

**IN THE  
UNITED STATES COURT OF APPEALS  
FOR THE SEVENTH CIRCUIT**

**NOS. 02-4222 and 02-4224**

UNITED STATES OF AMERICA, ) Appeal from the  
) United States District Court  
Plaintiff-Appellee, ) Central District of Illinois  
) At Springfield  
v. )

) No. 00-CR-30021

ROBERT T. MITRIONE and )  
MARLA A DEVORE, )

) Honorable Jeanne E. Scott  
Defendants-Appellants. ) United States District Judge

**BRIEF OF PLAINTIFF-APPELLEE**

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**JURISDICTIONAL STATEMENT**

The jurisdictional summaries in defendants' briefs are not complete and correct.

The district court had jurisdiction pursuant to 18 U.S.C. § 3231, which provides exclusive jurisdiction for offenses against the United States. Defendants were charged with conspiracy to defraud the United States, in violation of 18 U.S.C. § 371; mail fraud, in violation of 18 U.S.C. § 1341; filing false claims, in violation of 18 U.S.C. § 287; and health care fraud, in violation of 18 U.S.C. § 1347.

Defendants filed a joint motion for new trial based on newly-discovered evidence. Following a hearing, the district court allowed the motion as to Mitrione on Counts 1-6, 9-11 and 15, and as to DeVore on Counts 1, 3-5, 9-11 and 15. The convictions on those counts were vacated. The district court denied the motion as to both defendants on Counts 12 and 14.

The district court sentenced defendants on October 31, 2002, and entered its judgments on November 25, 2002.

Defendants Mitrione and DeVore filed timely notices of appeal on December 3, 2002, and December 4, 2002, respectively. This Court has appellate jurisdiction pursuant to 28 U.S.C. § 1291 and 18 U.S.C. § 3742(a)(1) and (2).

The transcripts of the trial are contained in several volumes, numbered sequentially. References to these transcripts are to "Tr:\_\_\_"; references to the transcript of the 8/9/01 telephonic pretrial conference are to "PretrialTr:\_\_\_"; references to the transcript of the hearing on the motion for new trial are to "NewTrialTr:\_\_\_"; references to the transcript of the court's ruling on the motion for new trial are to "RulingTr:\_\_\_"; references to the transcript of the sentencing hearing are to "SentTr:\_\_\_"; references to the government's exhibits at trial are to "Ex:\_\_\_"; references to the government's exhibits at sentencing are to "Ex:S\_\_\_"; references to the documents in the record are to the docket number on the district court's docket sheet, e.g., "R:\_\_\_"; references to Mitrione's Brief are to "MitrioneBr:\_\_\_"; references to DeVore's Brief are to "DeVoreBr:\_\_\_".

Count 13 was dismissed by the government. Counts 14 and 15 were renumbered as Counts 13 and 14 respectively, prior to submitting the verdict forms and indictment to the jury. (docket entry 9/13/01;PretrialTr:4)

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### **STATEMENT OF THE CASE 1**

This is a direct consolidated appeal of criminal convictions and sentences. The course of proceedings and the dispositions were as follows.

On April 7, 2000, defendants were charged in a 15-count indictment<sup>2</sup> with one count of conspiracy to defraud the United States, in violation of 18 U.S.C. § 371 (Count 1); eight counts of mail fraud, in violation of 18 U.S.C. § 1341 (Counts 2-3, 5, 7, and 10-13); five counts of filing false claims, in violation of 18 U.S.C. § 287 (Counts 4, 6, 8-9 and 14); and one count of health care fraud, in violation of 18 U.S.C. §§ 1347 and 2 (Count 15). (R:1) On April 27, 2000, defendants pleaded not guilty to the charges in the indictment. (docket entry 4/27/00)

On May 4, 2001, defendants filed a motion to dismiss the indictments, which the district court denied on July 6, 2001. (R:55,R:61)

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On September 13, 2001, following a jury trial, Mitrione was convicted of Counts 1-6, 9-12, and 14 (renumbered as Count 13), and acquitted on Counts 7 and 8. (docket entry 9/13/01;R:132) DeVore was convicted on Counts 1, 3-5, 9-12 and 14 (renumbered as Count 13), and acquitted on Counts 2 and 6-8. (docket entry 9/13/01;R:133)

