once, the Medicare regulations were clear, easy to explain, and logical. (It seemed fairly intuitive that Medicare should not allow a hospital to double bill and keep the extra money.) HCFA and the intermediary provided notice to all hospitals about Medicare secondary payer issues and credit balances since at least 1991. (Thus, we would not be in the position of "apologizing" to the jury for Government actions or inactions.) We had witness interviews and internal documents that showed at least reckless disregard on the part of hospital officials. Our major obstacle was determining damages.

Determining Damages

Early in the investigation, the HHS agent identified that West Jersey generated approximately \$1.9 million in credit balances for 8,200 accounts involving Medicare patients. However, we recognized that merely identifying the Medicare accounts which generated credit balances would not accurately reflect the Government's loss. First, if Medicare and another insurer were billed, and Medicare was the primary insurer, a credit balance was generated but at no loss to the Government. Second, even if Medicare were the secondary but billed as the primary, Medicare would still pay some amount, usually 20 percent of the claim. Therefore, we could not simply rely on the amount that Medicare paid for a particular patient, because that amount would be an overstatement of the Government's loss. We knew before we began determining our damages that they would be less than \$1.9 million.

Agent McDonald worked extensively with experts at HHS and our Part A intermediary to construct a "statistically valid" sample out of the universe of 8200 claims. (The methodology used to determine the statistically valid sample is beyond the scope of this article.) In short, he categorized the samples as: in-patient claims where Medicare was primary, in-patient claims where Medicare was not primary, and out-patient claims where Medicare was primary. Each group was further categorized by the amount of the claim: \$101 to \$1000, \$1001 to \$5000, and over \$5000. In total, 364 files were subpoenaed and audited.

The audit was conducted by David Ross, Internal Control Coordinator at Blue Cross/Blue Shield of New Jersey, our Part A intermediary. (At one point during the investigation, West Jersey offered to conduct the audit using its own expert; however, in this case, HHS preferred to perform the audit.) It was a time-consuming but thorough process, resulting in West Jersey contesting very few of Mr. Ross's determinations of the existence of credit balances but they did contest the methodology used in determining damages.

First, the hospital took exception to our extrapolation which treated “active” and “inactive” accounts the same. West Jersey argued that since it basically corrected any problems by 1992, our extrapolation overstated potential credit balances for recent accounts. Second, hospital attorneys disagreed with our reliance on the so-called *Bornstein* methodology for the treatment of approximately \$185,000 of refunds made by the hospital. I argued that under *United States v. Bornstein*, 423 U.S. 303, 314-17 (1976), the Government’s damages should be multiplied before compensatory payments are deducted. Its response was that some of the compensatory payments were, in fact, refunds in compliance with the regulations and, thus, are not covered under *Bornstein*. (We settled the case before that issue had to be resolved.) Ultimately, we settled the case using the hospital’s estimate of single damages and my multiplier.

West Jersey’s final argument was based on the statute of limitations. West Jersey argued that the Medicare intermediary knew about West Jersey’s write-offs as of 1992, so the statute of limitations expired for the credit balances that occurred from 1984 through 1988. Although we settled with West Jersey before filing suit, I intended to proceed primarily under a reverse false claim theory on the basis of false Form 838s. Section 3729(a)(7) of the False Claims Act specifically states that “knowingly mak[ing] . . . a false record or statement to conceal, avoid, or decrease an obligation to the Government” is a false claim. Clearly, by failing to identify all outstanding credit balances on Form 838s, West Jersey’s conduct fit into the definition of a reverse false claim. Since these forms were submitted quarterly beginning in 1992, I believed that the statute of limitations did not expire until August 1998, at the earliest—six years from the date the company first failed to identify all of its credit balances. (As an alternative theory, I also intended to include a count based on individual false claims that would have been submitted in instances where credit balances resulted from duplicate billings; services not rendered; or even when Medicare was the secondary payer, if we could have shown that West Jersey “knowingly” billed Medicare as the primary carrier.)

West Jersey’s attorneys argued that we could not “bootstrap” credit balances older than six years onto the reverse false claim submitted in 1992. Again, because the case settled before litigation, this issue was not briefed before a court.

The Settlement

Because West Jersey paid the settlement amount in full, the settlement agreement was straightforward. To avoid an overly broad release, we included an exhibit in the agreement—a 60-page computer printout of all identified patient accounts with credit balances. We thought this was the only way to avoid releasing any other fraud that may be discovered later with respect to particular claims. (To protect the patients’ privacy, the exhibit listed only the last four digits of patients’ social security numbers.) At the request of HHS-OGC, we also included a provision whereby West Jersey released HHS and its intermediaries for payments that they may have owed West Jersey for the released claims. We did not include other agencies in our settlement because the issue seemed specific to Medicare. We looked at credit balances involving Medicaid patients but West Jersey told us that the rules for Medicaid were different so no credit balances would

have resulted for these patients. Because of time constraints, we did not pursue the issue but referred it to the state Medicaid experts. Finally, we incorporated an extensive corporate compliance agreement in the settlement.

The successful resolution of this case is attributed to the outstanding efforts of Special Agent Jim McDonald and our Part A auditor, David Ross. Bill Heffron from the Office of General Counsel, Office of Inspector General, also provided invaluable assistance during the negotiations.

U.S. v. Virginia Psychiatric Company d.b.a. Poplar Springs Hospital

*Assistant United States Attorney Brian D. Miller
Eastern District of Virginia*

Criminal kickback cases are notoriously hard cases to prove, and they don't get any easier as civil cases. In fact, they just get harder and older. To bring a civil kickback case, the civil Assistant United States Attorney has to clear a number of initial hurdles.

Grand Jury

Most kickback cases begin as criminal investigations, which usually means that by the time the civil Assistant gets the referral, the case is based almost entirely on grand jury materials. Sometimes, in addition to everything else, a *qui tam* has been filed, adding another set of attorneys and parties with which to contend.* To gain access to even basic evidence, the civil Assistant has to be added to the [Federal Rules of Criminal Procedure, Rule] 6(e) list. In most United States Attorneys' offices, the civil Assistant will have to draft the *ex parte* motion, brief, and order for the criminal Assistant. It is a good idea to specify that the civil attorneys may have access to the investigators' impressions, notes, and analyses, and may use the same agents in the civil investigation.

Statute of Limitations Problems and Tolling Agreements

Many of these referrals will be so old that the civil Assistant will have an immediate statute of limitations problem. Today, many United States Attorneys' offices, including ours, have resolved these problems by adopting a more progressive attitude toward parallel proceedings. On the brighter side, limitations problems can provide the impetus to expedite the 6(e) motion. On the darker side, however, the civil case is either almost gone or claims are disappearing as time-barred before the civil Assistant begins.

When *Poplar Springs* was referred, our statute of limitations was about to run out. Fortunately, the hospital was willing to sign a tolling agreement. Most health care providers are interested in settlement and will usually sign a limited tolling agreement in order to pursue good faith settlement negotiations. Getting tolling agreements extended when negotiations stall, however, is trickier. At one point, negotiations stalled and the hospital was not willing to grant the long extension I proposed. We compromised on a shorter extension, which was then extended after more progress was made.

*For example, the case, *U.S. ex rel. Favret v. Charter Westbrook Behavioral Health Systems, Inc.* (E.D. Va.), in which we reached a settlement of \$2,000,000.

No Agents to Investigate

The agents who worked on the criminal investigation may be tainted by the grand jury process and, in an ideal world, the civil Assistant would have new agents assigned to the case. In the real world, however, the same agents will want to work the civil case too—they want some kind of case made to show for all their years of hard work. Consequently, the civil Assistant should make sure that the 6(e) order covers the use of the agents too. The abundance of caution will be appreciated by all. Recently, we asked for access to an audit that was performed using grand jury materials. While the judge had no problem finding that the pre-existing documents were not grand jury materials, he believed that the issue of whether the audit, witness interviews, and agent's analyses were grand jury materials, was a novel one. He ultimately granted access to them.

In the kickback area, another source of agents is now available. Previously, the Anti-Kickback Act did not appear to cover CHAMPUS. Congress has corrected this problem: It passed H.R. 3103, the Health Insurance Portability and Accountability Act of 1996, which extends the reach of the Anti-Kickback Statute to cover all "Federal health care payment programs." As a Federal health care payment program, CHAMPUS now falls within the scope of the Medicare/Medicaid Anti-Kickback Statute. Aside from adding CHAMPUS monies to the damages calculation, Defense Criminal Investigative Service (DCIS) agents can now assist in the investigation.

The Merits

After gaining access to the evidence and obtaining a tolling agreement, the civil Assistant finally has to face the ultimate question: Is there a civil case?

Two Cases in One: Establishing the Kickbacks First

The first issue is whether or not the kickbacks can be established. The civil Assistant gets two cases in one because the existence of kickbacks must be established before proceeding further. In *Poplar Springs*, we relied on documentary evidence—correspondence, memoranda, and contracts—to outline the Hospital's alleged efforts to provide direct and indirect compensation to health care providers in return for patient referrals during the period from January 1, 1986, through December 31, 1993.** Testimony is dubious in these cases. Obviously, even if a psychiatrist testified that he or she admitted a patient because of a kickback, or kept a patient as an inpatient longer than necessary because of a kickback, the psychiatrist's credibility would be attacked.

** Specifically, in return for patient referrals, Poplar allegedly engaged in (1) providing income guarantee agreements, (2) providing office rent subsidies, (3) granting low interest and no interest loans, (4) forgiving collection of loans, (5) providing "directorship" contracts, and (6) making "unreferred patient" assignments based upon admissions made by a health care provider.

Civil Theories

Proving a violation of the Medicare Anti-Kickback and Referral Law, 42 U.S.C. § 1320a-7b, is necessary but not sufficient. The Medicare Anti-Kickback Statute does not have civil remedies. There are a number of plausible civil theories: civil RICO, 18 U.S.C. § 1964, for example. The problem is finding and proving the predicate acts, and then suit can only be brought after the Criminal Assistant Attorney General's approval. The Anti-Kickback Act, 41 U.S.C. § 55, is more interesting but there must be a prime contractor/subcontractor relationship, which may or may not exist. Furthermore, damages are limited to double the amount of the kickback. Probably the best bet is the False Claims Act, 31 U.S.C. § 3729-3733.

Although an argument can be made that a violation of the Medicare Anti-Kickback Law, per se, is a violation of the False Claims Act (the provider is tacitly and falsely certifying that the patient was admitted in compliance with all Medicare rules and regulations), the better approach is to trace the kickback directly to Medicare payments.

In *Poplar Springs*, the hospital argued that there were no false claims or harm to the Government because these patients needed treatment, and that Medicare would have paid for these services anyway, wherever the patients were admitted. The hospital further argued that violation of Medicare Anti-Kickback and Self-Referral Laws, per se, is not a violation of the False Claims Act. However, we were able to trace the kickbacks to the cost reports submitted to Medicare Part A, under "physician recruitment" costs. This approach, though time-consuming, allowed us to avoid the hospital's arguments regarding medical necessity and damages, and to establish a false claim on both the cost report and damages.

Although civil kickback cases present a host of obstacles, they are surmountable. In *Poplar Springs*, our office reached a satisfactory settlement of \$500,000 to resolve an alleged scheme of a hospital providing incentives or kickbacks totaling about \$204,000 to psychiatrists for referring patients. Examples of the incentives used to induce referrals include the forgiveness of loans, loan forgiveness arrangements, office rent subsidies, granting low and no interest loans, income guarantee arrangements, and new patient assignments based on the number of admissions made by a particular health care provider.

United States v. Borders: An Example of Cooperation Among Law Enforcement, the Medical Community, and Insurance Companies in the Fight Against Health Care Fraud

*Assistant United States Attorney Linda L. Parker
Western District of Missouri*

In February 1993, Joe Pryor, M.D., a neurologist in Kansas City, Missouri, received a flyer soliciting referrals to Omega Medical Diagnostic Services, Inc. According to the flyer, Omega technicians could perform non-invasive neurodiagnostic testing in the offices of referring doctors and, in return, Omega would pay the doctors “rent” for their office space for the period of time it took to do the testing. Rental rates were quoted at \$300 per hour. In addition, Omega would waive any insurance co-payment the patients might have, and even pay a percentage of the patients’ deductible if it had not been met. The types of tests offered and the charges were listed in the flyer.

Dr. Pryor, who did both invasive and non-invasive neurodiagnostic testing, was concerned. He thought the tests should not be performed by technicians, particularly without a doctor’s supervision, and that if the referring doctors relied on the technicians’ test results, the result might be inappropriate treatment for the patients.* Pryor felt that the rates listed were high—much higher than he charged—and the room rental payments were kickbacks.

Dr. Pryor contacted the Metropolitan Medical Society and expressed his concerns, and the Society contacted John Renner, M.D., a local family practitioner who is dedicated to exposing quackery and fraud. Dr. Renner contacted the United States Attorney’s office.

About the same time, Tom Rhudy, D.C., a chiropractor, also reported to Dr. Renner that he received the same information and he met with an Omega representative. The representative told Dr. Rhudy that using Omega’s services would increase his office revenues and collections from insurance companies, and that when he referred a patient for testing, he would be “taken out of the loop”; i.e., Rhudy’s name would not appear on the insurance claims submitted by Omega for the testing but, rather, an out-of-town physician would be listed as the referring physician and would also complete the test evaluations. Dr. Rhudy reported that the flyers appeared to be targeted primarily at the chiropractic community, that this type of testing was not common in chiropractic practice, and that the presentation was geared to the greed-factor.

An FBI agent and I met with Drs. Renner and Rhudy, then with Dr. Pryor. Pryor educated us about neurodiagnostic testing—what it is, which medical specialties refer patients for testing, how test results are used by referring physicians, typical charges, the training that doctors administering the tests should have, and how technicians are used. Then we plotted the course of

*We learned during the investigation that the technicians did not have medical degrees. Their training was a three-day seminar in Florida.

the investigation: to obtain as many claim forms as possible from insurance companies, to obtain covertly as much information as possible about Omega's operation, to have a couple of agents tested undercover, and to obtain a search warrant for Omega's business premises.**

Dr. Rhudy agreed to cooperate in the investigation, as did Drs. Pryor and Renner. Rhudy contacted Omega for further information about their services and eventually referred two "patients" (both FBI agents) for testing. Dr. Pryor met with the prosecutive team on multiple occasions to answer questions and with the agents before the testing to tell them what symptoms they should describe and what to expect, and he reviewed and wrote critiques concerning Omega's findings after the tests. Both Drs. Rhudy and Pryor agreed to testify.

Blue Cross Blue Shield of Kansas City and Fortis Benefits Insurance Companies provided undercover insurance identification and coverage for the agents, including paying the claims submitted for the tests on the agents. The companies were later reimbursed by the FBI for the payments. A Blue Cross field representative also contacted Omega on five occasions about their operation, the services they provided, and the claims submitted; the contacts were consensually recorded.

The undercover tests were performed in a workout/exercise room in the same building where Dr. Rhudy worked. Despite the fact that the tests did not inconvenience Dr. Rhudy or impact the use of his office space, he was paid \$200 (not the \$300 represented in the flyer) for "room rental" for the first test performed.

