United States v. Greber: A New Era in Medicare Fraud Enforcement?

James P. Prenetta Jr.

Follow this and additional works at: https://scholarship.law.edu/jchlp

Recommended Citation
Available at: https://scholarship.law.edu/jchlp/vol3/iss1/21

This Comment is brought to you for free and open access by CUA Law Scholarship Repository. It has been accepted for inclusion in Journal of Contemporary Health Law & Policy (1985-2015) by an authorized editor of CUA Law Scholarship Repository. For more information, please contact edinger@law.edu.
UNITED STATES v. GREBER: A NEW ERA IN MEDICARE FRAUD ENFORCEMENT?

During the 1970's, Congress learned that its federally administered Medicare program was laden with fraud and abuse. Abuses permeating the program included such practices as fraudulent billing, kickback payments and unnecessary medical treatments. In order to curtail these fraudulent activities and their costly side effects, Congress began enacting legislation designed to eliminate this needless expenditure of federal dollars.

One of the earliest Congressional actions to curtail Medicare fraud occurred in 1972 with passage of the Medicare Penalties Provision, section 1877(b) of the Social Security Amendments (codified at 42 U.S.C. § 1395nn(b)). Section 1877(b) was significant because it established, for the first time, provisions that made it illegal for any individual to utilize Medicare funds in a manner that constituted either a bribe, kickback, or rebate. In 1977 Congress took further action to curtail Medicare fraud by enacting the Medicare Antifraud and Abuse Amendments, provisions designed to further hinder Medicare fraud by: (1) clarifying several provisions of section 1877(b), and (2) increasing the severity of penalties imposed for a section 1877(b) violation.

Since the passage of section 1877(b) in 1972, comparatively few federal

1. Congress Clears Bill to Cut Fraud, Abuse in Medicare, Medicaid, 35 CONG. Q. 2241 (1977) [hereinafter Congress Clears Bill to Cut Fraud].
2. Id. Kickbacks in the Medicare program also took a variety of other forms such as cash, long-term credit arrangements, gifts, supplies and equipment and the furnishing of business machines. See H.R. REP. No. 393(II), 95th Cong., 1st Sess., reprinted in 1977 U.S. CODE CONG. & ADMIN. NEWS 3039, 3049.
3. Congress Clears Bill to Cut Fraud, supra note 1. The Department of Health, Education and Welfare ("HEW") estimated that fraud and abuse in the federal health programs cost the federal government close to $900-million a year.
8. Id.
courts have interpreted its scope. Likewise, even fewer courts have had the opportunity to interpret section 1877(b) since its amendment in 1977. One court which has interpreted this provision, however, is the Third Circuit Court of Appeals in United States v. Greber. In particular, the Greber court was called upon to interpret section 1877(b)(2)(B). Because of the rarity of these post-1977 interpretations, this note will review the Greber decision and its particular interpretation of section 1877(b)(2)(B).

Beginning with an in-depth examination of the legislative history of section 1877(b), this note places particular emphasis on the specific changes that have been made to the act and then proceeds with a summary of the significant facts of the Greber decision. Thereafter, a critical review of the legal reasoning employed by the court of appeals is undertaken. The note concludes its discussion of the Greber opinion by reviewing the possible long-term effects, if any, the ruling of the Third Circuit could have on several other forms of health care relationships distinctive from those present in Greber. The general conclusion reached is that if the payment of fees in a health care arrangement is distributed either upon a flat rate basis for services actually rendered, or in accordance with a prearranged pro rata distribution formula based upon the percentage of an investor's financial contribution, no violation of section 1877(b) would result. However, if fees are distributed according to the number of patients or level of service provided, a section 1877(b) violation justifying the imposition of penalties would exist.

I. HISTORICAL DEVELOPMENT OF SECTION 1877(b)

In 1972, Congress enacted Public Law 92-603, commonly known as the Social Security Amendments of 1972. This comprehensive legislation had numerous objectives which included providing increased health care benefits

---

9. A review of past case law reveals that only two cases considered the scope of section 1877(b) as it was originally enacted. See United States v. Hancock, 604 F.2d 999 (7th Cir.), cert. denied, 444 U.S. 991 (1979); United States v. Porter, 591 F.2d 1048 (5th Cir. 1979).

10. Another case besides United States v. Greber, 760 F.2d 68 (3d Cir.), cert. denied, 106 S. Ct. 396 (1985) has reviewed the meaning and scope of section 1877(b), as amended in 1977. This case, however, provides little support for subsequent review because the court's cursory analysis of the statute was merely dicta since a reversal was granted on other grounds. United States v. Duz-Mor Diagnostic Laboratory, Inc., 650 F.2d 223 (9th Cir. 1981).


12. Id.

13. These conclusions are based on two factors: (1) that the health care arrangements utilize Medicare funds in some manner; and (2) that the health care arrangements do not satisfy the conditions of any section 1877(b) exemptions.

to recipients, and, more relevant to the subject of this note, elimination of health care fraud.\textsuperscript{15} Certain provisions of the 1972 legislation attempted to execute this latter objective by incorporating certain penalties into the Social Security laws.\textsuperscript{16} One of the provisions included in the Act to implement this objective was the Medicare Penalties Provision, section 1877(b).\textsuperscript{17}

As originally enacted, section 1877(b) (codified at 42 U.S.C. § 1395nn(b)) [hereinafter 1877(b)] included provisos which established penalties for practices such as soliciting, offering, or accepting kickbacks or bribes in conjunction with Medicare reimbursed health care services.\textsuperscript{18} Likewise, the newly enacted provision established penalties designed to hinder the practice of providing rebates for patient referrals.\textsuperscript{19}