On September 27, 2001, defendants filed motions for judgments of acquittal or for a new trial (R:146,R:147), which the district court denied on November 21, 2001. (R:149)

On April 10, 2002, defendants filed a joint motion for new trial based on newly discovered evidence. (R:165) On August 23, 2002, the district court denied the motion on Counts 12 and 14, and granted the motion on the remaining counts. (RulingTr:20)

On October 31, 2002, the district court sentenced Mitrione to 23 months imprisonment on each of Counts 12 and 14, to run concurrently; three years supervised release; restitution in the amount of \$11,255.65; and a \$200 special assessment. (docket entry 10/31/02;SentTr:190;R:236) The district court sentenced DeVore to 15 months imprisonment on each of Counts 12 and 14, to run concurrently; three years supervised release; restitution in the amount of \$11,255.65; and a \$200 special assessment. (docket entry 10/31/02;SentTr:188; R:234) The district court entered its judgments on November 25, 2002.

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(R:234,R:236)

Mitrione and DeVore filed timely notices of appeal on December 3, 2002 (R:248), and December 4, 2002 (R:251), respectively.

Mitrione and DeVore filed motions for release on bond pending appeal on December 3, 2002 (R:249), and on December 9, 2002 (R:254), respectively. On December 23, 2002, the district court granted defendants' motions. (R:263) On April 1, 2003, the government filed a motion to strike defendants' briefs as duplicative, in violation of this Court's December 16, 2002, Order. This Court denied the motion on April 10, 2003.

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#### **ISSUES PRESENTED FOR REVIEW**

- I. Whether the district court properly denied defendants' motion to dismiss the indictment because their conduct violated federal law.
- II. Whether the prosecutor, who delivered his closing argument one day after the September 11, 2001, terrorist attacks, properly encouraged the jury to continue to focus on the trial.
- III. Whether the district court properly denied the defendant's motion for a new trial on two counts of conviction where those counts were completely unaffected by the false testimony of a government witness.
- IV. Whether the district court properly enhanced DeVore's sentence for obstruction of justice after finding that she lied under oath.
- V. Whether the district court properly calculated the loss figure at sentencing.
- VI. Whether the district court properly ordered defendants to pay restitution to the Medicare program.

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#### **STATEMENT OF FACTS**

##### **I. Introduction**

On April 7, 2000, the defendants, Dr. Robert Mitrione and his office manager and biller, Marla DeVore, were indicted on charges of Medicaid and Medicare fraud. The fraud involved billing for services not provided (ghost billing), overstating the services that were provided (upcoding), and billing when the doctor had not actually performed the service (substitute billing). (R:1) Although defendants were convicted of charges relating to all three alleged billing practices, the district court granted defendants' motions for new trial on all counts of conviction except the two counts that involved substitute billing exclusively. The district court granted a new trial on all counts that relied at least in part on ghost billing and upcoding after finding that a government rebuttal witness had testified falsely. That witness rebutted defendants' defense to those counts, namely, that any errors on the bills were accidental. The court found that the false testimony did not affect the two pure substitute billing counts, however, because defendants defended those two counts on a different basis. (RulingTr:17-20)

##### **II. Background**

Mitrione established a psychiatric practice in Springfield, Illinois, in the early 1990s. (Tr:1657) Mitrione and Cecilia, his wife and assistant at the time, together use CPT as an acronym for "Current Procedural Terminology." CPTs are listed in a book of codes used for medical billing, which is published by the American Medical Association. (Tr:454,518)

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learned the billing aspect of the medical business. (Tr:654-55) They prepared the billings for Mitrione's hospital-based patients once every few weeks, by splitting billings between insurance companies, Medicare, and Medicaid, as each had a different procedure. (Tr:654,661;Ex:25A)

##### **A. Medicaid/IDPA**

In May 1991, Mitrione applied with the Illinois Department of Public Aid (IDPA), which administers the Medicaid program in the State of Illinois, to become a Medicaid provider. (Ex:1A;Tr:654-55,924,929)

IDPA dispatched an ombudsman to provide billing training to the Mitriones. (Tr:656) The ombudsman reviewed with the Mitriones all of the billing forms and CPT codes. (Tr:656-57) He also left a copy of the IDPA Provider Manual for Physicians. (Tr:657) This was the second copy the Mitriones had received, as all new providers are given the manual upon enrollment. (Tr:929)

Mitrione signed the IDPA agreement, which included specific requirements for billing Medicaid. (Tr:932;Exs:1A,1B) For example, Mitrione agreed to "comply with all current and future policy provisions as set forth in the applicable Medical Assistance Handbooks." (Tr:932;Exs:1A,1B) At the time, one such policy

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provided that physicians could not be paid under Illinois Medicaid for psychiatric services provided by employees under their supervision. The

handbook for physicians provided:

The provision of psychiatric services is limited . . . and must be personally provided by the physician who submits charges.