Special Agent Gene Noltkamper, the case agent, was the first tested. The testing was videotaped and recorded. Agent Noltkamper's cover story was that he was a dock worker who had prior back surgery. He told the technician that he stepped off the dock at work and was worried that he might have reinjured his back. He filled out some brief forms and the testing began. Electrodes were attached to his fingers and toes and various nerves were stimulated electronically, using a portable machine. The non-invasive testing took about two hours.

Later, a second agent was tested in the same fashion. Special Agent Joan Neal reported that she was an office worker and was experiencing some numbness and tingling in her hand. Her testing took only about seven minutes. Omega refused to pay Dr. Rhudy for that referral, since it was so short.

Using the above information, we applied for a search warrant for Omega's offices and computers. The magistrate judge was concerned that Dr. Pryor's cooperation could be a problem since he might be viewed as a competitor of Omega; nonetheless, she issued the warrant. During the

** About this time, we learned of a parallel investigation of Omega in St. Louis. Omega established their business in St. Louis, then expanded to Kansas City. Although the Omega operations were separate corporations, some individuals were active in both corporations, and the activities were the same. We coordinated the investigations, executing search warrants on the same date and coordinating the charges and timing of indictments.

search of the premises, agents interviewed the secretary and learned a great deal about Omega's business and the people involved. The computer was seized and also yielded a wealth of information. As well as containing the claims submitted for all the tests performed, the computer was programmed such that the diagnosis codes on billings were not related to the patients' actual situations. When the secretary prepared the bills, she entered either DUPPER (indicating that the tests were performed on the upper body) or DLOWER (indicating that the tests were performed on the lower body), and then the computer automatically generated the diagnosis code. The code was always the same no matter what the patient's complaint.

We obtained and analyzed copies of the actual claims submitted to the insurance companies, and created a database. The claims typically contained many false and misleading statements, including the identity of the referring physician (usually shown as a neurologist in St. Louis, Missouri, rather than the chiropractors in Kansas City); various dates (date of current illness, date of any similar illnesses, date of onset); the place of service; the diagnosis or nature of the illness or injury; the dates of the testing; and the diagnosis codes, among others. On some occasions, Omega submitted the reports of findings by Dr. Sanchez, a urologist in St. Louis who allegedly read the test results. These reports also contained false and misleading information, including statements that gave the impression that Dr. Sanchez had actually seen the patient.

The investigation also uncovered that Omega resubmitted claims which were not paid in full by the insurance companies in the first instance. The resubmitted claims were altered to avoid concerns the insurance companies had regarding Omega and/or the particular claims—among other things, the name and address of the company and the dates of service were changed, and multiple claims for lesser amounts were submitted in an attempt to avoid claims being scrutinized by the insurance companies.

In its brief existence in Kansas City, Omega submitted claims for approximately \$218,000 and received \$181,000 in payments. It paid chiropractors \$64,000 for the referrals.

Omega Medical Diagnostic Services, Inc., together with its principals William Borders, Joseph Fives, Lorrie Jean Culligan, and Thomas R. Culligan IV, and another corporate entity, Plaza Medical Diagnostic Services, Inc., were indicted on 32 counts in the Western District of Missouri on February 24, 1995. The indictment charged them with mail fraud, wire fraud, and conspiracy to commit those offenses. The fraud—described as a scheme to defraud insurance companies by submitting false and fraudulent claims, and the omission and concealment of material facts—lead insurance companies to believe that the services were medically necessary, appropriately performed by qualified professionals, and covered by insurance. It was also alleged that in order to induce referrals, physicians were improperly persuaded.

All defendants went to trial. The Government's case consisted of the testimony of Omega's secretarial staff in the Kansas City and St. Louis offices, a sampling of the patients tested and their referring chiropractors, representatives from the patients' insurance companies, and the two FBI agents. The Government attempted to call Dr. Pryor as an expert witness to testify that the tests

were not medically necessary, that they were not appropriately performed, and that they had been performed by unqualified people. He also would have testified about his review of the tests performed on the undercover agents. (Pryor reviewed the videotapes and the reports of findings.) But the defense objected and the court sustained the objections on the basis that the judge did not want to turn the criminal case into a medical malpractice case.

The primary defense was that the insurance companies were unfair to defendants and Omega: the defendants did the testing and, therefore, were entitled to payment. They contended the insurance companies unfairly “red-flagged” them and would not pay the claims they submitted.

Consequently, the defendants felt they were entitled to “do whatever it took” to get paid, even if this required multiple submission of false claims. The defendants brought in a billing expert to testify that the “referring physician” block on the standard claim form may not just mean the doctor who referred the patient for testing, but also the doctor who reviews the tests for which the patient was referred. They also tried to bring in an attorney to testify that the insurance companies should have paid the claims, but the court sustained the Government’s objection.

After eight days of trial, the jury returned multiple verdicts of guilty against all defendants, acquitted on some counts, and hung on others. The jury did not return guilty verdicts on either of the counts relating to the undercover testing. [The jurors said they did not feel those were “real” tests and claims.]

This prosecution was a success, not only in the eyes of law enforcement, but for the doctors involved, the Metropolitan Medical Society, and the insurance companies. Each felt they participated in a worthy cause—the battle to keep health care a quality product, ethical, and free of fraud.

The National Practitioner Data Bank

*Assistant General Counsel Thomas L. Read
Bureau of Prisons*

Congress created the National Practitioner Data Bank (NPDB) because of the increasing occurrences of medical malpractice litigation and the need to improve the quality of medical care nationwide. Title IV of Public Law 99-660, signed by President Reagan on November 14, 1986, established the NPDB as an information clearinghouse for the purpose of collecting and releasing certain information related to the professional competence and conduct of medical clinicians and health care practitioners. The NPDB is operated by the United States Department of Health and Human Services, Public Health Service. The health care entities that participate in the NPDB are hospitals and other organizations that provide health care services and/or engage in the professional review of health care providers, including the Federal Bureau of Prisons (BOP) and the Veterans Administration. These entities may access the data bank and are also responsible for reporting to the NPDB. In addition, the NPDB serves as the clearinghouse for all health care providers who have been found to be negligent in medical malpractice cases.

Any Government attorney working on a medical malpractice Federal Torts Claims Act case should consider the NPDB, not only as a potential source of information on the credentials of medical personnel, but also regarding the implications of settlement.

As a Federal agency providing medical services, the Federal BOP implemented Program Statement 6020.01, *National Practitioner Data Bank (Medical)*, on February 6, 1996, which established the procedures for BOP to participate in the NPDB. The Health Services Division (HSD) of BOP uses NPDB to verify the credentials of any health care provider prior to their employment. It is also used as a component of the privileging process for health care providers—the procedure which health care providers must be in compliance with before they are permitted to perform clinical duties in a medical setting.

Under the NPDB program, any health care practitioner found to be responsible or negligent for medical care they provided which resulted in the payment of a settlement or an adverse judgment could be reported to the NPDB. Health care providers include physicians, nurses, physician's assistants, dentists, dental hygienists, etc. In BOP, the process of reporting a health care provider is coordinated by the Office of Quality Management (OQM). A Quality Review Peer (QRP) group composed of doctors within the agency reviews every malpractice case where a payment is made based on negligence, and makes a recommendation to the BOP Medical Director as to whether the negligence should be reported to the NPDB. The Medical Director then has the final responsibility for reporting health care practitioners that he determines negligent in providing medical care within BOP.

Any staff member that the Medical Director determines should be reported to NPDB is notified prior to the filing of the report and is provided a copy of the proposed report. The staff member

has seven working days after receiving the report to provide information or comments for the Medical Director to consider prior to filing with the NPDB.

The NPDB applies only to cases involving medical malpractice or negligence. Thus, *Bivens* cases are not reported because they are based on constitutional issues.

A \$10,000 penalty may be imposed on the reporting agency if a case is reported to the NPDB over 30 days after payment. Thus, the tracking and reporting of all medical malpractice settlements or judgments takes on new significance now that the BOP is participating in the NPDB.

Attorney General Highlights

Acting Deputy Attorney General

Effective April 2, 1997, Seth P. Waxman became the Acting Deputy Attorney General.

Outgoing Principal Associate Deputy Attorney General

On Wednesday, April 9, 1997, Principal Associate Deputy Attorney General Merrick B. Garland took the oath for the U.S. Court of Appeals for the District of Columbia Circuit.

Honors and Awards

Recipients of the Attorney General's 45th Annual Awards

At the Attorney General's 45th Annual Awards Ceremony scheduled for Friday, June 13, 1997, in the Andrew W. Mellon Departmental Auditorium, Attorney General Janet Reno will present awards to the following employees for their outstanding and dedicated service to the Department.

Exceptional Service Award—The Department's highest award for employee performance.

Donna A. Bucella

Principal Deputy Director
Senior Litigation Counsel
Executive Office for United States Attorneys
Assistant United States Attorney
Southern District of Florida

Michael J. Garcia

Dietrich L. Snell
Assistant United States Attorneys

Lillie A. Grant

Paralegal Specialist
Southern District of New York

Francis J. Pellegrino

Special Agent
New York Field Office
Federal Bureau of Investigation

Matthew T. Besheer

Detective
New York/New Jersey Port Authority

Distinguished Service Award—The Department's second highest award for employee performance.

Valerie Caproni

Chief, Criminal Division

Alan Vinegrad

Deputy Chief, Criminal Division

Office of the United States Attorney

Eastern District of New York

Felice M. Muollo, Jr.

Special Agent

Drug Enforcement Administration

Gary R. Spratling

Deputy Assistant Attorney General

Antitrust Division

James M. Griffin

Chief, Chicago Office

Antitrust Division

Scott R. Lasser

Assistant United States Attorney

Northern District of Illinois

Robert K. Herndon

Brian D. Shepard

Special Agents

Springfield Field Office

Federal Bureau of Investigation

Mary Elizabeth Tom

Acting United States Trustee

Office of the United States Trustee

Southern District of New York

Paul W. Virtue

Principal Deputy General Counsel

Immigration and Naturalization Service

Eric Acker

Assistant United States Attorney

Southern District of California

Joseph Allen

Assistant United States Attorney

Eastern District of Michigan

Nicholas Altamari

Assistant United States Attorney

Eastern District of Virginia

Jacqueline Arango

Assistant United States Attorney
Southern District of Florida

Tammy Avery

Former Assistant United States Attorney
Eastern District of Pennsylvania

Laura Birkmeyer

Assistant United States Attorney
Southern District of California

John Farley

Trial Attorney
Litigation and Drug Intelligence Unit
Narcotic and Dangerous Drug Section
Criminal Division

Richard Getchell

Assistant United States Attorney
Southern District of Florida

John Katko

Trial Attorney
Narcotic and Dangerous Drug Section
Criminal Division

Jon King

Assistant United States Attorney
Northern District of Illinois

Mari Maloney

Assistant District Attorney
Office of the Special Narcotics Prosecutor
City of New York

Ron May

Assistant United States Attorney
Northern District of Illinois

Jo Ellen Mazurek

Trial Attorney
Litigation and Drug Intelligence Unit
Narcotic and Dangerous Drug Section
Criminal Division

Jane Meyers

Assistant United States Attorney
District of New Jersey

Stephen Miller

Assistant United States Attorney
Eastern District of Virginia

Samantha Philips

Assistant United States Attorney
Central District of California

Michael Sklaire

Senior Trial Attorney
Office of Enforcement Operations
Criminal Division

Karen Tandy

Trial Attorney
Litigation and Drug Intelligence Unit
Narcotic and Dangerous Drug Section
Criminal Division

Theresa Van Vliet

Chief, Narcotic and Dangerous Drug Section
Criminal Division

John K. Wallace, III

Trial Attorney
Litigation and Drug Intelligence Unit
Narcotic and Dangerous Drug Section
Criminal Division

Mark J. Balthazard

Assistant United States Attorney
Economic Crimes Unit
District of Massachusetts

Gill P. Beck

Assistant United States Attorney
Civil Division
Middle District of North Carolina

Dara Corrigan

Assistant United States Attorney
District of Massachusetts

Laurence Freedman

Trial Attorney
Commercial Litigation Section
Civil Division

Richard S. Glaser, Jr.

Assistant United States Attorney and
Chief, Criminal Division
Middle District of North Carolina

David A. Koenigsberg

Senior Litigation Counsel
Affirmative Civil Enforcement Coordinator
Southern District of New York

Carol C. Lam

Assistant United States Attorney and
Chief, Major Frauds and Economic Crimes Section
Southern District of California

Michael Loucks

Assistant United States Attorney and
Chief, Health Care Fraud
Criminal Division
District of Massachusetts

Lewis Morris

Assistant Inspector General for Legal Affairs
Office of Counsel
Office of the Inspector General
Department of Health and Human Services

James G. Sheehan

Assistant United States Attorney and
Chief, Civil Division
Eastern District of Pennsylvania

David W. Waterbury

Senior Counsel
Director of Medicaid Fraud Control Unit
Washington State Attorney General's Office

Susan G. Winkler

Assistant United States Attorney
Civil Division
District of Massachusetts

Steven M. Cohen

Alexandra A. E. Shapiro

Assistant United States Attorneys

John O'Malley

Intelligence Research Specialist

Richard B. Zabel

Deputy Chief, Narcotics Unit
Southern District of New York

Richard S. Demberger

Special Agent
New York Field Office
Federal Bureau of Investigation

Allen D. Applbaum

Tai H. Park

Chauncey G. Parker

Assistant United States Attorneys
Southern District of New York

George J. Ennis

Special Agent
New York Field Office
Federal Bureau of Investigation

Diedre D. Gordon
Keith F. Kolovich
Special Agents
New York Field Office
Immigration and Naturalization Service

Hays Gorey, Jr.
Trial Attorney
Antitrust Division

Irving L. Gornstein
Assistant to the Solicitor General
Office of the Solicitor General

Briane M. Grey
Special Agent
Bangkok Country Office
Drug Enforcement Administration

Rosemary A. Hart
Attorney Advisor and Senior Counsel
Office of Legal Counsel

Katherine Hazard
Trial Attorney
Appellate Section
Environment and Natural Resources Division

Gary P. Jordan
First Assistant United States Attorney
District of Maryland

Steven K. Smith
Chief, Law Enforcement, Adjudication and Federal Statistics
Bureau of Justice Statistics
Office of Justice Programs

Mary C. Lawton Lifetime Service Award—Recognizes employees who have served at least 20 years in the Department and have demonstrated high standards of excellence and dedication throughout their careers. This award is given only in exceptional circumstances to those individuals of special merit and is not awarded to express general appreciation for tenure alone.

Frederick D. Hess
Director
Office of Enforcement Operations

Criminal Division

Exceptional Heroism Award—Recognizes an extraordinary act of courage of voluntary risk of life during the performance of the official duty.

Jacob W. Knight

Correctional Officer
Federal Correctional Institution
El Reno, Oklahoma
Federal Bureau of Prisons

William French Smith Award—For Outstanding Contribution to Cooperative Law Enforcement is an honorary award granted to recognize state and local law enforcement officials who, through their participation in Law Enforcement Coordinating Committees, have made significant contributions to cooperative law enforcement endeavors and objectives.

Richard Neal

Commissioner of Police
Philadelphia Police Department
Philadelphia, Pennsylvania

Meritorious Public Service Award—Top public service award granted by the Department, recognizes the most significant contributions of citizens and organizations who have assisted the Department in accomplishment of its mission and objective.