The legislative history of section 1877(b) indicates that Congress intended to address several problems by its passage.\textsuperscript{20} First, Congress expected that section 1877(b) would curtail certain activities that were considered either unlawful or professionally unethical. In addition, Congress expected that section 1877(b) would hinder practices which were contributing unnecessarily to the high cost of the Medicare program.\textsuperscript{21} As Senate Report 92-1230\textsuperscript{22} states, the purpose of section 1877(b) was to:

Provide penalties for certain practices which have long been regarded by professional organizations as unethical as well as unlawful in some jurisdictions, and which contribute appreciably to the cost of the Medicare and Medicaid programs . . . [including] such

\begin{footnotes}
\item 15. H.R. REP. NO. 231, supra note 5, at 1, \textit{reprinted in} 1972 U.S. CODE CONG. \& ADMIN. NEWS at 4989. Other purposes of this act were to provide improved computation methods, raise the earning base under the OASDI program, improve the operating effectiveness of the maternal and child health programs, and the authorization of a family assistance plan providing basic benefits to low-income families with children with incentives for employment and training to improve the capacity for employment of members of such families.
\item 16. \textit{Id.}
\item 17. Social Security Amendments of 1972, 86 Stat. at 1419 (codified prior to amendment at 42 U.S.C. § 1395ii). Section 1877(b) states:
\begin{itemize}
  \item (b) Whoever furnishes items or services to an individual for which payment is or may be made under this title and who solicits, offers, or receives any —
  \begin{itemize}
    \item (1) Kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or:
    \begin{itemize}
      \item (2) rebate of any fees or charge for referring any such individual to another person for the furnishing of such items or services, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.
    \end{itemize}
  \end{itemize}
\end{itemize}
\item 18. \textit{Id.}
\item 19. \textit{Id.}
\item 21. \textit{Id.}
\item 22. \textit{Id.}
\end{footnotes}
practices as soliciting, offering, or accepting of kickbacks or bribes, including the rebating of a portion of a fee or charge for a patient referral.\textsuperscript{23}

Under the 1972 version of section 1877(b), the penalties imposed for these fraudulent practices were limited to a fine not exceeding $10,000, imprisonment for a maximum of one year, or both.\textsuperscript{24} Conviction under this law was classified as a misdemeanor.\textsuperscript{25}

In the years following the passage of section 1877(b), Congress learned that the provision was deficient in three important ways.\textsuperscript{26} First and foremost, Congress became cognizant of the fact that the penalties imposed by section 1877(b) were ineffective as a deterrent.\textsuperscript{27} Secondly, Congress learned that section 1877(b) was unclear and in need of clarification.\textsuperscript{28} And finally, Congress learned that other federal criminal statutes imposed felony status on activities classified as misdemeanors under section 1877(b).\textsuperscript{29}

In 1975 and 1976, Congress reviewed potential changes to section 1877(b) which would address the existing deficiencies in the law.\textsuperscript{30} But, in each of these legislative sessions, major revisions failed to obtain final approval.\textsuperscript{31} In 1977, however, the various supporters of Medicare reform garnished enough support in Congress to get legislation enacted.\textsuperscript{32} The 1977 amendments included provisions which clarified the language of section 1877(b) and increased the penalties associated with a subsection (B) violation.\textsuperscript{33} Public Law 95-142, the Medicare Antifraud and Abuse Amendments, was the law

\textsuperscript{23} Id.
\textsuperscript{24} H.R. REP. NO. 231, supra note 5, at 93, reprinted in 1972 U.S. CODE CONG. & ADMIN. NEWS at 5093.
\textsuperscript{25} Id.
\textsuperscript{26} H.R. REP. NO. 393(II), supra note 2, at 53, reprinted in 1977 U.S. CODE CONG. & ADMIN. NEWS at 3055.
\textsuperscript{27} Id.
\textsuperscript{28} Id. In particular, many United States Attorneys who were trying to enforce the original version of section 1877(b) in their prosecution of Medicare fraud, let Congress know that the Act was in need of clarification.
\textsuperscript{29} Id.
\textsuperscript{30} Medicare Amendments, 32 CONG. Q. ALMANAC 563 (1976); Medicare Hearings, 31 CONG. Q. ALMANAC 615 (1975).
\textsuperscript{31} The House Ways and Means Health Subcommittee and the Senate Finance Subcommittee on Health reviewed basic changes in the Medicare program during the 1975-1976 session. The two panels held hearings in July and August to review the soaring costs of Medicare and Medicaid resulting from fraud and abuse in these programs. Except for legislation creating an Office of Inspector General in the Department of Health, Education and Welfare to investigate fraud and abuse, no other major changes were made in 1976. Medicare Amendments, supra note 30, at 564.
\textsuperscript{32} Congress Clears Bill to Cut Fraud, supra note 1.
\textsuperscript{33} Id.
to implement these changes. 34

The Medicare Antifraud and Abuse Amendments [hereinafter Antifraud Amendments] increased the penalties of a section 1877(b) violation to a maximum fine of $25,000, imprisonment for up to five years, or both. 35 The Antifraud Amendments also upgraded violations of section 1877(b) from a misdemeanor to felony status. 36 Because these alterations increased the dis-

(b) illegal remunerations
(1) Whoever knowingly and willfully solicits or receives any remuneration including any kick-back, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind
(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this subchapter, or
(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing or ordering any good, facility, service, or item for which payment may be made in whole or in part under this subchapter,
shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kick-back, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person
(A) to refer an individual to a person for the furnishing or arranging of any item or service for which payment may be made in whole or in part under this subchapter, or
(B) to purchase, lease, order or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this subchapter shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to
(A) a discount or other reduction in price obtained by a provider of service or other entity under this subchapter if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this subchapter; and
(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

36. Id. This change in the Medicare Penalties Provisions was a positive step towards deterring Medicare fraud. It brought the penalties provision in line, regarding liability, with other penalty provisions aimed at the same type of activities. And, this alteration created a much stronger deterrent to those who might intend to violate the Act in the future.
incentive for committing illegal activities by increasing the penalties associated with a section 1877(b) violation, they constituted a constructive move towards hindering Medicare fraud.

Another change implemented by the passage of the Antifraud Amendments was the incorporation of the "any remunerations" language into the law. This language, which was defined to encompass "kickbacks, bribes, or rebates which may be made directly or indirectly, overtly or covertly, in cash or in kind," was designed to bring clarity to the prior vague law.

The attempt to clarify the meaning of section 1877(b) through the addition of the "any remuneration" language failed, however, to accomplish its objective because Congress neglected to define the meaning of several important terms: namely, kickbacks, bribes, and rebates. This omission was significant because these terms are not susceptible to unanimous definition.

The final change implemented by the Antifraud Amendments was the codification of two specific section 1877(b) liability exemptions. These exemptions, like the superfetation of the "any remuneration" language discussed previously, were designed to clarify what types of practices were violations of section 1877(b). The first of these exemptions applied to specific business arrangements between employers and employees. Under this exemption, any amount paid by an employer to his employee in conjunction with a bona fide employment relationship was excluded from section 1877(b) liability. In addition, the Antifraud Amendments excluded from section 1877(b) liability the practice of granting price reductions or price discounts.

38. Id.
40. See generally id.
41. Id. See also Social Security Amendments of 1972, 86 Stat. at 1419 (codified prior to amendment at 42 U.S.C. § 1395ii).
42. As a review of past case law reveals, the terms kickback, rebate, and bribe have been defined in many different ways by the courts. For different uses of the term bribe, see generally United States v. Walsh, 700 F.2d 846, 854 (2d Cir. 1983); United States v. Tapert, 625 F.2d 111, 121 (6th Cir. 1980); United States v. Sisk, 476 F. Supp. 1061, 1062 (M.D. Tenn. 1979). For various definitions of the term kickback employed by the courts, see generally United States v. Hancock, 604 F.2d 999, 1002 (7th Cir. 1979); United States v. Porter, 591 F.2d 1048, 1054 (5th Cir. 1979); Boehm v. United States, 123 F.2d 791, 812 (8th Cir. 1941); United States v. Weingarden, 468 F. Supp. 410, 412 (E.D. Mich. 1979). For various definitions given the term rebate, see generally Hanna Furnace Corp. v. United States, 53 F. Supp. 341, 343 (W.D.N.Y. 1943); Clark v. Page Oil Co., 38 F. Supp. 384, 385 (W.D. Pa. 1941).
44. See generally id.
45. Id.
46. Id.
when such activities were properly disclosed and reflected in the costs claimed or charges made by the provider of Medicare services.\textsuperscript{47}

Since the passage of the 1977 Antifraud Amendments Congress has altered section 1877(b) one additional time.\textsuperscript{48} In 1980, Congress passed Public Law 96-499 which made a small but critically important change in the language of the Act.\textsuperscript{49} The 1980 amendment called for insertion of the "knowingly and willfully" language following "whoever" in subsection (B), part (1) and (2) of the law.\textsuperscript{50} This change imposed for the first time a burden upon the government to establish that a section 1877(b) violation was committed with specific criminal intent.\textsuperscript{51} This version of section 1877(b), reflecting the 1980 amendment, was presented to the Greber court for interpretation.

II. THE COURT OF APPEALS DECISION IN \textit{UNITED STATES v. GREBER}

\textbf{A. Factual Background}

The case of \textit{United States v. Greber,}\textsuperscript{52} as heard on appeal before the Third Circuit, arose from the conviction of Dr. Alvin Greber in the Unites States District Court for the Eastern District of Pennsylvania for violations of section 1877(b)(2)(B).\textsuperscript{53} The defendant was an osteopathic physician, board

\textsuperscript{47} Id. The committee noted in the legislative history that it included an exemption for the practice of discounting or other reductions in price from the range of financial transactions to be considered illegal under Medicare and Medicaid because it wanted to ensure that the practice of discounting in the normal course of business transactions would not be deemed illegal. In fact, the committee noted that it wanted to encourage providers to seek discounts which would result in savings to Medicare and Medicaid program costs.

\textsuperscript{48} 42 U.S.C. § 1395nn(b) (1983).

\textsuperscript{49} See generally id.

\textsuperscript{50} Id.

\textsuperscript{51} H.R. 1167, 96th Cong., 2d Sess. (1980). The purpose of the 1980 amendment was reflected in the committee recommendation to the House of Representatives which stated that "the committee is concerned that criminal penalties may be imposed under current law to an individual whose conduct, while improper, was inadvertent. Accordingly, the section clarifies current law to assure that only persons who knowingly and willfully engage in the prescribed conduct could be subject to criminal sanctions." The Committee on Interstate and Foreign Commerce submitted this recommendation to the House of Representatives pursuant to the passage of the Omnibus Reconciliation Act, a taxing act having an affect on the Medicare/Medicaid programs.

\textsuperscript{52} 760 F.2d 68 (3d Cir. 1985).