Karen Marie Degan

Medical Assistant and Office Manager

Thomas Kiley

Attorney
Quincy, Massachusetts

Excellence in Law Enforcement Award—Recognizes outstanding professional achievements by law enforcement officers of the Department.

Jeffrey T. Krill

Special Agent
Phoenix Division
Federal Bureau of Investigation

Joseph Lestrangle

Special Agent
Investigations Division
New York Field Office
Office of the Inspector General

Isaias Lopez, Jr.
Criminal Investigator
Swanton Sector Anti-Smuggling Unit
Immigration and Naturalization Service

Kingman K. Wong
Supervisory Special Agent

Carol K. O. Lee

Nelson Low

Peter K. Won

Special Agents
San Francisco Field Office
Federal Bureau of Investigation

Excellence in Management Award—Recognizes outstanding administrative or managerial achievements which have significantly improved the operations or productivity of the Department, or reduced costs.

John C. Hardwick
Chief, Office of Information Systems
Federal Bureau of Prisons

Equal Employment Opportunity Award—The Department's highest award for performance in support of the Equal Employment Opportunity Program.

Affirmative Employment Programs Team

Annalisa Diane Lee

Team Leader

Wanda Frazier

Isabel Howell

Elaine Mirabella

Delores Witcher

Equal Employment Opportunity Specialists
United States Marshals Service

Career Enhancement Award—Recognizes outstanding efforts to encourage upward mobility of lower-graded employees throughout the Department.

Irene C. Piechota
Employee Development Manager
Federal Correctional Institution
Pekin, Illinois
Federal Bureau of Prisons

Service to Disabled Employees Award—Recognizes outstanding services to the Handicapped Program.

Ruth Lusher

Supervisory Technical Services Officer
Civil Rights Division

Excellence in Legal Support Award, Paralegal Category—Recognizes outstanding achievements in the field of legal support to attorneys by a paralegal specialist.

Deborah J. Clifton

Legislative Assistant
Office of Legislative Affairs

Excellence in Legal Support Award, Secretarial Category—Recognizes outstanding achievements in the field of legal support to attorneys by a legal secretary.

David Diaz

Legal Clerk
Office of the United States Trustee
Corpus Christi, Texas

Excellence in Administrative Support Award, Administrative Category—Recognizes outstanding performance in administrative or managerial support by an administrative employee.

Ann Sloan

Case Management Specialist
Records Management Unit
Environment and Natural Resources Division

Excellence in Administrative Support Award, Secretarial Category—Recognizes outstanding performance in administrative or managerial support by a secretary or non-administrative type employee.

Barbara A. Wells

Office Automation Clerk
Executive Secretariat
Justice Management Division

Outstanding Service in FOIA Administration—Recognizes exceptional dedication and effort to the implementation of the Freedom of Information Act.

Bonnie L. Gay

Acting Assistant Director

Danita M. Best

Secretary

John F. Boseker

Acting Attorney-in-Charge

Shirley B. Botts

Paralegal Specialist

Sara J. Donaldson

Paralegal Specialist

Conya Gilmore

Clerk

Florence Holloway

Paralegal Specialist

Michael W. Jones

Paralegal Specialist

Tina M. Joyner

Paralegal Specialist

Gwyn Hutchins Le Doux

Paralegal Specialist

Delores O. Montgomery

Senior Paralegal Specialist

Urshula Swann

Legal Technician

Sonja R. Whitaker

Legal Technician

Executive Office for United States Attorneys

Outstanding Contributions by a New Employee Award—A new award established by the Attorney General to recognize exceptional performance and notable accomplishments towards the Department's mission by an employee with fewer than five years of service with the Department. The Attorney General's Award for Outstanding Contributions by a New Employee will be awarded for the first time to three employees.

Robert M. Lewandowski

General Attorney

Laredo Sector

Immigration and Naturalization Service

Vincent N. Micone, III

Senior Events Management Specialist/Volunteer Program Manager

Personnel Staff

Justice Management Division

Pamela J. Smith

Attorney Advisor

Office of Legislative Affairs

Cubby Dorsey Award—Recognizes extraordinary performance and contributions by wage grade system employees, including laborers, mechanics, and skilled craft workers.

Louis R. Naber, Jr.

Maintenance Foreman
Facilities and Administrative Services Staff
Justice Management Division

John Marshall Awards—The Department’s highest awards offered only to attorneys, for contributions and excellence in specialized areas of legal performance.

John Marshall Award, Trial of Litigation

John Hinton, III

Trial Attorney
Tax Division

Brien T. O’Connor

Supervisory Assistant United States Attorney

David J. Apfel

Assistant United States Attorney

Thomas Zappala

Auditor
District of Massachusetts

John Marshall Award, Participation in Litigation

Ellen M. Athas

Jean E. Williams

Assistant Section Chiefs

Albert M. Ferlo, Jr.

Michelle Gilbert

David C. Shilton

Senior Trial Attorneys
Environment and Natural Resources Division

Constantine D. Georges

Michael E. McMahon

Albert J. Winters, Jr.

Assistant United States Attorneys
Eastern District of Louisiana

Nelson S. T. Thayer, Jr.

Trial Attorney

Peter McCloskey

Former Trial Attorney

Civil Rights Division

John Marshall Award, Support of Litigation

Randy I. Bellows

Robert C. Chestnut

Thomas G. Connolly

Vincent L. Gamble

Kathleen M. Kahoe

Assistant United States Attorneys

John J. Dion

Deputy Chief, Internal Security Division

Eastern District of Virginia

Martha Stansell-Gamm

Deputy Chief, Computer Crime and Intellectual Property Section

Criminal Division

John Marshall Award, Handling of Appeals

Anne Almy

Deputy Chief, Appellate Section

Environment and Natural Resources Division

Mark B. Stern

Appellate Litigation Counsel

Appellate Section

Civil Division

John Marshall Award, Providing Legal Advice

Jo Ann Farrington

Deputy Chief, Public Integrity Section

Criminal Division

Martin S. Lederman

Attorney Advisor

Office of Legal Counsel

John Marshall Award, Preparation or Handling of Legislation

Gregory M. Jones

Senior Attorney Advisor

Office of Legislative Affairs

John Marshall Award, Asset Forfeiture

Michael A. Perez

Director

Asset Forfeiture Management Staff

Justice Management Division

John Marshall Award, Alternative Dispute Resolution

Eve L. Hill

Trial Attorney

Disability Rights Section

Civil Rights Division

James W. Jennings, Jr.

Assistant United States Attorney

Western District of Texas

Outstanding Achievement Awards

On March 27, 1997, Attorney General Reno presented an award to Gary R. Spratling, Deputy Assistant Attorney General for Criminal Enforcement, Antitrust Division, for his “singular dedication to the enforcement of the antitrust law and his extraordinary contribution to the protection of our free market economy.” Outstanding Achievement Awards also were presented to the “team” that prosecuted Archer Daniels Midland Company (ADM) and others for criminal antitrust violations in the food and feed additives industry. This case involved three separate investigations out of three different offices. There were 30 people on the team. The lead prosecutors were Jim Griffin, Chief of the Antitrust Division, Chicago field office; Phil Warren, Lead Attorney, Antitrust Division, San Francisco field office; Scott Watson, Lead Attorney, Antitrust Division, Atlanta field office; and First Assistant United States Attorney Scott Lassar, Northern District of Illinois. The investigations broke up two international cartels affecting over a billion dollars in commerce in the lysine and citric acid markets worldwide. The investigations have resulted in criminal charges against eight companies and ten individuals; convictions of defendants from four countries on three continents; and total fines of more than \$195 million, including a \$100 million fine paid by ADM—nearly seven times larger than the highest fine previously imposed in a criminal antitrust case. The Attorney General considers these prosecutions one of the Department’s most important achievements in white collar criminal enforcement during her tenure.

Crime Victim Service Awards

On April 18, 1997, in a ceremony in the Great Hall, as part of the annual observance of National Crime Victims Rights Week, April 13-19, the Attorney General presented the Crime Victim Service Award, the highest Federal award for service to victims, to ten individuals and four programs from nine states. The recipients were:

Evelyn M. Dillon, a volunteer victim advocate with the Genesee County Victim Assistance Program in Batavia, New York

Loretta Lewis-Golden, Director of the Rape/Crime Victim Advocate Program in Gainesville, Florida

Ellen J. Halbert, Editor of *Crime Victims Report* in Austin, Texas

Sue G. Hathorn, Mississippi Voices for Children and Youth

Physician **Astrid Heppenstall Heger**, Assistant Professor of Pediatrics, and Executive Director of the Los Angeles County/University of Southern California Violence Intervention Program
Attorney **Jay Howell**, the first Executive Director for the National Center for Missing and Exploited Children

Karen A. McLaughlin, Senior Policy Analyst with the Center for Violence Prevention, Newton, Massachusetts

Pastor **Roderick Mitchell**, Executive Director of Exodus Center for Life in Cleveland,

Mississippi Violent Crime Counselor Karen Muelhaupt, Des Moines, Iowa

Director Viki C. Sharp, Pima County Attorney's Victim Witness Program

Gang Victim Services Program, Orange County, California

DNA-People's Legal Services, Inc., Shiprock, New Mexico

Victims for Justice, Anchorage, Alaska

Ples W. Felix, Jr., and **Azim Khamisa**, founders of the Tariq Khamisa Foundation, received a Special Community Service Award at the ceremony.

Many of the recipients survived acts of violence to become victim advocates. Invited guests included advocates for victims' rights, representatives from law enforcement and judicial organizations, community activists, and Members of Congress.

Clinton Administration Firearms Initiatives

On March 5, 1997, EOUSA Director Carol DiBattiste forwarded to United States Attorneys and First Assistant United States Attorneys President Clinton's announcement on Firearms Initiatives, including three measures to protect children, neighbors, and law enforcement from gun violence and accidents. The three measures are (1) issuing a directive to Federal agencies and departments requiring child safety locks and proper instructions with every handgun issued to a law enforcement agent; (2) changing Federal firearms law, requiring greater proof of residency before purchasing a firearm; and (3) proposing legislation to ban "cop killer" bullets. For personnel in USAOs, your office should have a copy of this memo. If not, you may call (202) 616-1681.

Naturalization Team

On April 28, 1997, Attorney General Reno assigned Criminal Division Executive Officer Robert K. Bratt to serve as the Immigration and Naturalization Service's (INS) Executive Director for Naturalization Operations. Working directly under the Commissioner, his first priority will be to ensure that current naturalization case processing follows quality assurance procedures. He will manage the field operations staff responsible for implementing those procedures, and will

supervise the implementation of recommendations stemming from the ongoing review by INS and KPMG Peat Marwick of more than one million naturalizations granted in Fiscal Year 1996.

Also assigned to INS's naturalization team is former Comptroller General of the United States Charles A. Bowsher, who will serve as Special Advisor to the Commissioner, a part-time, non-compensated contract position. He will assist in the development of the action plan and advise the Commissioner on the best ways to implement the new procedures.

DOJ Developing Protocol for Victims of Aviation Disasters Caused by Criminal Activity

The tragic crash of TWA Flight #800 on July 17, 1996, and the inability to determine quickly the cause of the explosion, revealed the need for multiple agency coordination in investigating the disaster and providing services to families of victims, including accurate information about the crash and recovery efforts, assistance to families who wish to travel to the crash site, and assistance in providing appropriate victim services, including crisis counseling, victim compensation, and other mental health support.

In September 1996, the White House responded to this need by directing the National Transportation Safety Board (NTSB) to coordinate the roles of the Departments of Justice, Defense, and State, and other Federal agencies with responsibilities for victim services. Subsequently, Congress passed the Aviation Disaster Family Assistance Act of 1996, establishing NTSB in all domestic aviation disasters as "a point of contact within the Federal Government for the families of passengers involved in the accident and a liaison between the air carrier . . . and the families." Title VII of Public Law 104-264, 142 Cong. Rec. H11303.

Because the Office for Victims of Crimes' (OVC) history of advocacy on behalf of crime victims and its early work with survivors of airline crashes, the Attorney General designated OVC as the lead DOJ agency to work with NTSB on a coordinated Government protocol for aviation disasters. In conjunction with other DOJ components, including the FBI and the Executive Office for United States Attorneys (EOUSA), OVC developed a Memorandum of Understanding (MOU) to ensure that the needs of victims and their survivors are addressed in a sensitive and appropriate manner following an aviation disaster resulting from criminal activity. The MOU, signed by the Attorney General and Chairman Hall of the NTSB, became effective on January 28, 1997.

Under the Memorandum, NTSB is the *coordinator* of services to victims and their families in all aviation disasters, *whether or not of criminal origin*, pursuant to the Aviation Disaster Family Assistance Act of 1996. If there is a possibility that an aviation disaster was caused by criminal activity, representatives from OVC, FBI, and EOUSA meet immediately with NTSB to coordinate efforts, including how to address the informational needs of victims and their families. If a crash is determined to have been the result of criminal activity, DOJ is responsible for the victim-witness notifications and services required under the Victims of Crime Act of 1984, as amended; the Victim and Witness Protection Act of 1982; and the 1995 *Attorney General Guidelines for Victim and Witness Assistance*.

As soon as it is determined that the crash was caused by criminal activity, DOJ personnel, including the FBI and staff of the United States Attorney's office responsible for notifying victims of their rights under Federal law and of the availability of state compensation and assistance programs, will be provided space in the disaster field office set up by NTSB and the American Red Cross.

For further information, contact Kim Lesnak, EOUSA, (202) 616- 6792; Bobi Wallace, FBI, (202) 324-1127; or Judy Bonderman, OVC, (202) 305-2984.

Superfund Reauthorization

On March 6, 1997, the Environment and Natural Resources Division released *Superfund 1996: A Report to the Attorney General*, which documents one of Superfund's best years. By calling on responsible parties to pay for environmental cleanups across the country, Superfund saves taxpayers money; cleans up polluted sites quickly; and spares everyone from costly, time-consuming lawsuits. The Environmental Protection Agency and DOJ's Environment and Natural Resources Division produced a record number of judgments and settlement agreements in 1996, generating \$790 million worth of cleanup work at contaminated sites. The Division is entering into prospective purchaser agreements that encourage new purchasers to buy and redevelop Superfund properties without the fear of liability. The Superfund statute is up for reauthorization this year. In a statement about the report and Superfund's reauthorization, the Attorney General said, "Today's report includes dozens of success stories from all across the country, and I am happy to report that we are moving forward to meet the President's goal of completing 900 site clean-ups by the year 2000." For personnel in USAOs, your office should have a copy of the report. If not, you may call (202) 616-1681.