\textsuperscript{53} Id. at 70. Dr. Greber was also convicted of mail fraud on the grounds that he caused Cardio-Med to bill Medicare for monitorings which were medically unnecessary. These mail fraud charges also arose from Greber's alleged use of the mail to bill for hospital visits he never made. Greber was also charged with violations of 18 U.S.C. § 1001 (1982) (the false statement statute) for allegedly submitting claim forms representing that the Holter Monitors had been operating for eight hours or more when in fact they were not. Medicare required at least 9 hours of operation to qualify for reimbursement.
certified in internal medicine and cardiology. Furthermore, he was a staff member of the Albert Einstein Cardiology Department, held an assistant professorship at the Philadelphia College of Osteopathic Medicine, and was the president and part-owner of Cardio-Med, Inc., a medical laboratory facility which he formed. It was from his position as chief-executive of Cardio-Med that the charges against Dr. Greber under section 1877(b)(2)(B) stemmed.

Evidence admitted at trial indicated that Cardio-Med, under Dr. Greber's management and direction had been engaged in the practice of billing Medicare for Holter Monitoring services, and when payment was received, of forwarding a portion of that fee to the physician who had referred the patient to Cardio-Med for services. Evidence produced at trial further demonstrated that the fee paid to the referring physicians averaged forty-percent of the Medicare payment which Cardio-Med had received.

Dr. Greber contested the allegations made by the prosecution and insisted that the payments made by Cardio-Med to referring physicians were "consultation fees" or "interpretation fees" for services rendered to the patients. He argued further that he was advised by the Pennsylvania Medical Society Board of Censors in Philadelphia that the payment of referral fees was not prohibited if the physician to whom the

---

54. Id. at 69.
55. Brief for Appellant at 5, United States v. Greber, 760 F.2d 68 (3d Cir. 1985) [hereinafter Appellant Brief]. Cardio-Med was a corporation formed for the purpose of engaging in the business of transtelephonic pacemaker analysis. This procedure involves ascertaining the effectiveness of the pacemaker device via a telephone hook-up with a machine located in the offices of Cardio-Med. The principle purpose of transtelephonic pacemaker analysis is to ascertain when replacement batteries are needed lest the pacemaker fail to operate.
56. Greber, 760 F.2d at 70.
57. A Holter Monitor is a device worn for approximately twenty-four hours by a patient. During this time the monitor records all of the cardiac activity of the patient on a cassette tape. This tape is then scanned by a computer which is operated by a cardiac technician in order to ascertain important cardiac activity occurring during the patient's normal activity. See Appellant Brief, supra note 55.
58. Greber, 760 F.2d at 70.
59. Id.
60. Id. See also Appellant Brief, supra note 55, at 6-7, which recites testimony given by Frank Lowell, an employee of Cardio-Med who supplied technical assistance for Dr. Greber. This testimony reveals how Cardio-Med received its income from Medicare and in turn paid referring physicians. Lowell testified that Cardio-Med engaged in two methods of billing, one of which was to bill simultaneously on behalf of both itself and the referring physicians. A bill submitted by Cardio-Med consisted of a recording fee, a scanning fee, and an interpretation fee. Upon payment by Medicare, Cardio-Med would deduct its fee for services rendered, which included: installing the monitor, reading and interpreting initial findings, and delivering the results to the individual physicians. The referring physicians fee was in turn paid to that doctor.
payment was made shared responsibilities for the diagnostic report.\textsuperscript{61}

At trial, the prosecution introduced evidence which demonstrated that payments made by Cardio-Med were not, as Dr. Greber claimed, legitimate consultation fees for interpreting Holter Monitor results.\textsuperscript{62} The evidence showed instead, that in many instances a physician ordering Holter Monitoring services received the "interpretation fees" even when Greber himself performed the interpretation services.\textsuperscript{63} In addition, the government evidence showed that Cardio-Med exercised no control over the physicians who ordered tests and in many instances received no products from them.\textsuperscript{64} The prosecution's evidence demonstrated further that the Medical Society never advised Cardio-Med that referral fees were legitimate if paid to a physician for shared diagnostic interpretation services.\textsuperscript{65} Rather, the evidence demonstrated that the Medical Society actually advised Cardio-Med that two separate bills should be submitted to Medicare for Holter Monitoring services, one for the physician's interpretation services and another for the technical work performed by Cardio-Med.\textsuperscript{66} Based primarily upon these evidentiary findings, Dr. Greber was convicted by the trial court of section 1877(b)(2)(B) violations. Dr. Greber appealed this conviction to the Third Circuit asserting six claims of defense.\textsuperscript{67} Only those arguments pressed most strongly by the defendant are discussed herein.

One of the primary arguments asserted by Dr. Greber on appeal was the claim that the evidence produced at trial was insufficient to warrant a con-

\begin{itemize}
\item \textsuperscript{61} Greber, 760 F.2d at 70.
\item \textsuperscript{62} Id.
\item \textsuperscript{63} Id.
\item \textsuperscript{64} Appellant Brief, supra note 55, at 6-7.
\item \textsuperscript{65} Greber, 760 F.2d at 70.
\item \textsuperscript{66} Id.
\item \textsuperscript{67} Appellant Brief, supra note 55, at Table of Contents. The six arguments raised by the appellant as justification for a reversal of his conviction were:
\begin{enumerate}
\item The evidence was insufficient to warrant a conviction under 42 U.S.C. § 1395nn(b)(2)(B).
\item The trial court erred in instructing the jury to disregard evidence establishing alternative purposes for the fees alleged in counts 18 through 23.
\item The trial court erred in failing to instruct the jury as to the defense theory requested by the defendant.
\item The trial court erred in failing to conduct a hearing concerning the off-the-record communications between government rebuttal witnesses and the jury.
\item The trial court erred in failing to conduct a hearing for the purpose of gathering facts surrounding the government's ex parte communications with a potential defense witness.
\item The cumulative effect of the trial court's errors as set forth in arguments 1-5 above, requires a reversal of all convictions and the grant of a new trial as to this entire indictment.
\end{enumerate}
\end{itemize}
viction under section 1877(b)(2)(B). In this regard, Dr. Greber argued that the government failed to present any evidence to contradict the claim that the fees paid by Cardio-Med were either earned or intended to be earned by the physicians involved. Dr. Greber further contended that the trial judge improperly instructed the jury regarding the necessary elements of a section 1877(b)(2)(B) violation. The instruction disputed by Dr. Greber stated that, “even if the physician interpreting the test does so as a consultant to Cardio-Med, that fact was immaterial if a purpose of the fee was to induce the ordering of services, from Cardio-Med” (emphasis added). According to Greber, compensation paid to a physician for professional services rendered could violate section 1877(b)(2)(B) only by a showing that the payment was designed solely to induce future service orders.

B. The Appeals Court Decision

The Third Circuit upheld the conviction of Dr. Greber on all counts, finding initially that the trial court had sufficient evidence to conclude that Medicare fraud had been proven. However, the court failed to disclose which evidence it deemed sufficient to prove fraud on the part of Dr. Greber.

68. Greber, 760 F.2d at 70.
69. Appellant Brief, supra note 55, at 18-19. According to Greber, such proof needed to be introduced because, as a matter of law, no criminal intent can exist where one person pays another an amount of money which they legitimately earned by performing appropriate and necessary services.
70. Greber, 760 F.2d at 70.
71. Id. at 69; see also Appellant Brief, supra note 55, at 24. Here, Greber argued that this particular jury instruction as well as several others made by the trial judge were critically defective. One of the other jury instructions Greber contested was one where the judge instructed the jury that any other purpose of the payments to referring physicians would be “immaterial.” Likewise, he contested an instruction made at two points by the judge which said that the government had to prove that “the purpose” of the payment was inducement, but if the government proved “that purpose,” the “other purposes” of the fee would be irrelevant.
72. Greber, 760 F.2d at 70.
73. Id.
74. Id. at 72.
75. See generally id. at 68. The evidence that must have prompted the appeals court to rule that the record adequately supported a guilty verdict included some or perhaps all of the following factors:

1) Evidence that the physician received “interpretation fees” even though the defendant had actually evaluated the data himself.
2) The testimony made by Dr. Greber in an earlier proceeding which stated that “if the doctor didn’t get his consulting fee, he wouldn’t be using our service . . . . So the doctors got a consulting fee.”
3) The testimony of Frank Lowell, an employee of Greber’s, which demonstrated that the Board of Censors of the Philadelphia County Medical Society never condoned or validated Greber’s billing practices. See text accompanying note 60.
In upholding the Greber conviction, the appellate court also concluded that the trial judge had correctly instructed the jury when he directed that: "if one purpose of the payment was to induce future referrals, the Medicare statute has been violated."\textsuperscript{76} In reaching this conclusion, the appellate court relied upon three justifications.\textsuperscript{77} First, the court found support in the alleged purposes of section 1877(b)(2)(B).\textsuperscript{78} According to the Greber court, the legislative history demonstrated that Congress had two objectives in passing section 1877(b)(2)(B): (1) an intent to eradicate the practice of physicians choosing a laboratory based on the size of kickbacks received\textsuperscript{79} and (2) an intent to "combat financial incentives [paid to] physicians for ordering particular services patients did not require."\textsuperscript{80} In support of these propositions, the Third Circuit cited testimony given before a congressional committee which had reviewed the proposed revisions to the Medicare Penalties Provisions.\textsuperscript{81} The committee testimony stated that: "Physicians often determine which laboratories would do the test work for their medicaid patients by the amounts of kickbacks and rebates offered by the laboratory . . . . Kickbacks take a number of forms including cash, long term credit arrangements, gifts, supplies and equipment and the furnishing of business machines."\textsuperscript{82}

Relying on these purposes, the Greber court apparently reasoned that even if a physician performs some services for the financial incentives received, the potential for Medicare fraud still exists because doctors could continue to: (1) choose a laboratory based on the amount of kickbacks received and (2) continue to provide unnecessary services.\textsuperscript{83} Consequently, the Greber court concluded that any payments made to physicians, even if the payments were also intended to compensate the doctor for professional services, violated section 1877(b)(2)(B).\textsuperscript{84}

The Third Circuit found additional support for upholding the instruction in the language of section 1877(b)(2)(B) in particular, in the "any remuneration" language added to the penalties provision in 1977.\textsuperscript{85} The appellate
court derived support from this language by utilizing the following chain of reasoning: first, the court noted that under ordinary circumstances the word "remunerate" means "to pay an equivalent for services." The court next noted that in the context of section 1877(b)(2)(B) the "remunerates" language had been written to include items such as kickbacks and bribes. Next, the court reasoned that by including such items as kickbacks and bribes, the statute had expanded the meaning of "remunerates" to cover situations where no service was performed and concluded accordingly that the "any remuneration" language expands section 1877(b)(2)(B) to include "not only sums for which no actual service was performed, but also those amounts for which some professional time was expended."