Chemical Weapons Convention

On April 25, 1997, the Senate ratified the Chemical Weapons Convention. In remarks before the Senate ratified the Convention, Attorney General Reno said that the Convention would ". . . give our law enforcement community one more tool to combat chemical terrorism." The Convention bans the development, production, stockpiling, transfer, and use of deadly chemical weapons. More than 160 countries have signed on to the Convention, and nearly 70 have ratified it. Under the Convention, member countries will be required to eliminate chemical weapons they possess, and to account for certain precursor chemicals they produce or transfer. By restricting the trade of certain chemicals with non-party nations, the Convention will discourage manufacturers from doing business with these regimes. This means fewer chemical weapons, greater scrutiny over production, and a better chance to detect the transfer of dangerous precursor chemicals. The Convention improves the sharing of information among law enforcement agencies worldwide, giving American law enforcement more early warnings that can help prevent an attack and save lives. Finally, member nations will enact criminal laws to implement the Convention's ban on developing, stockpiling, producing, transferring, or using chemical weapons. Currently, many countries only outlaw the use of chemical weapons. These new laws will help law enforcement agencies to investigate and prosecute chemical weapons-related activities and improve chances of detecting terrorists before they strike.

Safeguarding Grand Jury Information

On April 10, 1997, EOUSA Director Carol DiBattiste forwarded to United States Attorneys, First Assistant United States Attorneys, and District Office Security Managers, a March 12, 1997, memo from Deputy Attorney General Gorelick, providing updated guidance for the safeguarding of Grand Jury Information. In August 1996, the Office of Inspector General issued an inspection report on safeguarding grand jury material at USAOs, including three concerns related to grand jury material: access, storage, and transmission. Deputy Attorney General Gorelick's memo summarizes the concerns and requirements of these three areas.

To ensure implementation of these procedures, EOUSA Director Carol DiBattiste asked the Evaluation and Review Staff to place special emphasis on reviewing the safeguarding of grand jury materials during evaluations of USAOs over the next 12 months. For additional information, contact Assistant Director Tommie Barnes, Security Programs Staff, (202) 616-6878; AEX13(TBARNES). For personnel in USAOs, your office should have a copy of this memo. If not, you may call (202) 616-1681.

Megan's Law Guidelines

On April 4, 1997, the Federal Register published Department issued guidelines to assist states in implementing Megan's Law and the Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Act. The Wetterling Act, encouraging states to adopt effective registration systems for released sex offenders, was passed as part of President Clinton's 1994 Crime Act. In May 1996, the President signed Megan's Law, which amends the Wetterling Act, by requiring states to release relevant information concerning registered child molesters and sexually violent offenders to the public, when necessary. In addition to the April 4, 1997, Federal Register, the guidelines also can be found on the Internet at the Violence Against Women Office's site, www.usdoj.gov/vawo/jwguid2.htm. For further information, contact the Violence Against Women Office, (202) 616-8894.

Community Anti-Drug Initiatives

On April 9, 1997, Attorney General Reno sent a memo to United States Attorneys stating that the Department, the American Bar Association (ABA), and the American Medical Association (AMA) have agreed to collaborate on steps to encourage community anti-drug initiatives. Representatives from interested local bar and medical associations will be seeking the assistance of United States Attorneys in developing community anti-drug coalition activities. United States Attorney Fred Thieman, Western District of Pennsylvania, has been leading this initiative as Chair of the Attorney General's Advisory Committee's (AGAC) Drug Abuse Prevention/Controlled Substance Subcommittee. ABA President Lee Cooper and AMA President Dr. Daniel Johnson have written letters to state and local bar and medical associations' presidents in the districts. The Attorney General has urged United States Attorneys to facilitate the efforts of these local organizations in building and expanding effective, innovative programs to address problems of substance abuse and violence in communities.

Operation 2006

On April 9, 1997, the Attorney General commented on “Operation 2006,” a new church-based anti-crime program stating, “This new coalition of religious organizations to combat crime is very good news. ‘Operation 2006’ is a national effort to mobilize black churches as partners in the effort to end crime in some of our most dangerous neighborhoods. Modeled on Boston’s Ten Point Coalition, it provides just the sort of active involvement that can make a real difference in reducing crime and giving young people a future free of violence. I have seen it work . . . We want to work closely with ‘Operation 2006’ and all grassroots efforts to fight crime.”

AG Endorses Peer Mediation Programs

On March 5, 1997, Attorney General Reno called on schools across the country to consider adopting peer mediation programs like the ones operating in the Nation’s Capitol. At an event highlighting a peer mediation program operating in several Washington, D.C., schools, the Attorney General watched as students demonstrated how they mediate conflicts among their peers. She stated, “If students can learn how to talk through their disputes, they won’t have to resort to fists and guns . . . When something works, it makes sense to make sure everyone knows about it.” Several studies—including those done in New York City, Nevada, and New Mexico—have shown that conflict resolution programs lead to a decrease in violence at schools. The Administration’s Anti-Gang and Youth Violence legislation sent to Congress the week of February 24, 1997, would authorize \$75 million to fund initiatives such as violence intervention programs, after-school and summer activities, and dispute resolution programs.

Combating Violence Based on Sexual Orientation

On March 11, 1997, in response to data released by the National Coalition of Anti-Violence Programs showing an increase in the number of hate crimes motivated by a victim’s sexual orientation, the Attorney General announced that, “Recent reports, including data from the FBI, have shown a disturbing rise in the number of hate crimes based on race, color, national origin, religion, and sexual orientation . . . Last year, Congress took a positive step by extending until 2002 the Hate Crime Statistics Act, enabling the Justice Department to collect hate crime statistics from state and local law enforcement agencies . . . Federal hate crime statutes do not permit us to prosecute offenses motivated by a victim’s sexual orientation. But under the 1994 Crime Act, anyone who otherwise violates Federal law can serve a longer sentence if they committed the offense because of the sexual orientation of the victim.”

United States Attorneys' Offices/Executive Office for United States Attorneys

Appointments

Nomination of New Deputy Attorney General

On April 14, 1997, President Clinton nominated United States Attorney Eric Holder, District of Columbia, for the position of Deputy Attorney General.

Eastern District of California

On April 19, 1997, Paul Seave became interim United States Attorney for the Eastern District of California. Mr. Seave served as the First Assistant United States Attorney in the Eastern District of California for the past four years.

Northern District of New York

On March 5, 1997, Assistant United States Attorney George A. Yanthis, Northern District of New York, was appointed as a magistrate judge in the Southern District of New York. Mr. Yanthis served most recently as the Chief of the Criminal Division. The eight-year term appointment is expected to take effect in several months.

Honors and Awards

DOJ Volunteer Awards Ceremony

On Friday, April 18, 1997, Attorney General Janet Reno recognized the volunteer activities of all Department employees at the National Volunteer Week Awards Ceremony. Ms. Marcia Milton, Director of the School to Work Transition Program, received the Volunteer Citizen Service Award for her outstanding volunteer efforts in partnership with EOUSA. The names of the volunteer awardees from the United States Attorneys' offices and EOUSA, and the schools awarded, appear below. For further information, please contact Assistant Director Kimberly Lesnak, EOUSA's LECC/Victim-Witness Staff, (202) 616-6792.

National Volunteer Award Recipients

Northern District of Alabama

John Charles Bell

District of Alaska

Kenneth Roosa

Middle District of Florida

Sara Boswell
Belinda Brown
Virginia M. Covington
Adelaide G. Few
Jeffrey L. Hahn
Frank V. Hall
Diane Kerr
Regina J. Polite
Janice A. Ramsey

Southern District of Florida

Mary K. Butler

Southern District of Illinois

Catherine M. Rodick

Northern District of Iowa

Maureen Oviatt
Patrick J. Reinert
The Entire United States Attorney's Office

District of Kansas

Richard Schodorf
Lanny Welch
Jackie Williams

Middle District of Louisiana

Joan B. Armitage
Nanch J. Bergeron
Hazel M. Brown
Patricia Ann Carney
Sherron C. Casse
Wilfred J. Christian
Joyce Coxe
Benita J. Crouch
Michael Reese Davis
Neil J. Gallagher
John J. Gaupp
Colin D. Gloston
Charlene B. Green
Ian F. Hipwell
L. J. Hymel
Brian A. Jackson
M. Patricia Jones

Arlyn T. Kaufman
Iris M. Kimble
Richard B. Launey
James Stanley Lemelle
Sherrie O. Lemings
Frederick A. Menner, Jr.
Randall B. Miller
James L. Nelson
Robert W. Piedrahita
René Salomon
Debbie N. Thompson
James P. Thompson
Lyman E. Thornton, III
Russell F. Trapp
Terea S. Vampran
Dennis C. Weber

District of Maryland

Bonnie S. Greenberg
W. Warren Hamel
Susan M. Ringler
Sandra Wilkinson

District of Massachusetts

Joanne V. Russell

Eastern District of Michigan

Terry Berg
Carolyn Bell-Harbin
Christine D. Bloomfield
Michael Carithers
James Chavis
Ellen Christensen
Patrick Corbett
Krishna S. Dighe
Karen Gibbs Ernst
Edward Ewell
Bonita Gardner
Saul A. Green
Connie Posey Harris
Lynn Helland
Jacqueline Hotz
Marlene Juhasz
Mike Leibson
Regina McCullough

Blondell Morey
Lilliana Nicely
Linda Parker
Beryl Robbins
Kelvin Scott
Tamaya Standifer
Pamela Thompson
Robin Thompson
Craig Weier
Christopher Yates

Western District of Michigan

Mark V. Courtade

District of New Mexico

Mick I. R. Gutierrez

Northern District of Ohio

Michele Blair
Kira A. Crawford
William Edwards
Vikki G. Friday
Tom Gruscinske
Joanne M. Harrison
Michele D. Hohm
Rolanda Jackson
Nora Jones
Patti Joyce
Robert W. Kern
Mary Ellen Kilbane
Debbie Kusber
Marlon A. Primes
Deborah Kovac Rump
Anne Shugrue
Roberta Sladick
Judy Smurthwaite
Emily Sweeney

District of South Dakota

Joanne Bender
Mary Dearborn
Craig Gaumer
Kim Gillickson
Dawn Harigan
John Holm

Dennis Holmes
LeAnn LaFave
Robert Mandel
Lois Matson
Gregg Peterman
Misty Puleo
Karen Schreier
Bonnie Ulrich
John Ulrich
Jan Walline

Eastern District of Tennessee

M. Kent Anderson
John T. Buckingham
Steven H. Cook
James R. Dedrick
Sandra P. Dennis
Janice R. Eason
Edward L. Holt
Gail Holt
Donna K. Kidd
Michael J. Mitchell
Penny Reilly
J. Edgar Schmutzer
Helen C.T. Smith
Jason Thompson
Rosalyn Vogel
D. Gregory Weddle
Michael E. Winck
Paige A. Winck

Eastern District of Texas

Madeline Badon
June Berg
Sandra Bridge
Judy Carter
Fran Domingue
Keith Giblin
Randall L. Fluke
Princess Franklin
Terri L. Hagan
Tom Keighnhoff
Donna Krise
Loretta Lee
Gregg A. Marchessault

Cisselon S. Nichols
Bob Rawls

Northern District of Texas

Derenda Bailey
Marc Barta
Nina Bellah
Mabel Bradley
Roy Jean Capio
Missy Clark
Paul E. Coggins
Mattie Compton
Linda Cook
Patrick Dansby
James Dewberrt
Charles Dobbs
Olga Garcia
Paul Gartner
Angie Henson
Virginia Howard
Diane Kozub
Michael Martinez
Carrie McMahan
Karen Nesbitt
Carrie Rodriguez
Paula Sitzman
Richard Vance
Delonia Watson

Southern District of Texas

Brian T. Moffatt

Western District of Texas

Kay L. Braune
Patty Franco
Ricardo Meza
Rhonda G. McCuan
David Landel Nichols

District of Utah

Stephen Roth
Paul M. Warner

Eastern District of Wisconsin

Penny C. Fleming

Jan Klika
Eric J. Klumb
Christian R. Larsen
William J. Lipscomb
Silvia Martin
Pamela Pepper
Monica Rimai

Executive Office for United States Attorneys

Tiffany Andrews
Russell Adams
Michael Bailie
Elisha Barnette
Dawn S. Belton
Theresa Bertucci
B. Marie Blackmon
Jane Bondurant
Keith Bratt
Donna Bucella
Romaine Cutchember
Eleanor Davis
Carol DiBattiste
Jamie Embrey
Patrice Floria
Cyrstal Gaines
Ray Gilkes
Angie Hammond
Shelly Hardy
Janis Harrington
Fatima Howell
Donna H. Johnson
Kristena Kornegay
Kim Lesnak
Jo-Ann Martinez
Eileen Shelley Menton
James Miles
Janice Milner
Laverne Parks
Pam Press
Cassandra Powell
Mark Small
Faye Smith
Chaunette Stokes
David H. Tait
Brenda Taylor

H. Daryl Thomas
Barbara Walker
Darlene Washington
Michelle Whitted
Claudia White
Cynthia R. White

Schools

Anacostia High School, District of Columbia Public School
Ballou High School, District of Columbia Public School
Potomac High School, District of Columbia Public School
Walter Krenshaw Middle School, Ohio Public School
Kenneth Clement Elementary School, Ohio Public School

Significant Issues/Events

Attorney General's Advisory Committee Meetings

The Attorney General's Advisory Committee (AGAC) met on March 20-21, 1997, in Washington, D.C. Some items discussed by the Committee were performance appraisals, OPR, the Youth Handgun Act, Civil Rights resources, health care fraud, legislation, BOP taping of prisoner conversations, outside activities, environmental issues, and emergency representation of AUSAs. Another meeting was held on April 24-25, 1997, in Washington, D.C., and some items discussed were the FBI Working Group, health care fraud, reduction in IRS's Criminal Investigative Division resources, death penalty cases, revocation of naturalization proceedings, expanded outreach and recruitment of attorneys, and legislative proposals and updates.

The AGAC met at the United States Attorneys' Conference in Santa Fe and will meet again on June 25-26 in Washington, D.C.

Criminal and Civil

FY 96 United States Attorneys' Annual Statistical Report Shows Higher Conviction Rate

On March 17, 1997, EOUSA released the Annual Statistical Report for FY 96 which announced that United States Attorneys' offices completed more cases and convicted more violent criminals, drug traffickers, and other criminals in FY 96 than in FY 95. The report summarizes the criminal prosecution and civil litigation work of the 94 United States Attorneys' offices, including highlights in criminal prosecution, violent crime, drugs, immigration, health care fraud, civil litigation, affirmative civil enforcement, and debt collection. For personnel in USAOs, your office should have a copy of this report. If not, you may call (202) 616-1681.

Charging Decisions, Plea Agreements, and Substantial Assistance Motions

On April 7, 1997, EOUSA Director Carol DiBattiste forwarded a memo to United States Attorneys, First Assistant United States Attorneys, and Criminal Chiefs, from Acting Assistant Attorney General John C. Keeney, Criminal Division, and AGAC Chair Donald K. Stern, concerning the applicable Department policy on charging decisions, plea agreements, and substantial assistance motions and their impact on the Sentencing Guidelines. In December 1995, the United States Sentencing Commission, in an oversight hearing before Congress, expressed concern that some Federal prosecutors are exercising prosecutorial discretion to avoid mandatory statutory and guideline sentences by using charging decisions, plea bargain agreements, and substantial assistance motions. The Commission told Congress that inconsistent use of prosecutorial discretion undermines the goals of the Sentencing Reform Act. For personnel in USAOs, your office should have a copy of this memo. If not, you may call (202) 616-1681.

Victim Rights Legislation Passed

On March 20, 1997, Louis DeFalaise forwarded to United States Attorneys, First Assistant United States Attorneys, Criminal Chiefs, and Victim-Witness Coordinators, the "Victims Rights Clarification Act of 1997." This legislation passed the House and Senate and is awaiting the President's signature. The act would prevent judges from barring victims of a crime or their survivors from any Federal criminal trial, as long as they are not scheduled to testify during the guilt-or-innocence phase of the proceedings. The legislation states that it "shall apply in cases pending on the date of the enactment of this Act." Questions regarding this legislation should be directed to Assistant Director Kim Lesnak, EOUSA's LECC/VW Staff, at (202) 616-6792 or aex12(klesnak), or David Naimon, Counsel to the Director's office, at (202) 305-2433 or aex15(dnaimon).

Recently Enacted Criminal Provisions

On February 18, 1997, EOUSA Director Carol DiBattiste forwarded to United States Attorneys, First Assistant United States Attorneys, and Criminal Chiefs a memo from Acting Assistant Attorney General Mark M. Richard, Criminal Division, containing guidance on recently enacted criminal provisions related to certain immigration offenses, violence against women, and gun-free school zones. For personnel in USAOs, your office should have a copy of this memo. If not, you may call (202) 616-1681.

Asset Forfeiture Reinvigoration

On March 26, 1997, EOUSA Director Carol DiBattiste forwarded to United States Attorneys, First Assistant United States Attorneys, Criminal Chiefs, and Asset Forfeiture Assistant United States Attorney contacts, copies of the Reinvigoration Memorandum prepared for the Attorney General by the Asset Forfeiture and Money Laundering Section, Criminal Division. Statistics show that the number of seizures and forfeitures remained flat in Fiscal Year 1996 and continued to be significantly down from Fiscal Year 1993 levels. The memorandum discusses the efforts of the Department's asset forfeiture components to reinvigorate asset forfeiture. With continued direction from the highest levels of the Department, resolution of the double jeopardy issue in June 1996, and several asset forfeiture law enforcement and training initiatives begun in Fiscal

Year 1996, it is expected that the use of forfeiture during Fiscal Year 1997 will increase, which should be reflected in the Asset Forfeiture Fund in Fiscal Year 1998 and thereafter. Questions regarding asset forfeiture should be directed to Assistant Director Suzanne M. Warner, EOUSA's Legal Programs, (202) 616-6444.

Monetary Thresholds for Adoptive Forfeitures

On March 26, 1997, EOUSA Director Carol DiBattiste forwarded to United States Attorneys, First Assistant United States Attorneys, Criminal Chiefs, and Asset Forfeiture Assistant United States Attorney contacts, Asset Forfeiture Policy Directive 97-1, Monetary Thresholds for Adoptive Forfeitures. The Deputy Attorney General approved a return to the 1990 levels for monetary thresholds governing Federal adoption of state and local seizures. The Asset Forfeiture State and Local Working Group requested the reduction in the thresholds because criminals in many districts have adapted their operations to the higher, March 1994, threshold levels by employing equipment and property of lower values that they know will not be seized. As law enforcement needs require, United States Attorneys, in consultation with district law enforcement agencies, may raise or lower the thresholds for judicial forfeitures. Thresholds may be waived in individual cases for compelling law enforcement reasons. Questions regarding these monetary thresholds should be directed to Assistant Director Suzanne M. Warner, EOUSA's Legal Programs, (202) 616-6444. For personnel in USAOs, your office should have a copy of this memo. If not, you may call (202) 616-1681.

Asset Forfeiture Best Practices

On March 7, 1997, EOUSA Director Carol DiBattiste forwarded to United States Attorneys, First Assistant United States Attorneys, Criminal Chiefs, and Asset Forfeiture Assistant United States Attorney contacts, a copy of the Criminal Division's February 1997 *Best Practices Memorandum*, from the Asset Forfeiture and Money Laundering Section. The booklet includes a sample "model plan" for the effective use of forfeiture in criminal investigations and other suggestions to improve the forfeiture program in USAOs. Questions should be directed to Assistant Director Suzanne M. Warner, Legal Programs, (202) 616-6444. For personnel in USAOs, your office should have a copy of this booklet. If not, you may (202) 616-1681.

Criminal Debt Data Management

On April 17, 1997, EOUSA Director Carol DiBattiste sent a memo to United States Attorneys, First Assistant United States Attorneys, Criminal Chiefs, and Civil Chiefs regarding the closing of the National Fine Center (NFC) and the challenge for USAOs to identify and pursue other ways to make criminal debt data management more efficient. The Department is focusing its efforts on implementing the recommendations of the independent assessment conducted by Coopers & Lybrand (C&L) and improving criminal debt data management without a centralized NFC. Ms. DiBattiste's memo discusses some of the significant observations in C&L's report and the Department's efforts to implement C&L's recommendations. Her memo suggests steps to take in the districts to help improve the efficiency of managing criminal debt data. For personnel in USAOs, your office should have a copy of this memo. If not, you may call (202) 616-1681.

***Robinson v. Shell Oil*—Title VII Retaliation Issue**

On March 7, 1997, EOUSA Director Carol DiBattiste sent a memo to United States Attorneys, First Assistant United States Attorneys, and Administrative Officers concerning disagreement among some Circuit courts about whether the term “employees” in § 704a of Title VII includes former employees. The Supreme Court resolved the conflict when it held in *Robinson v. Shell Oil Co.*, No. 95-1376, 1997 WL 63007 (U.S. Feb. 18, 1997), that the term “employees” in Title VII includes former employees. Therefore, former employees may sue employers for allegedly retaliatory post-employment actions. For personnel in USAOs, your office should have a copy of this memo. If not, you may call (202) 616-1681.

State Environmental Audit Laws

On March 19, 1997, EOUSA Director Carol DiBattiste forwarded a memo to United States Attorneys from United States Attorney Edward L. Dowd, Jr., Eastern District of Missouri; United States Attorney Robert C. Bundy, District of Alaska; and Assistant Attorney General Lois Schiffer, Environment and Natural Resources Division (ENRD), announcing that ENRD is requesting the assistance of United States Attorneys for the possible adoption of Environmental Audit laws by various states. Accompanying the memo are a copy of the information distributed last year and an updated list of states in which legislation has passed or is pending. Questions should be directed to Senior Counsel to the Director Louis DeFalaise, (202) 616-2128. For personnel in USAOs, your office should have a copy of this memo. If not, you may call (202) 616-1681.

Child Support Recovery Act Guidelines

On February 27, 1997, EOUSA Director Carol DiBattiste forwarded to United States Attorneys the Attorney General’s Prosecutive Guidelines and Procedures for the Child Support Recovery Act (CSRA) of 1992 (Revised 2/97). The policies and procedures are intended to ensure effective prosecution of the CSRA by providing a means for selecting egregious cases that states are unable to handle because of their interstate nature. For personnel in USAOs, your office should have a copy of this memo. If not, you may call (202) 616-1681.

Informants

On March 6, 1997, EOUSA Director Carol DiBattiste forwarded to United States Attorneys, First Assistant United States Attorneys, and Criminal Chiefs, a handout updated by Judge Stephen S. Trott, Ninth Circuit Court of Appeals, on informants and an Informant Check List that is used to guide prosecutors through many issues and problems involved in the use of informants. For personnel in USAOs, your office should have a copy of this memo. If not, you may call (202) 616-1681. The outline is also available on USABook as a chapter of the “Federal Crimes of Violence” book.

Emergency Witness Assistance Program

The Emergency Witness Assistance Program (EWAP) was developed as a pilot program to provide United States Attorneys' offices (USAOs) with the flexibility to address a critical need: emergency assistance to witnesses to ensure their well-being and to ensure that they will be available for court proceedings or other activities related to cases. The program also addresses the physical, mental, or emotional reservations that witnesses or prospective witnesses may have about participating in specific matters before or after they agree to cooperate with, testify, or be available for the Government.

EWAP is different from the Witness Security Program; the Limited Services Protection Program; and the Washington, D.C., USAO's Short Term Protection Program, in that it does not provide physical protective services for witnesses, such as protective details or entrance into the Witness Security Program; custody arrangements; or a law enforcement presence. EWAP addresses a witness's fears, whether valid or not, about assisting the Government, and promotes the peace of mind of witnesses when they have relevant information to contribute, thereby enhancing their ability to testify. The program only provides emergency financial and other assistance to witnesses for these purposes. This assistance will not exceed one month unless there are extenuating circumstances. While witnesses receiving EWAP assistance may choose to leave their immediate surroundings (with the concurrence of the USAO) as a way to alleviate their fears, and while the Department may provide financial assistance to do so, the Department does not provide them with protective services.

The funds can be used for a range of services, including:

- **Transportation** to enable witnesses to leave their neighborhood/town/city/state temporarily.
- **Temporary Housing/Moving Expenses**, including one month's deposit on rental property and moving expenses (truck rental, etc.), if these expenses are less than hotel/motel stays. Dependents and other family members may be included, as appropriate.
- **Temporary Subsistence**, a reasonable portion of the Federal per diem standard.
- **Miscellaneous Expenses** up to \$250 for window security locks, other locks, repairs, and other things to alleviate a witness's physical, mental, or emotional concerns related to cooperating with the Government.
- **Emergency Telephone Service**, including cellular telephone service for witnesses without telephones so they have direct contact with AUSAs or LECC/VW Coordinators.
- **Child or Elder Care** for dependent family members if reasonably necessary.
- **Other Transportation Expenses** necessary for school or immediate medical and/or counseling needs.

The LECC/Victim-Witness Staff encourages each United States Attorney's office to take an active role in the EWAP Plan in their district. If you have any questions, please contact the LECC/Victim-Witness Staff at (202) 616-6792.

Crackdown on Interstate Cigarette Smuggling

On April 23, 1997, United States Attorney Helen F. Fahey, Eastern District of Virginia, and the Attorneys General of Virginia, New York, Maryland, and Pennsylvania announced a new joint crackdown on interstate cigarette smuggling on the East Coast involving the use of multistate surveillance operations and seizures, as well as Federal prosecutions in Virginia for trafficking in contraband cigarettes, and money laundering. The initiative, called "Operation Butt-Out," is aimed at the increasing problem of individuals and organized groups purchasing cigarettes in Virginia and illegally transporting them to New York, Maryland, and Pennsylvania for resale without paying applicable local cigarette taxes in Virginia or the resale states, thus violating numerous Federal statutes. Twenty-six persons and five corporations, in nine cases involving trafficking in contraband cigarettes, have been indicted by a Federal grand jury under Operation Butt-Out, and investigations are continuing into other groups and individuals.

Violence Against Women Act Update

On February 24, 1997, EOUSA Director Carol DiBattiste sent a memo to United States Attorneys, Criminal Chiefs, and Violence Against Women Act (VAWA) Points of Contact, thanking those who attended the Point of Contact Conference in January, and advising them of the following two recent developments.

- On January 31, 1997, the United States Attorney's office for the Southern District of New York won a conviction in *U.S. v. Rita Gluzman*. Gluzman, convicted under § 2261 (a) (1) of traveling interstate to murder her estranged husband, was the first woman charged and convicted under VAWA.
- On February 4, 1997, the United States Attorney's office for the District of Maine won a motion for upward departure based on a defendant's domestic violence history in *U.S. v. David Lee*. Lee pled guilty to a felon in possession of a firearm charge. At sentencing, the USAO established that Lee committed domestic abuse based on the testimony of four separate women victimized over a ten-year span. The USAO argued that this history of domestic violence is a factor that is not adequately addressed in the Guidelines. The district court accepted the argument, granted the upward departure, and increased Lee's sentence from four to seven years. This case should encourage USAOs to seek upward departure in appropriate circumstances if a defendant has a history of domestic violence.

On April 10, 1997, EOUSA Director Carol DiBattiste forwarded to VAWA Points of Contact the first installment of documents provided to assist in the evaluation and prosecution of VAWA cases and in the establishment of state and local partnerships. EOUSA will continue to develop additional materials to assist in efforts to create or join existing state and local partnerships that

target domestic violence. Requests, questions, or ideas should be directed to EOUSA Violence Against Women Act Specialist Margaret Groban, (207) 780-3293, ext. 5.

Administration

Attorney Recruitment

On March 4, 1997, Attorney General Janet Reno forwarded to United States Attorneys, EOUSA Director Carol DiBattiste's memo regarding recruitment for current and future Southwest Border and Health Care Fraud positions. The Department's Office of Attorney Personnel Management (OAPM) has offered to assist the United States Attorneys' offices and EOUSA in current and future attorney recruitment efforts by sending vacancy announcements to a diverse group of legal publications and law schools. OAPM has two lists of publications resources—the "basic" network of national advertising sources and diversity-oriented organizations and an "optional" network of all law schools in the country accredited by the American Bar Association. The two lists and sample vacancy announcements are included in Ms. DiBattiste's memo. For personnel in USAOs, your office should have a copy of these memoranda. If not, you may call (202) 616-1681.

Oversight of Background Investigations and Reinvestigations

On April 3, 1997, EOUSA Director Carol DiBattiste sent a memo via electronic mail to United States Attorneys, First Assistant United States Attorneys, District Office Security Managers, and Administrative Officers to remind employees of the importance of the reinvestigation program and to ensure that accurate records of National Security Information (NSI) clearances are maintained. Reinvestigations are required for employees who have access to National Security Information in conjunction with their duties in United States Attorneys' offices. Other employees are selected for reinvestigation depending on the age of their background investigation. Reinvestigation is an important program, and all employees selected for reinvestigation should complete the required paperwork and return it within two weeks. EOUSA's Evaluation and Review Staff (EARS) will verify during EARS office reviews that accurate records of NSI clearances are being maintained. For additional information, contact Assistant Director Tommie Barnes, Security Programs Staff, (202) 616-6878.

Administratively Determined Pay Plan Revisions

On April 28, 1997, EOUSA Director Carol DiBattiste sent a memo to United States Attorneys, for distribution to all Assistant United States Attorneys, containing a detailed overview of the revisions to the Administratively Determined (AD) Pay Plan which pertains to non-supervisory line Assistant United States Attorneys and becomes effective July 1, 1997. The memo includes a copy of the revised pay structure and pay policies, revised pay plan chart, discontinued pay plan charts, and questions and answers about the revised AD pay plan. For personnel in USAOs, your office should have a copy of this memo. If not, you may call (202) 616-1681.

Removal and Maintenance of Documents

On April 11, 1997, EOUSA Director Carol DiBattiste forwarded to United States Attorneys, First Assistant United States Attorneys, and Administrative Officers, Order DOJ 2710.8A, which sets forth the policy and procedures governing the removal of documentary materials from Department of Justice custody by employees leaving the Department. This Order supersedes Order DOJ 2710.8, and applies to all DOJ employees regardless of the type or duration of their employment. The Order sets forth the requirements and responsibilities associated with handling, maintaining, and removing DOJ materials to avoid violations of specific Federal laws and associated civil/criminal penalties, and to ensure that Department employees know the proper procedures for removal of documentary materials and that component heads are familiar with their responsibilities. Questions regarding this Order should be directed to Acting Assistant Director Bonnie L. Gay or Acting Attorney in Charge John Boseker, EOUSA's FOIA Staff, (202) 616-6757. For personnel in USAOs, your office should have a copy of this memo. If not, you may call (202) 616-1681.