Lastly, the appellate court relied upon case law interpreting section 1877(b)(2)(B) and its sister statute, section 1909(b)(2)(B) to affirm the Greber conviction. Specifically, the court relied upon three cases for support: United States v. Hancock (a case in which a chiropractor was indicted for receiving kickbacks for referring blood and tissue specimens to a laboratory following the court's finding that "kickback" meant "a percentage payment . . . for granting assistance by one in a position to open up or control a source of income"); United States v. Tapert (a decision in which five osteopathic physicians were convicted of receiving kickbacks for the transmittal of certain blood and urine samples to a laboratory following a Sixth Circuit finding that "kickback" was correctly defined by the Seventh Circuit in Hancock); and United States v. Duz-Mor Diagnostic Laboratory (a case in which the defendants were indicted and charged with offering to pay remuneration as an inducement for the referral of medical services). According to the Greber court, this line of cases supported the trial court in

---

86. Id. The Greber court took its definition of "remunerate" from WEBSTERS THIRD NEW INTERNATIONAL DICTIONARY (1966).
87. Id. See also supra note 85 and accompanying text.
88. Greber, 760 F.2d at 70.
89. Id. The Greber court also stated more specifically in its opinion that "by adding 'remuneration' to the statute in the 1977 amendment, Congress sought to make it clear that even if the transaction was not considered to be a 'kickback' for which no service had been rendered payment nevertheless violated the act." Id. at 72.
90. Greber, 760 F.2d at 71-72. The appeals court relied on case law utilizing both § 1877(b) and § 1909(b) (the Medicaid Penalties Provisions) because the operative language of each statute is identical. Compare 42 U.S.C. § 1396(b) with 42 U.S.C. § 1395nn(b).
91. 604 F.2d 999 (7th Cir.), cert. denied, Hancock v. United States, 444 U.S. 999 (1979).
93. 650 F.2d 233 (9th Cir. 1981).
struction\textsuperscript{94} because these cases demonstrated that courts have interpreted section 1877(b) or 1909(b) even without the "any remuneration" language to encompass situations where some actual service was performed in conjunction with the "kickback" payment.\textsuperscript{95}

Not all courts interpreting the pre-1977 version of section 1877(b) agreed with the expansive construction given this statute by the Hancock line of decisions. The Fifth Circuit, in United States v. Porter,\textsuperscript{96} employed a more restrictive interpretation of the Medicare Penalties Provisions. In Porter, the court reversed the conviction of two physicians and one laboratory operator who had been indicted for offering or receiving kickbacks or bribes in connection with furnishing Medicare services.\textsuperscript{97} The court based this conclusion on a finding that the term "kickback" meant "the secret return to an earlier possessor of part of a sum received."\textsuperscript{98} Consequently, the court stated that "once the labs lawfully received a lawful fee — there was no outstanding restriction on what the lab could do with the money."\textsuperscript{99} Apparently, the appellate court reasoned that once the laboratory received the funds from Medicare, payments by the lab to others would be "corrupt" only if paid to a government official or agent.\textsuperscript{100}

The Greber court rightly rejected the interpretation given section 1877(b) by Porter and correctly utilized the Hancock line of decisions in finding support for its conclusion that the trial judge properly instructed the jury when he stated that a section 1877(b) violation could exist "if the physician interpreting the test did so as a consultant . . . that fact was immaterial if a purpose of the fee was to induce the ordering of services . . . ."\textsuperscript{101} This conclusion is based on a review of the case law interpreting the term "kickback" in both similar and diverse contexts. The doctrine correctly consulted in this situation was that of United States v. Steward\textsuperscript{102} which states that if a

\textsuperscript{94} Greber, 760 F.2d at 72.
\textsuperscript{95} See generally id. at 71-72.
\textsuperscript{96} 591 F.2d 1048 (5th Cir. 1979). The Porter decision was in fact the first decision to interpret section 1877(b).
\textsuperscript{97} Id. at 1050.
\textsuperscript{98} Id. at 1054.
\textsuperscript{99} Id.
\textsuperscript{100} Id.
\textsuperscript{101} Greber, 760 F.2d at 71.
\textsuperscript{102} 311 U.S. 60, 63 (1940). Other cases following the doctrine promulgated by the Supreme Court in Steward include NLRB v. Amax Coal Co., 453 U.S. 322 (1981); Perrin v. United States, 444 U.S. 37 (1975) (a fundamental cannon of statutory construction is that unless otherwise defined, words will be interpreted as taking its ordinary, contemporary, common meaning); Banks v. Chicago Grain Trimmers Ass'n, 390 U.S. 459 (1968) (in the absence of persuasive reasons to the contrary, the Supreme Court attributes to the words of a statute its ordinary meaning); Malat v. Riddell, 383 U.S. 569 (1966); Inner City Broadcasting Corp. v.
statute does not define the terms, it must be assumed that Congress intended the words to be used as commonly or ordinarily understood.  

The weight of case law tends to support a broader definition of the term "kickback," i.e., one that encompasses more than merely "a return of part of a sum received . . . ," as contended by the Porter court. For example, in United States v. Engle, the Eighth Circuit concluded that a vending company which received permission to install cigarette machines in a restaurant chain, following the payment of clandestine payments to the chain president, had paid "kickbacks." Likewise, in ITT Community Development Corp. v. Barton, a chief engineer was found to have taken "kickbacks" when he received compensation from the party to whom he had granted an ITT construction contract. A final example, which demonstrates that courts have typically defined "kickbacks" in a fashion consistent with the definition utilized in Greber, is the Sixth Circuit decision in United States v. Foster. In Foster, the court concluded that the term "kickback" encompassed situations where borrowers of bank loans made payments from the loan proceeds to bank officers authorized to make such loans. Thus, relying on the prior case law, the statutory language, and congressional intent behind section 1877(b), it appears that the Greber court correctly concluded that section 1877(b)(2)(B) could be violated "if the payments were intended to induce the physicians to use Cardio-Med's services . . . even if the payments were also intended to compensate for professional services."

III. THE POSSIBLE IMPACT OF UNITED STATES V. GREBER UPON THE FUTURE OF HEALTH CARE RELATIONSHIPS

What impact will the decision in United States v. Greber have upon health care business relationships in the future? Is it likely that the decision will cause a dramatic increase in the number of investigations and prosecutions taking place under section 1877(b)(2)(B)? Or, is it more likely that the

Sanders, 733 F.2d 154 (D.C. Cir. 1984); Railroad Yardmasters of Am. v. Harris, 721 F.2d 1332 (D.C. Cir. 1983); March v. United States, 506 F.2d 1306 (D.C. Cir. 1974).
103. Steward, 311 U.S. 60.
104. United States v. Porter, 591 F.2d 1048, 1054 (5th Cir. 1979).
105. Id.
106. 458 F.2d 1017 (8th Cir. 1972).
107. Id. at 1020.
108. 569 F.2d 1351 (5th Cir. 1978).
109. Id. at 1353.
110. 566 F.2d 1045 (6th Cir. 1977).
111. Id. at 1050.
112. Greber, 760 F.2d at 70.
113. 760 F.2d 68 (3d Cir. 1985).
**Greber** decision will have only limited impact, being circumscribed to factual situations similar to or identical to that in **Greber**? At the time of this publication, no definitive answers are available; only mere speculation regarding the impact of **Greber** can be undertaken. The final segment of this note undertakes such speculation. This supposition proceeds with an analysis of the possible impact of **Greber**, if any, upon a cross-section of health care business relationships.114

### A. Cooperative Ventures Between Doctors That Form An Independent Laboratory Facility

In these types of arrangements, a group of physicians either in sole or small medical practices, form a corporation or cooperative to establish a duly-authorized laboratory which performs tests at their request.115 Often the impetus for such joint ventures is the fact that physicians wish to provide laboratory services for their patients while at the same time avoiding the prohibitive costs of purchasing the laboratory equipment individually.116 These types of health care arrangements may employ a variety of different billing practices.117 For example, the cooperative may bill the patient directly for the lab test it performs.118 Alternatively, the cooperative may adopt a billing process by which it charges the physicians in accordance with established Medicare procedures, and the physicians, in turn, bill the patients for the lab services.119

These types of physician cooperatives may also employ alternative methods for distributing dividends at the end of each year.120 In certain instances, for example, cooperatives may distribute dividends to the participating physicians according to the number of tests each physician had requested during the course of the year.121 In other instances, however, such dividend distributions are made on a *pro rata* basis according to the interest which each doctor has in the cooperative.122

In view of the **Greber** decision, it appears that a physicians' cooperative

---

114. This segment of the note does not attempt to review **Greber**'s possible impact on all types of health care arrangements but rather, merely reviews a representational cross-section.


116. Id. at 1.

117. Id.

118. Id.

119. Id.

120. Id.

121. Id.

122. Id.
which has a year-end dividend distribution based upon the number of referrals each participating doctor has made could be found to violate section 1877(b). By paying dividends in this manner, the amount of income a physician receives from the laboratory is directly related to the number of tests he refers to the lab. Thus, the physician has a direct incentive to order an excessive number of laboratory tests which in turn increases the possibility of unnecessary drain on the Medicare program. Since the Greber court observed that section 1877(b), as construed, was intended to prevent such unnecessary drain, this would appear to be the very type of health care arrangement the statute was intended to address.

If a physicians' cooperative based its year-end dividend distribution on a pro rata basis, according to the percentage interest each physician owned in the joint endeavour, it is arguable that a violation of section 1877(b), even as construed by Greber, would not be found. This assumption is based upon a belief that the following conditions place this arrangement beyond the scope of section 1877(b): (1) the fact that the distribution of dividends is based on a prearranged distribution formula rather than a per-referral basis; (2) the fact that the parties involved in this transaction accept all the financial risks associated with this business venture; and (3) the fact that an argument can be made that an individual cannot be said to be receiving payments in exchange for referrals to another, as is required under section 1877(b), when that individual is essentially referring patients to himself as a joint venturer.123

B. Inducements Offered to Physicians to Practice in Hospitals

These types of arrangements can arise in a variety of different factual contexts and can involve significant variations in the types of incentives employed.124 For example, in one instance it might be found that an inner-city hospital was offering physicians free office space, paid clerical staff, or some type of guaranteed income arrangement.125 Contrariwise, it might be found that a rural hospital was offering incentives to physicians which consisted of free housing, cash or cars.126 Although these factual situations differ substantially, each has one common denominator — the purpose for which the

124. Department of Health and Human Services Contact Report, Inducements Offered to Physicians to Practice in Hospitals — Possible Conflict with Illegal Remunerations Provisions of Public Law 95-142 (July 12, 1979) (available through the editorial offices of the J. CONTEMP. HEALTH L. & POL'Y, Catholic University, Columbus School of Law, Washington, D.C. 20064).
125. Id. at 1.
126. Id.
incentives are offered. In these examples, as in many similar arrangements, a hospital offers some form of incentive, typically to recent medical school graduates, in an effort to acquire needed physicians for their staff.\(^{127}\)

Whether these types of inducement arrangements violate section 1877(b), as interpreted by *Greber*, depends significantly upon whether the incentive programs condition compensation to the physician upon either the number of patients the physician refers to the contracting facility, or the number of services the hospital provides to the physician’s patients.\(^{128}\) If such a connection exists, it is likely that the arrangement would violate section 1877(b). This conclusion is based on the fact that if the inducement paid to the doctor is conditioned upon one of the above stipulated qualifications, the physician would have a direct incentive to make excessive referrals, to order services superfluously, or to overtreat patients. This in turn would increase the possibility of unnecessary drain on the Medicare program. Since the *Greber* court indicated that section 1877(b) was designed to eradicate this type of unnecessary drain,\(^{129}\) it appears analytically correct to conclude that such a health care relationship would violate the act.