Debriefing of Departing Employees

On April 21, 1997, EOUSA Director Carol DiBattiste sent a memo to United States Attorneys, First Assistant United States Attorneys, District Office Security Managers, and Administrative Officers regarding procedures to ensure that departing employees with access to classified information are debriefed. Classified information, including "extra" copies, is not personal property and may not be removed from the Government's control by departing employees. District Office Security Managers must ensure that all cleared personnel departing their offices are debriefed, and the debriefing should include reminders that the responsibility to protect classified information, including that in an employee's memory, does not end with a person's departure from Government service. In addition, a person who no longer has a security clearance is still subject to criminal and civil liability for the unauthorized disclosure of classified information he or she learned while cleared. Questions regarding debriefings should be directed to Arlene DeLong, EOUSA's Security Programs Staff, (202) 616-6638. For employees in USAOs, your office should have a copy of this memo. If not, you may call (202) 616-1681.

Home Use of WordPerfect Software

On March 7, 1997, EOUSA Director Carol DiBattiste sent a memo to United States Attorneys, First Assistant United States Attorneys, and Administrative Officers concerning the appropriate use of WordPerfect under the Corel License Program. There is no legal restriction against the use of WordPerfect software on home PCs. The license states, "Nonconcurrent usage: Nonconcurrent home and laptop use under the same license is allowed at no extra charge." Under this provision, a user is permitted to use WordPerfect software that is loaded on multiple computers, **as long as only one copy of the software is being accessed at a time**. This memo covers only WordPerfect word processing software. Each product has different licensing language and restrictions; therefore, software or hardware for home use must be approved by EOUSA to ensure that it meets established guidelines. Contact Assistant Director Carol Sloan or Gerry Connolly, EOUSA's Office Automation Staff, (202) 616-6969, about the use of software products at home.

Special Assistant United States Attorney Program

On March 21, 1997, EOUSA Director Carol DiBattiste sent a memo to United States Attorneys, Administrative Officers, and Personnel Officers on the procedures for appointing Special Assistant United States Attorneys (SAUSAs) and guidance on their role and scope of SAUSA activities. Questions regarding appointment of SAUSAs should be directed to EOUSA's Personnel Staff Assistant Director Debbie S. Brown, (202) 616-6873, or Debi Cleary or Dorothy Croom, Personnel Staff, (202) 616-6800. Questions regarding the proper role of SAUSAs should be directed to Robert Marcovici, EOUSA's Legal Counsel staff, (202) 514-4024. For personnel in USAOs, your office should have a copy of this memo. If not, you may call (202) 616-1681.

Off-Duty Conduct/Outside Activities

On April 2, 1997, Attorney General Reno forwarded to heads of Department components DOJ's policy on off-duty conduct of Department employees. On April 30, 1997, EOUSA Director Carol DiBattiste sent a memo to United States Attorneys forwarding this policy.

On April 30, 1997, EOUSA Director Carol DiBattiste forwarded to Employees of the United States Attorneys' offices and EOUSA employees, the supplemental regulation on ethical standards of conduct and outside activities (attached as **Appendix A**).

For further information on these issues, please contact Juliet Eurich, Legal Counsel, EOUSA, (202) 514-4024.

Changes in Policies Pertaining to Details

On April 16, 1997, EOUSA Director Carol DiBattiste forwarded to United States Attorneys, First Assistant United States Attorneys, and Administrative Officers the two new Department Policy Guidelines pertaining to details. The first policy, "Details of Employees to Organizations Outside the Department of Justice," states that (1) requests for details outside DOJ should not exceed one year, (2) approvals of details lasting more than a year will be given only if warranted by special circumstances, (3) no detail outside the Department will be permitted beyond three years without the approval of the Attorney General, and (4) current details that have already exceeded three years will not be extended without the Attorney General's approval. All requests for details outside of DOJ must be submitted to and processed through EOUSA for approval by the Deputy Attorney General and the Attorney General. The second policy, "Policy Guidelines for Authorizing and Administering Extended Travel Assignments," was issued by Assistant Attorney General for Administration Stephen R. Colgate in an attempt to bring all components of the Department into consistent application of the rules and regulations covering extended travel (in excess of 30 days). Questions concerning these policies should be directed to Theresa Bertucci, (202) 514-4506, or Rob Hall, (202) 514-4295. For personnel in USAOs, your office should have a copy of this memo. If not, you may call (202) 616-1681.

Sexual Harassment in the Department

On March 20, 1997, EOUSA Director Carol DiBattiste forwarded to United States Attorneys and Sexual Harassment Points of Contact, the Attorney General's memo dated February 24, 1997,

concerning the results of a 1996 survey regarding sexual harassment. The memo included the Department of Justice's Study of "Sexual Harassment in the Workplace." EOUSA is committed to providing awareness and training strategies to achieve a goal of eliminating all incidents of sexual harassment in the work environment. For personnel in USAOs, your office should have a copy of this memo. If not, you may call (202) 616-1681.

Statement to the House Appropriations Subcommittee

On March 21, 1997, EOUSA forwarded to United States Attorneys a copy of EOUSA Director Carol DiBattiste's short oral statement to the House Appropriations Subcommittee, and the long written statement submitted for the record. She testified as part of a panel with DEA Administrator Thomas Constantine and Criminal Division Deputy Assistant Attorney General Mary Lee Warren, who appeared for OCDETF. The hearing focused on drugs; however, the written statement reflects the entire appropriation request. For personnel in USAOs, your office should have a copy of Ms. DiBattiste's statements. If not, you may call (202) 616-1681.

Commendations Issue

Next month there will be a Special Commendations Issue of the *United States Attorneys' Bulletin*, recognizing Assistant United States Attorneys who have received awards or been commended from January 1 to May 30, 1997.

Video Teleconferencing Update

There are currently 197 video teleconferencing systems installed and operational in staffed United States Attorneys' offices. These systems will be operational in all staffed United States Attorneys' offices by August 1997.

New EOUSA Organization Chart

On February 4, 1997, Attorney General Janet Reno approved the new organization chart for EOUSA. A copy is attached as **Appendix B**.

EOUSA Organizational Title Changes

The titles of the managers in Resource Management and Planning (formerly Financial Management Staff) have changed to better reflect currently assigned duties. The new titles are: Frank M. Kalder, Deputy Director, Resource Management and Planning; Michael T. McDonough, Assistant Director, Budget Formulation; Charlotte A. Saunders, Assistant Director, Budget Execution; and Barbara A. Tone, Assistant Director, Data Analysis Group. These changes are consistent with the duties, responsibilities, and reporting arrangements contained in the EOUSA reorganization recently approved by Congress.

Other

National Association of Attorneys General Publications

On April 21, 1997, EOUSA Director Carol DiBattiste forwarded to United States Attorneys, First Assistant United States Attorneys, and Criminal Chiefs, a memorandum from Director Nicholas M. Gess, Office of Intergovernmental Affairs, that discusses topical reports published by the National Association of Attorneys General in program areas such as criminal law, consumer protection, antitrust law, and health care fraud, and requests that United States Attorneys' offices consider contributing significant case examples to these publications. Case examples should be sent to National Association of Attorneys General, 750 First Street, N.E., Suite 1100, Washington, D.C. 20002, with a copy to Director Nicholas M. Gess, DOJ's Office of Governmental Affairs. For personnel in USAOs, your office should have a copy of this memo. If not, you may call (202) 616-1681.

Southern District of Texas Annual Report

The Southern District of Texas' Annual Report for Fiscal Year 1996 outlines their efforts in representing the United States in litigation, working with investigative agencies to enforce Federal laws, and developing partnerships throughout the Southern District of Texas to promote comprehensive law enforcement and crime prevention programs. This report and other information about the United States Attorney's office for the Southern District of Texas can be accessed through the Internet at www.usdoj.gov/usao.

Branch Office for District of Montana Opens

On March 27, 1997, United States Attorney Sherry Matteucci announced that the branch office in Missoula is open and staffed by Assistant United States Attorneys Kris A. McLean and William W. Mercer. The office is located in the Russell Smith Courthouse, 201 East Broadway, Suite 210. The mailing address is P.O. Box 8329, Missoula, MT 59807. The telephone number is (406) 542-8851; the fax number is (406) 542-1476.

Office of Legal Education

OLE Projected Courses

OLE Director Michael W. Bailie is pleased to announce projected course offerings for the months of June through September 1997 for the Attorney General's Advocacy Institute (AGAI) and the Legal Education Institute (LEI). Lists of these courses are on the following pages.

AGAI

AGAI provides legal education programs to Assistant United States Attorneys (AUSAs) and attorneys assigned to Department of Justice (DOJ) Divisions. The courses listed are tentative; however, OLE sends Email announcements to all United States Attorneys' offices (USAOs) and DOJ Divisions approximately eight weeks prior to the courses.

LEI

LEI provides legal education programs to Executive Branch attorneys (except AUSAs), paralegals, and support personnel. LEI also offers courses designed specifically for paralegal and support personnel from USAOs. OLE funds all costs for paralegals and support staff personnel from USAOs who attend LEI courses. Approximately eight weeks prior to each course, OLE sends Email announcements to all USAOs and DOJ Divisions requesting nominations for each course. Nominations are to be returned to OLE via Fax, and then student selections are made.

Other LEI courses offered for Executive Branch attorneys (except AUSAs), paralegals, and support personnel are officially announced via quarterly mailings to Federal departments, agencies, and USAOs. Nomination forms are available in your Administrative Office or attached as **Appendix C**. They must be received by OLE at least 30 days prior to the commencement of each course. Notice of acceptance or non-selection will be mailed to the address typed in the address box on the nomination form approximately three weeks prior to the course. Please note that OLE does not fund travel or per diem costs for students who attend LEI courses.

Videotape Lending Library

A list of videotapes offered through OLE, and instructions for obtaining them, are attached as **Appendix D**.

Office of Legal Education Contact Information

Address: Bicentennial Building, Room 7600 Telephone: (202) 616-6700
600 E Street, NW FAX: (202) 616-6476
Washington, DC 20530-0001

Director Michael W. Bailie
Deputy Director Kent Cassibry, FAUSA, SDTX
Assistant Director (AGAI-Criminal) Jackie Chooljian, AUSA, CDCA
Assistant Director (AGAI-Criminal) Stewart Robinson, AUSA, NDTX
Assistant Director (AGAI-Civil and Appellate) Patricia Kerwin, AUSA, MDFL
Assistant Director (AGAI-Asset Forfeiture and
Financial Litigation) Tony Hall, AUSA, Idaho
Assistant Director (LEI) Donna Preston
Assistant Director (LEI) Eileen Gleason, AUSA, EDLA
Assistant Director (LEI-Paralegal and Support) Donna Kennedy
Assistant Director (Victim-Witness) Michelle Tapken, AUSA, South Dakota

AGAI COURSES

Date	Course	Participants
June		
2-6	Advanced Criminal Trial	AUSAs, DOJ Attorneys
3-5	Advanced Asset Forfeiture	AUSAs, DOJ Attorneys
9-13	Appellate Advocacy	AUSAs, DOJ Attorneys
10-13	Grand Jury Seminar	AUSAs, DOJ Attorneys
11-13	Overview of Archaeological and Historic Resources	AUSAs, DOJ Attorneys
16-27	Civil Trial Advocacy	AUSAs, DOJ Attorneys
24-27	Fraud Seminar	AUSAs, DOJ Attorneys
24-27	Native American Issues	AUSAs, DOJ Attorneys
July		
8-10	Bankruptcy for Support Staff	AUSAs, DOJ Attorneys
8-17	Criminal Trial Advocacy	AUSAs, DOJ Attorneys
9-11	Computer Crimes	AUSAs, DOJ Attorneys
9-11	Advanced Alternative Dispute Resolution	AUSAs, DOJ Attorneys
21-25	Advanced Civil Trial	AUSAs, DOJ Attorneys
22-25	Special Assistant United States Attorneys Small Business Administration Seminar	AUSAs, DOJ Attorneys
29-8/1	Health Care Fraud	AUSAs, DOJ Attorneys
August		
4-8	Criminal Chiefs	Criminal Chiefs
5-7	Asset Forfeiture for Criminal Prosecutors	AUSAs, DOJ Attorneys
11-15	Civil Federal Practice	AUSAs, DOJ Attorneys
11-20	Criminal Trial Advocacy	AUSAs, DOJ Attorneys
12-15	Environmental Crimes	AUSAs, DOJ Attorneys
19-21	Financial Litigation for Attorneys	AUSAs, DOJ Attorneys
25-28	Employment Discrimination	AUSAs, DOJ Attorneys
26-29	Complex Prosecutions	AUSAs, DOJ Attorneys
September		
8-12	Appellate Advocacy	AUSAs, DOJ Attorneys
8-12	Criminal Federal Practice	AUSAs, DOJ Attorneys
9-11	Advanced Money Laundering	AUSAs, DOJ Attorneys
15-19	Advanced Civil Trial	AUSAs, DOJ Attorneys
16-18	Advanced Bankruptcy	AUSAs, DOJ Attorneys
22-26	Advanced Criminal Trial	AUSAs, DOJ Attorneys
23-26	Health Care Fraud	AUSAs, DOJ Attorneys
24-25	Dispute Resolution/Enhanced Negotiations	AUSAs, DOJ Attorneys

LEI COURSES

Date	Course	Participants
June		
2-3	Agency Civil Practice	Agency Attorneys
6	Statutes and Legislative Histories	Agency Attorneys
17-20	USA Secretaries Seminar	USA Secretaries
20	Legal Writing	Agency Attorneys/Paralegals
24-25	Freedom of Information Act for Attorneys and Access Professionals	Agency Attorneys
26	Privacy Act	Agency Attorneys
30-7/2	Trial Preparation	Agency Attorneys
July		
14-18	Legal Support Staff	USAO Support Staff
21-23	Attorney Supervisors	Agency Attorneys
21-25	Civil Paralegal	USAO Paralegals
28-30	Negotiation Skills	Agency Attorneys
31	Introduction to Freedom of Information Act	Agency Attorneys
August		
1	Legal Writing	Agency Attorneys
4-8	Support Staff Supervisors	Support Staff Supervisors
5-8	Fraud, Debarment, and Suspension Federal Acquisition Regulations	Agency Attorneys
18-22	Criminal Paralegal	USAO Paralegals
21-22	Evidence	Agency Attorneys
26-27	Federal Administrative Process	Agency Attorneys
26-27	Freedom of Information Act for Attorneys and Access Professionals	Agency Attorneys
September		
3-5	Environmental Law	Agency Attorneys
8-12	Legal Support Staff	USAO Support Staff
9	Appellate Skills	Agency Attorneys
11	Statutes and Legislative Histories	Agency Attorneys
22-26	Legal Research and Writing Refresher	USAO Attorneys/Paralegals

Computer Tips

Keeping Text Together

Proper legal writing often requires affirmative steps to keep text on the same line or the same page. Don't give in to the temptation to use manual brute force methods (hard carriage returns or hard page breaks) because the text won't align properly if it is edited in the future. WordPerfect has a number of graceful tools to keep text together without creating problems in future edits.

Keeping text on the same line: This usually comes into play when a citation to a case or statute comes close to the end of the line. You can solve this problem by using *hard spaces* inside your citations. WordPerfect will not break a line on a hard space. In WordPerfect 5.1 for DOS, create a hard space by pressing <Home>, and then the space bar. In WordPerfect for Windows, select hard space from the Other Codes menu (Format, Line, Other Codes). This technique can also be used to create hard dashes -- <Home>space, <Home>dash, <Home>dash, <Home>space, to prevent line breaks that place the dash at the beginning or end of the line.

Keeping text on the same page: The primary tool here is Widow/Orphan Control. A *widow* is the last line of a paragraph appearing alone at the top of a page. An *orphan* is the first line of a paragraph appearing alone at the bottom of a page. If you turn Widow/Orphan Control on, WordPerfect will automatically adjust text between pages to avoid any widows or orphans. In WordPerfect 5.1 for DOS, turn on Widow/Orphan Control by pressing <Shift F8>, **1** Line, and then **9** Widow/Orphan. In WordPerfect for Windows, select Format, Page, and Keep Text Together.

If you want to keep more than one line together, use Block Protection. It tells WordPerfect not to break text inside the block. Block protection is particularly useful in keeping headings on the same line as the associated text, and keeping lists and tables on one page. To protect a block of text in WordPerfect for DOS, mark the text by pressing the <F12> key, and then press <Shift F8>. In WordPerfect for Windows, use the mouse or shift key to mark the text, and then select Format, Page, and Keep Text Together.

DOJ Highlights

Appointments

Klein to be Nominated as AAG of Antitrust

On February 28, 1997, President Clinton announced his intent to nominate Joel I. Klein as Assistant Attorney General, Antitrust Division. Joel I. Klein has served as Acting Assistant Attorney General for the Antitrust Division since October 1996. Prior to serving in his current position, Mr. Klein was Deputy Assistant Attorney General, where he successfully argued the landmark Microsoft case on appeal. Before his service in the Antitrust Division, Mr. Klein served as Deputy Counsel to President Clinton. In private practice, Mr. Klein argued 10 cases before the United States Supreme Court. President Clinton stated, "Joel Klein is an outstanding attorney and dedicated public servant. He has served me well over the past three years and I am confident that he will continue to do a superb job in the Antitrust Division." Attorney General Reno stated, "He has participated in many important competition matters and I am so pleased that the President has chosen him to lead the Antitrust Division."

FBI Announces New Deputy Director

On February 27, 1997, FBI Director Louis J. Freeh announced the appointment of William J. Esposito as the FBI's new Deputy Director. Director Freeh stated, "Bill Esposito is a career Special Agent who is superbly qualified to be the Bureau's No.2 official because of more than 26 years of outstanding FBI performance and distinguished service to the American people and to Federal law enforcement . . . He brings integrity and a valuable and diverse investigative background to one of the most important posts in the FBI." Esposito served as Deputy Assistant Director of the Criminal Investigative Division, Special Agent in Charge of the San Diego Division, Chief of the White-Collar Crimes Section at FBI Headquarters, and the Assistant Special Agent in Charge of the Baltimore and Cleveland Divisions. Attorney General Reno stated, "William Esposito for the last two years has been one of the FBI's 11 Assistant Directors, the Bureau's third-ranking position. He brings to his new assignment excellent skills as an investigator and manager."

Antitrust Division

Revisions to Merger Guidelines

On April 8, 1997, the Department and the Federal Trade Commission (FTC) revised a portion of their joint Merger Guidelines to clarify how agencies analyze claims that a merger is likely to lower costs, improve product quality, or otherwise achieve efficiencies. The Horizontal Merger Guidelines are designed to give merging parties and the public guidance on how DOJ and FTC analyze the competitive effects of a merger and decide whether to challenge a merger under antitrust laws. The revisions affect Section 4 of the Merger Guidelines, making clear that the agencies will take efficiencies into account as part of their analysis of the competitive effects of a

merger. They also provide explicit guidance on issues such as how the agencies determine if the claimed efficiencies are properly attributable to the merger; what the parties must do to substantiate their efficiencies claims; the circumstances in which the agencies are likely to find efficiencies claims persuasive; and the limited circumstances under which consideration will be given to out-of-market efficiencies and to in-market efficiencies that are not expected to have short-term, direct effects on prices. For a copy of the revised Section 4 of the Guidelines, call (202) 616-1681.

Digest of Business Reviews

On March 20, 1997, the Antitrust Division released the 1996 annual supplement and revised indexes to the "Digest of Business Reviews." Under the Business Review procedure, a firm describes proposed business activity to the Antitrust Division and receives a letter stating whether the Division would challenge the action as a violation of Federal antitrust laws. The updated indexes permit research of all Business Review letters issued since 1968 according to topic, commodity, or service involved, and the name of the requesting party. Copies of the Digest, supplements, revised indexes, and Business Review letters are available from the Legal Procedures Unit of the Antitrust Division, Department of Justice, Suite 215 Liberty Place, 325 Seventh Street, N.W., Washington, D.C. 20004, or by calling (202) 514-2481.

Criminal Division

Directory

In March 1997, the Criminal Division published *Expertise in the Criminal Division*, a directory prepared at the Attorney General's request and distributed to DOJ components. For personnel in USAOs, your office should have a copy of this directory. If not, you may call (202) 616-1681.

Asset Forfeiture and Money Laundering Section (AFMLS)

Asset Forfeiture News

The March/April 1997 issue of the *Asset Forfeiture News* was published in April. This issue covers changes in forfeiture authority of the Immigration and Naturalization Service, civil forfeitures under the Internal Revenue Code, program changes in Department of the Treasury's *Equitable Sharing Guide*, new procedures for processing Department of Justice equitable sharing requests, frequently asked questions concerning equitable sharing reporting requirements for state and local agencies, and successful equitable sharing stories from Department of the Treasury and DOJ. To subscribe to the *Asset Forfeiture News*, fax your name, organization, address, and telephone and fax numbers to AFMLS at (202) 616-1344; or write to AFMLS, Criminal Division, Department of Justice, 1400 New York Avenue, N.W., Suite 10100, Washington, D.C. 20005. To submit articles on any asset forfeiture topic, contact the editor at (202) 514-1263.

Federal Money Laundering Cases

Federal Money Laundering Cases, a supplement to the AFMLS's *Money Laundering Manual*, is available. This handbook, a research tool and guide for Federal prosecutors, is a compilation of cases interpreting the Federal money laundering statutes (18 U.S.C. §§ 1956 and 1957) and related forfeiture provisions (18 U.S.C. §§ 981 and 982). To request a copy, contact AFMLS at (202) 514-1263; or fax your name, organization, address, and telephone and fax numbers to (202) 616-1344. This handbook is updated regularly on the Asset Forfeiture Bulletin Board (AFBB); the substantive money laundering cases are in the file, "mlcases," and the forfeiture cases are in the file, "mlfft." To request assistance in accessing the AFBB, contact the system operator at (202) 307-0265.

Community Oriented Policing Services

Communities Receive More Funds to Add Cops

On April 2, 1997, the Office of Community Oriented Policing Services (COPS) announced that 351 law enforcement agencies will receive grants of more than \$105 million to hire more than 1,500 additional police officers and sheriffs' deputies for 47 states. The grants are part of the Clinton Administration's program to add 100,000 police officers and sheriffs' deputies to the nation's streets—an increase of almost 20 percent in the country's police ranks. The grants are awarded under the COPS Universal Hiring Program which provides funding for 75 percent of the total salary and benefits of each officer hired for three years, up to a maximum of \$75,000 per officer. The remainder will be paid by state or local funds. The Administration has announced funds for more than 9,000 jurisdictions to add over 56,000 officers and deputies to the nation's streets.

Federal Bureau of Investigation

Giglio Implementation Plan

On April 17, 1997, EOUSA Director Carol DiBattiste forwarded to United States Attorneys, First Assistant United States Attorneys, and Criminal Chiefs, the FBI's implementation plan for the Department's policy regarding the disclosure to prosecutors of potential impeachment information concerning the Giglio policy. Attorney General Reno approved this policy on December 9, 1996. For personnel in USAOs, your office should have a copy of this memo. If not, you may call (202) 616-1681.

Office of Justice Programs

OJP's Partnerships in Indian Country

Laurie Robinson
Assistant Attorney General

In recent years, the Office of Justice Programs (OJP) has sharpened its focus on justice-related needs in Indian Country. For too long, Indian Country was not a part of our thinking, our plans, or our programs. But under the leadership of Attorney General Reno and working closely with the Office of Tribal Justice, under the direction of Tom LeClaire, I think we have made tremendous strides in providing services and support to Indian Country, helping tribal leaders and service providers more effectively control and prevent crime.

The numbers tell much of the story. In recent years, OJP's overall funding in Indian Country has increased dramatically, from just over \$2 million in FY 1992 to more than \$15 million in FY 1996. With expanded grant opportunities and better communication with tribal leaders, we expect to provide even more funding in FY 1997. Last year, the Violence Against Women Grants Office (VAWGO) awarded 66 grants totaling \$5.2 million under the STOP Violence Against Indian Women Discretionary Grants Program. This was the largest number of DOJ grants ever made to Indian communities at one time. New and expanded efforts by the Executive Office for Weed and Seed, the Bureau of Justice Assistance, and the Office for Victims of Crime (OVC) promise further expansions of our efforts in the future.

But an equally important side to our emphasis on issues affecting American Indians and Alaska Natives is our commitment to communicating with tribal governments in a way that reflects the Department's Policy on Indian Sovereignty and Government-to-Government Relations. As you know, the Attorney General has made clear her expectation that DOJ will strive to promote tribal sovereignty in all our activities in Indian Country. OJP is working to make sure that our programs are effectively communicated to tribal leaders and that we are responsive to the needs of Indian Country. Our efforts are coordinated through an OJP American Indian and Alaska Native Affairs Desk, which I set up two years ago to provide American Indian and Alaska Native tribes direct access to information and funding materials, to serve as OJP's liaison to the Attorney General's Advisory Committee's Subcommittee on Native Americans, and to provide guidance to OJP on new program development to improve services in Indian Country. The Indian Desk, under the direction of Norena Henry, recently published *OJP Partnership Initiatives in Indian Country*, a new resource guide to available funding, and has established its own Home Page on the World Wide Web (<http://www.ojp.usdoj.gov/aian>). These are just a few of the ways in which the Indian Desk is reaching out to provide tribal leaders with the most comprehensive and current information about the resources available to them.

Our Indian Desk's work with the AGAC Subcommittee on Native Americans provides OJP with an important link to United States Attorneys who are at the front line of efforts to prevent and control crime in Indian Country. United States Attorneys can contact our Indian Desk for referrals to appropriate OJP programs, and provide us with important information about programs and services that are lacking in Indian Country, or issues that need to be addressed. Recognizing the close relationship between subcommittee members and tribal leaders, each month the Indian Desk mails information packets to all subcommittee members, including new OJP publications, programs, and initiatives. We hope that by providing this information to subcommittee members, they will have the necessary tools to assist us in meeting our commitment to effectively communicate with tribal leaders.

Programmatic Partnerships

Our successes in reaching out to previously underserved populations in Indian Country rest largely on the many important partnerships we have built with United States Attorneys' offices; tribal leaders; service providers; and other offices in OJP, the Department, and other Federal agencies. These partnerships allow us to work together to coordinate service delivery, streamline the application and monitoring process, and better communicate new programs to tribes.

One of OJP's most innovative new programs is a partnership between OVC and VAWGO to coordinate applications for and monitor the Victim Assistance in Indian Country and STOP Violence Against Indian Women Discretionary Grants Program. In the past, funding for the Victim Assistance Program was awarded to the states, which subgrant funds to tribes and monitor the programs. But, in accordance with the Government-to-Government relationship advocated by the Attorney General, OVC is exploring ways to make grants directly to tribes. This year, OVC and VAWGO issued a *joint* application kit to the Standing Rock and Pine Ridge reservations, which each received funding under both programs in 1996. When FY 1997 continuation funding is awarded, both grant programs will be monitored by VAWGO, which will coordinate with OVC. The grant application requires tribes to coordinate their activities with the local United States Attorney's office. If this approach is successful, OJP will consider expanding it in the future.

The National Institute of Justice is evaluating the Indian Country Justice Initiative, a multi-jurisdictional, multi-departmental project being implemented at Northern Cheyenne Nation in Montana and Laguna Pueblo in New Mexico. The initiative aims to improve the Department's responsiveness to criminal justice needs in Indian Country and to increase its enforcement of laws against violent and other major crimes committed on reservations. Activities are planned and carried out in collaboration with tribal officers, officials from the Bureau of Indian Affairs (BIA), regional officials from the United States Probation Office, and the United States Attorneys in Montana and New Mexico. The evaluation will track implementation of the initiative at these two pilot sites, and identify which implementation methods have the greatest impact on outcomes.

As part of the Indian Country Justice Initiative, the Weed and Seed Office is supporting pilot programs at each site. The sites can use Weed and Seed funding to address the cultural considerations unique to Indian Country, and to coordinate services provided through grants from the OJP Bureaus and other sources. Special Assistant United States Attorneys Kathleen Bliss in New Mexico and Tracy Toulou in Montana assist the sites to implement the Weed and Seed strategy in their communities.

Recognizing the importance of culturally appropriate training for tribal law enforcement officials, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) this year will sponsor a five-day workshop geared to tribal law enforcement. The workshop will be coordinated with United States Attorneys' offices in states with large Indian populations, and will facilitate law enforcement responses to youth crime and delinquency. The curriculum will focus on issues of particular concern to tribal law enforcement officials, such as substance abuse, gangs, gun violence, domestic abuse, and child abuse. The tribal law enforcement workshop is one of a series

of seven workshops on youth crime that OJJDP is sponsoring for law enforcement agencies around the country.

The Bureau of Justice Assistance's (BJA) Tribal Strategies Against Violence program is a tribal-Federal partnership designed to empower tribal communities through the development and implementation of a comprehensive, reservation-wide strategy to reduce crime, violence, and substance abuse. BJA funding supports the formation of a centralized planning team, which includes tribal service providers, law enforcement representatives, representatives of local United States Attorneys' staffs, business and community leaders, and youth. Since FY 1995, the program has expanded to seven sites across the country.

Finally, the Bureau of Justice Statistics is working with BIA and BJA to identify pilot sites for a case-based, criminal justice tracking system in Indian Country. The system will be compatible with the National Incident-Based Reporting System, and will be accessible by tribal law enforcement agencies. The system will allow tribal law enforcement officials to track case outcomes, enhance the adjudication of criminal cases, and track violent offenders. In addition, and perhaps most importantly, the system will provide reliable and comprehensive data that will allow law enforcement to target problem areas and effectively plan for new programs, such as drug courts.

I am proud of the enormous expansion of OJP's services in Indian Country in recent years; however, I know that we can and must do even more in the future. With the continued support and partnership of the United States Attorneys, tribal leaders, and Indian Country service providers, OJP will continue to listen and be responsive to the needs of American Indians and Alaska Natives, providing tribal governments with the programs, services, technical assistance, and training they need to ensure healthy tribal communities.