**C. Joint Ventures Between Hospitals and Durable Medical Equipment Suppliers or Home Health Agencies**

This type of arrangement may involve an agreement between either a durable medical equipment supplier ("DME") or a home health agency ("HHA") and a hospital to establish a partnership for the purpose of forming a new DME supplier organization.\(^{130}\) This new entity, which generally has the objective of ensuring the continuity of health care, will provide necessary DME services to patients who have been discharged from the hospital.\(^{131}\) In these types of arrangements, each party may make either a capital contribution to the joint venture or merely perform services in furtherance of its operation, or both.\(^{132}\) Likewise, these types of partnership agreements will usually distribute any net profits derived from the operation according to a prearranged formula, which will often coincide with the proportional contribution that each party made to the capital structure of the newly formed DME entity.\(^{133}\) These types of health care business relationships are

\(^{127}\) *Id.*

\(^{128}\) *Id.* at 2.

\(^{129}\) United States v. Greber, 760 F.2d 68, 71 (3d Cir. 1985).

\(^{130}\) Telephone interview with Kevin Barry, Attorney at Law, Pierson, Ball & Dowd (May 1986) [hereinafter Barry interview].

\(^{131}\) *Id.*

\(^{132}\) *Id.*

\(^{133}\) *Id.*
arguably beyond the scope of section 1877(b) criminal liability, even as construed by the court in *United States v. Greber.*

D. Contractual Arrangements Between DME Suppliers and Respiratory Therapists

These types of health care arrangements generally involve a situation in which a DME supplier establishes a contractual agreement with an independent respiratory therapist who is on the staff of a locally run hospital. The therapist will be paid by the DME supplier to provide equipment-related services to patients who were previously treated by that therapist during their stay at the hospital. The therapist would receive payments based on the actual amount of services rendered on behalf of the DME supplier. In some instances, however, the compensation paid to the therapist may be made pursuant to a *bona fide* employment relationship that has been established between the DME supplier and the therapist.

In an arrangement made between a DME supplier and a respiratory therapist based upon a *bona fide* business relationship, no question as to the presence of a section 1877(b) violation really exists. If a health care relationship is found to be truly *bona fide* in nature, there is a clear exemption under the law. In a situation where the DME supplier pays a respiratory therapist based on the actual amount of service rendered, however, a possible section 1877(b) violation may exist because under these conditions it can be argued that one element, albeit not an exclusive or even a primary element, is to promote the enhancement of future referrals.

E. Applicability of Section 1877(b) to Pathologist Payment Arrangements

These arrangements normally arise between a pathologist and a hospital. Generally, the pathologist agrees to perform professional services for

---

134. 760 F.2d 68 (3d Cir. 1985). For the argument in support of this conclusion, review the earlier discussion regarding the validity of cooperative ventures between doctors and independent laboratory facilities, *supra* section III(A) and accompanying footnotes.


136. *Id.*

137. *Id.*

138. *Id.*

139. As section 1877(b)(3)(B) states, paragraphs (1) and (2) shall not apply to any amount paid by an employer to an employee (who has a *bona fide* employment relationship with such employer) for employment in the provision of covered items or services. *Supra* note 34.

140. And as the court in *Greber* concluded, if one purpose of the payment was to induce future referrals, the Medicare statute has been violated. 760 F.2d at 69.

141. Department of Health and Human Services Contact Report, Questions on Applicability of Illegal Remunerations Provisions to Pathologist Payment Arrangements (Sept. 9, 1980)
the hospital, using hospital equipment.\textsuperscript{142} The pathologist is usually compensated for his services according to a percentage of the total intake the hospital receives for pathological services.\textsuperscript{143} One final characteristic of these arrangements is that the pathologist is generally not in a position to control which patients are referred to him for his services — usually another physician orders the lab test or other services that are performed.\textsuperscript{144}

Even in view of the \textit{Greber} court's interpretation of section 1877(b), it is unlikely that these types of health care relationships would be subject to criminal liability under section 1877(b) because the pathologist has no control over which patients receive his services. Consequently, it appears unreasonable to conclude that the statutory prerequisites, for example, the requirement that a payment be made either for the referral of patients or as an inducement for the referral of patients, are present. It is more likely in this factual context that the percentage payments made by the hospital to the pathologist constitute merely payments for professional services rendered.

\section*{IV. Conclusion}

In view of the legislative history of section 1877(b), both in its original and amended forms, and in view of the prior case law interpreting the scope of this statute, it is apparent that the \textit{Greber} court came to a proper conclusion when it upheld the interpretation of section 1877(b)(2)(B) given by the trial judge. What is not as clear, however, at the time of this publication, is the question of how far-reaching the \textit{Greber} decision will be. Only with time will it become clear whether the Third Circuit will employ its interpretation in other factual situations involving section 1877(b), or limit its application to factual situations identical to that in \textit{Greber}. Likewise, only with time will it be learned whether other circuits will adopt the interpretations given to section 1877(b) by the \textit{Greber} court. If the more expansive \textit{Greber} construction is upheld in the future, however, it appears likely that if a health care relationship distributes fees upon either a flat rate basis or in accordance with a prearranged \textit{pro rata} distribution formula based upon the percentage of financial contribution by the investor, no violation of section 1877(b) will be found. If, however, the payment of fees in the health care arrangement is distributed according to the number of patients or level of service that is

\begin{flushleft}
\footnotesize
(available through the editorial offices of the \textit{J. CONTEMP. HEALTH L. & POL’Y}, Catholic University, Columbus School of Law, Washington, D.C. 20064).
\end{flushleft}

\begin{flushleft}
\footnotesize
\textsuperscript{142. Id. at 1.}
\textsuperscript{143. Id.}
\textsuperscript{144. Id.}
\end{flushleft}
provided, a violation of section 1877(b) as interpreted by Greber will likely exist.

James P. Prenetta, Jr.