Grants to Establish or Enhance Drug Courts

On April 4, 1997, the Department announced that more than 125 communities will receive approximately \$16 million in Department grants to plan, implement, or enhance drug courts, which allow communities to require nonviolent drug offenders to undergo intensive drug treatment in lieu of jail or prison sentences. Drug courts combine intensive judicial supervision, mandatory drug testing, escalating sanctions, and drug treatment to break the cycle of addiction and criminal activity. Drug court participants have substantially reduced drug use, and those 50 to 65 percent who graduate from the program stop using drugs. OJP's Drug Court Clearinghouse, operated by American University, reports that the average cost for the treatment component of a drug court program is between \$900 and \$2,200 per participant. Savings in jail days alone are estimated to be at least \$5,000 per participant. Additionally, female drug court participants have given birth to more than 200 drug-free babies while enrolled in various drug courts. These babies could have been born with addictions that would result in social service costs of \$250,000 per child. United States Attorney Sherry Scheel Matteucci stated, "This is an innovative program which will have a greater impact on these offenders who were previously cycled through the criminal justice system at the taxpayers' expense. Research has shown drug courts do have an impact."

Grants for Second Year of Prison Construction Program

On April 11, 1997, the Department announced that, under the Violent Offender Incarceration and Truth-in-Sentencing Programs, it will award \$78.5 million for states, the District of Columbia, and eligible territories to provide additional prison space to incarcerate violent offenders for longer periods of time. Last year, the first year of the program, the Department provided \$376 million to states under these programs.

Annual Report

The Office of Justice Programs' (OJP) Annual Report for FY 1996 is now available. This report describes OJP's major initiatives in FY 1996, its Crime Act program offices, and bureaus. For a copy of this publication, contact Marlene Beckman, (202) 307-5933, or write to OJP, 633 Indiana Avenue, N.W., Washington, D.C. 20531.

Bureau of Justice Assistance

Monographs

The following Bureau of Justice Assistance (BJA) monographs are available: "Addressing Community Gang Problems: A Model for Problem Solving," "Urban Street Gang Enforcement," and "A Policymaker's Guide to Hate Crimes." For copies, contact the BJA Clearinghouse, (800) 688-4252, or write, P.O. Box 6000, Rockville, MD 20849-6000.

Bureau of Justice Statistics

Publications

The Bureau of Justice Statistics (BJS) publication: "Lifetime Likelihood of Going to State or Federal Prison," is available. For a copy, contact the BJS Clearinghouse, (800) 732-3277, or write, P.O. Box 6000, Rockville, MD 20849-6000.

National Institute of Justice

Publications

The following National Institute of Justice (NIJ) publications are available: "Hair Assays and Urinalysis Results for Juvenile Drug Offenders," "The Department of Justice and Department of Defense Joint Technology Program: Second Anniversary Report," and "Ethnicity, Crime, and Immigration." For copies, contact the National Criminal Justice Reference Service (NCJRS), (800) 851-3420, or write, Box 6000, Rockville, MD 20849-6000.

Office of Juvenile Justice and Delinquency Prevention

Juvenile Justice Bulletin

The following Office of Juvenile Justice and Delinquency Prevention (OJJDP) Juvenile Justice Bulletins are available: "Court Appointed Special Advocates: A Voice for Abused and Neglected Children in Court" and "Child Development—Community Policing: Partnership in a Climate of Violence." For copies, contact the Juvenile Justice Clearinghouse, (800) 638-8736, or write, Box 6000, Rockville, MD 20849-6000.

New Training for Missing Children Cases

On April 14, 1997, OJJDP and the National Center for Missing and Exploited Children (NCMEC) opened The Jimmy Ryce Law Enforcement Training Center to help law enforcement respond to child kidnapping and abduction cases by providing training on current practices and research on investigating missing children cases. The Center was named for Jimmy Ryce, a nine-year old boy who was abducted on his way home from school and murdered in southern Florida in 1995.

An OJJDP fact sheet, *Jimmy Ryce Law Enforcement Training Center Program*, provides details on the training programs and resources available through the Ryce Center, located on the first floor of the NCMEC building at 2101 Wilson Boulevard, Arlington, Virginia 22201. The fact sheet is available from OJJDP's Juvenile Justice Clearinghouse, Box 6000, Rockville, MD 20857, or by calling (800) 638-8736. Information about the Ryce Center and other OJJDP programs, publications, and conferences is available through the clearinghouse and at OJJDP's Web Site, <http://www.ncjrs.org/ojjhome.htm>. Additional information about NCMEC is available at (800) 843-5678 and at its Web Site, <http://www.missingkids.com>.

Office for Victims of Crime

Newsletter

In February 1997, the Office for Victims of Crime (OVC) published the first edition of its "OVC Advocate—Advocating for the Fair Treatment of Crime Victims." The newsletter will cover major projects and practices used to benefit crime victims. For copies of this newsletter, contact OVC, (202) 307-5983, or write 633 Indiana Avenue, N.W., Washington, D.C. 20531.

Immigration and Naturalization Service

Hammer Award

On March 4, 1997, the National Olympic Planning Group received a National Performance Review Hammer Award for their outstanding, coordinated efforts aimed at expediting airport processing for international visitors to the 1996 Olympics in Atlanta, Georgia. Group members were from INS; State Department; U.S. Customs Service; Atlanta Committee for the Olympic Games (ACOG); FBI; DOJ; OJP; the National Crime Prevention Council; and Thomas De La Rue, Inc. The National Olympic Planning Group reengineered the entry process for international

Olympic visitors, expediting the inspection process for Olympic Family Members once they arrived at a port of entry in the United States, and accelerating the accreditation process.

Removal of Illegal Aliens

On February 10, 1997, INS published a fact sheet concerning the processes by which illegal aliens can be removed from the United States. The two broad categories are Final Order Removals and Other Removals. Final Order Removals are carried out pursuant to a final order of deportation or exclusion issued by an immigration judge, a Federal judge, or an INS officer, and they fall into two subcategories—criminal and noncriminal. Criminal removal, pursuant to a final order, is the removal of an alien who has been convicted of a crime in the United States any time prior to removal. Other Removals under INS control or supervision are carried out without a final order of deportation or exclusion, and they are categorized as:

(1) Interior Voluntary Returns Under Safeguard—including aliens apprehended more than 72 hours after their entry who elect to return to their country under INS supervision or control without a formal immigration hearing. Roughly 95 percent of Other Removals fall into this category. This category does not include aliens apprehended and returned at the border.

(2) Voluntary Departures Under Docket Control—this is a form of relief from deportation granted to an alien by an immigration judge or INS district director. It allows the alien to depart “voluntarily” in lieu of a deportation order. The alien must depart by a specified date and is only counted if the departure is confirmed by INS.

(3) Withdrawals Under Docket Control—this category includes aliens found by INS to be inadmissible at a port of entry who elect to withdraw their application for admission after INS has referred the case to an immigration judge for an exclusion hearing. This category does not include inadmissible aliens who withdraw their applications and immediately depart the country.

The Fact Sheet includes two bar graphs comparing INS Criminal and Noncriminal Alien Final Order Removals from FY 1993 to FY 1997, as well as Final Order Removals v. Other Removals for the first quarter of FY 1997. If you would like a copy of the fact sheet, contact INS’s Office of Public Affairs, (202) 514-2648.

FY 1997 Final Order Removals; New Tracking System

On February 10, 1997, INS announced that during the first quarter of FY 1997, there were 18,988 Final Order Removals of criminal and noncriminal aliens, 24 percent higher than the first quarter of FY 1996. Additionally, a new tracking system that more accurately reflects INS alien removal efforts recorded an additional 20,886 Other Removals.

Accompanying this announcement are a bar graph comparing the first quarter removals of FY 1996 with those of the first quarter of FY 1997, and a chart which details the top nationalities in FY 1997 Final Order Removals. If you would like a copy of the announcement, bar graph, and chart, contact INS’s Office of Public Affairs, (202) 514-2648.

Legal Immigration Figures

On April 22, 1997, INS announced that 915,900 persons legally immigrated to the United States in FY 1996, a 27 percent increase over FY 1995's total of 720,461. The expected increase in FY 1996 was driven by three primary factors: (1) a carry over of unused visas from FY 1995 that increased the available family-based immigrant visas; (2) an increase of employment-based immigrant visas in FY 1996; and (3) an increase in admissions of immediate relatives of United States citizens, driven in part by increased processing of adjustment of status applications.

Ethics and Professional Responsibility

Closing Arguments—Misleading Assertions

In a closing argument, defense counsel chastised the Government for not calling a certain witness. In rebuttal, the Federal prosecutor told the jury: “don’t be misled that the Government could have called” the witness. A court of appeals found misconduct in this remark because it implied that the Government could not have called the potential witness (who had entered a cooperation agreement). Based on its investigation, OPR concluded that the prosecutor’s remark was misconduct because it implied that the Government was unable to call the witness, although the prosecutor had good reason to believe that the witness would testify if the Government called him. OPR also concluded that the misconduct was not intentional or undertaken in bad faith because it was based on the inexperienced prosecutor’s mistaken belief about permissible arguments to the jury.

Government Lawyers—Private Representation

A corporation’s president complained that a Justice Department (DOJ) lawyer had improperly acted as counsel for a former employee of the corporation. The employee had been deposed in conjunction with a lawsuit a competitor brought against the company. The president also asserted that the DOJ lawyer revealed confidential company information and the former employee, on the advice of counsel, encouraged corporate employees to breach their employment agreements. OPR determined that the DOJ lawyer was the husband of the former employee and that he had taken annual leave to attend the deposition. Because the United States was not a party to the lawsuit, this representation complied with the standards of conduct. OPR also concluded that the allegations that the DOJ lawyer had disclosed confidential information and advised his wife to encourage others to breach corporate agreements were unsupported and did not warrant investigation.

Career Opportunities

The U.S. Department of Justice is an Equal Opportunity/Reasonable Accommodation Employer. It is the policy of the Department of Justice to Achieve a drug-free workplace and persons selected for the following positions will be required to pass a urinalysis test to screen for illegal drug use prior to final appointment.

The following announcements can be found on the Internet at <http://www.usdoj.gov/gopherdata/oapm/jobs>.

United States Attorney's Office Western District of Michigan Notice of Open Application Policy for Assistant United States Attorney Positions

The United States Attorney's office (USAO) for the Western District of Michigan is accepting applications for the positions of Assistant United States Attorney on an open, continuous basis. Applications are active for one year from the month of receipt. The Western District of Michigan covers roughly the western half of the lower peninsula and the entire upper peninsula. The main office of the United States Attorney's office is located in Grand Rapids, Michigan, with a staffed branch office in Marquette, and unstaffed offices in Lansing and Kalamazoo. The United States Attorney's office is a Federal Government office within the Department of Justice.

The United States Attorney's Office prosecutes Federal criminal cases and asserts and defends the interests of the United States and its agencies through civil litigation in Federal District Court and through appellate litigation in the Sixth Circuit Court of Appeals.

Positions for Assistant United States Attorney are available on an unpredictable basis and public advertisement of these positions is rare. This announcement serves as a notice and solicitation for applications.

Appointments of non-U.S. citizens to attorney positions are infrequent and are made only if necessary to accommodate the Department's mission. Please indicate in your application whether or not you are a U.S. Citizen. Applicant must possess a J.D. degree and have at least one year of post-J.D. experience. Applicant must be an active member of the bar in good standing (any jurisdiction). Resumes should be sent to:

United States Attorney's Office
Attn United States Attorney Michael H. Dettmer
PO Box 208
Grand Rapids MI 49501-0208

No telephone calls please. Employment is contingent upon the satisfactory completion of a background investigation adjudicated by the Department of Justice.

**U.S. Department of Justice
Office of Legal Counsel Attorney Position**

DOJ's Office of Legal Counsel (OLC), is seeking a highly qualified attorney to serve as attorney-adviser. OLC's principal function is to assist the Attorney General in fulfilling the role of legal adviser to the President and Executive Branch agencies. More specifically, OLC's responsibilities include the following:

- Advise the Attorney General, the White House Counsel, all executive departments and agencies, and the various components of the Department of Justice on constitutional and statutory matters
- Resolve legal disputes within the Executive Branch through the issuance of binding legal opinions
- Review for constitutionality legislation proposed by the President or by Congress
- Review for legality and form all executive orders, proclamations and memoranda proposed to be issued by the President and all Attorney General orders and regulations

Because OLC's 24 attorneys handle some of the most difficult and important legal issues confronting the Executive Branch, it is highly selective in its hiring. Applicants must possess a J.D. degree, be an active member of the bar in good standing (any jurisdiction), and have at least one year of post-J.D. legal experience. The ideal candidate will have exceptional academic credentials, judicial clerkship or comparable experience, strong background in constitutional law, and outstanding legal research and writing skills. Salary is dependent on experience. No telephone calls please. Please submit resumes to:

US Department of Justice
Office of Legal Counsel
Attn Dawn Johnsen, Acting Assistant Attorney General
Room 5224
950 Pennsylvania Avenue NW
Washington DC 20530-0001

**GS-14 to GS-15 Experienced Attorney
Executive Office for Immigration Review**

DOJ's Office of Attorney Personnel Management is seeking an experienced attorney to serve as Pro Bono Coordinator for the Executive Office for Immigration Review, Office of the Director, Pro Bono Unit, located in Falls Church, Virginia.

Incumbent will develop and coordinate a nationwide program to promote and facilitate pro bono efforts both before the Immigration Judges and the Board of Immigration Appeals. Specific duties of this position include, but are not limited to, analyzing program effectiveness, including pro bono representation on a city-by-city basis; developing action plans, both short- and long-term, to address problems; providing support and organizational assistance to those supplying pro bono work; evaluating legislative changes in terms of effect on the pro bono program, method of operation, and extent of operation; and recommending policies and developing procedures and regulations implementing new or amended legislation for the pro bono program. Applicants must possess a J.D. degree, be an active member of the bar in good standing (any jurisdiction), and have three or more years of post-J.D. experience. Applicants must also possess superior oral and written communication skills; strong interpersonal skills; general knowledge of pro bono programs, including ethics and conflict of interest laws and related issues; knowledge of Immigration Court environment; knowledge of INS detention center environment; knowledge of Bar Association activities; and knowledge of Immigration law. Applicants must submit **two copies** of either an OF-612 (Optional Application for Federal Employment) or resume, and a current performance appraisal (if applicable) to the address below. Applications for this position must be received by June 20, 1997.

US Department of Justice
Executive Office for Immigration Review
Office of the Associate Director
Attn Bridgette Hill
Personnel Staff
5107 Leesburg Pike Suite 2300
Falls Church VA 22041

Two copies of current SF-171 (Application for Federal Employment) will still be accepted as well. No telephone calls please. Salary is dependent on experience. Possible range is GS-14 (\$64,555-\$83,922) to GS-15 (\$75,935-\$98,714). Employment is also contingent upon the satisfactory completion of a background investigation adjudicated by the Department of Justice.

The *USABulletin* Wants You

Below is our **revised** schedule for the next three issues. In order for us to continue to bring you the latest, most interesting, and useful information, please contact us with your ideas or suggestions for future issues. If there is specific information you would like us to include in the *USABs* below, please contact David Nissman at AVISC01(DNISSMAN) or (809) 773-3920. Articles, stories, or other significant issues and events should be Emailed to Wanda Morat at AEX12(BULLETIN).

August 1997

October 1997

December 1997

Electronic Investigative Techniques

Trial Techniques

Law Enforcement Retrieval Services