Services provided by a psychologist, social worker, etc. are not reimbursable.

(Tr:659,941;Ex:1C,Section A-210.7)(emphasis in original). This provision was patterned after 89 Ill. Admin. Code § 140.413 and added to the physician's handbook to cut down on the abuse and overuse of government resources.

(Tr:940)

#### B. Medicare

Mitrione was also enrolled as a provider with the Medicare Part B system, which, like Medicaid, is a "fee for service" program in which providers bill for their services. (Tr:447,611;Ex:28)

Under specific circumstances, Medicare (unlike Illinois Medicaid) allows providers to delegate certain psychological services to others in their employ. Medicare regulations require the services to be: (1) medically necessary; (2) an integral yet incidental part of a physician's professional service; (3) commonly provided in a physician's office; (4) either rendered without charge or included in the physician's bill; (5) representative of an expense incurred by the physician or

¶Mitrione and DeVore were married after the indictment in this case was returned.

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non-physician in his or her professional practice; (6) performed under the direct supervision of the physician, non-physician, or physician-directed center; and (7) initiated or managed by the employing physician. (Tr:462-63)

According to the Medicare Carrier's Manual, to fulfill the "direct supervision" requirement, the physician – not a proxy – must be present within the same office suite, available, and able to intervene in case of an emergency. (Tr:459,479) The Medicare rules did not allow payment for the services of unlicensed mental health providers, regardless of whether a physician was present. (Tr:477,479)

#### C. Mitrione and Associates

In 1992, Mitrione expanded his practice to include patient care at The Mental Health Center of Central Illinois (MHC), a state funded, not-for-profit mental health clinic in Springfield. (Tr:688,1661) Mental health clinics funded by the State of Illinois differ from private physician practices. Specifically, such clinics are permitted to bill Medicaid for non-physician services. (Tr:953-54,956)

In September 1994, the Mitriones fell behind in their billing. (Tr:662,1663) At that time, Mitrione brought Marla DeVore,<sup>4</sup> a counselor whom he met at MHC, into the practice as his new office manager. He also moved the office to another site, renamed it Mitrione and Associates (M&A), and officially re-opened the

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office on February 1, 1995. (Tr:1662,1664-65)

##### 1. The billing system at M&A

DeVore was placed in charge of the office. (Tr:1665) She recruited Shari McGowan, a nurse at the MHC, to help her set up a billing system. (Tr:1064-66)

DeVore taught McGowan how to enter billing information on Mitrione's computer. (Tr:1065-66)

DeVore and Mitrione designed a "superbill," which contained the five codes primarily used in the practice. (Tr:1071-72) Typically, the doctor or a therapist who provided the service placed his or her name on the superbill and placed a checkmark next to the code to indicate the service provided. (Tr:141,1072) The superbills therefore provided the essential information that M&A employees needed to prepare claim forms. (Tr:139,1071-72,1204,1216) Shortly after defendants became aware of the official inquiries into their billing practices, they ordered the destruction of years of these superbills. (Tr:820,1339-40,1342,1371-72, 2095-96)

Mitrione and DeVore instituted a policy to bill IDPA for the services of nonphysicians, and caused their billing clerks to substitute Mitrione's name for that of a non-physician on the claim forms sent to IDPA. (Tr:1146-47,1197,1204,01227-28) To do this, the clerks changed the name of the service provider when manually filling out the IDPA billing forms. (Tr:1147,1197,1204,1227-28)

¶During her employment with defendants, Kuethe married and changed her name to "Goff." She will be referred to as "Goff" throughout this brief.

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DeVore reviewed the claims before they were sent to Medicare, IDPA, or the insurance companies. (Tr:1073,1126) She also reviewed rejected claims and instructed McGowan how to rebill. (Tr:1075-76) If McGowan had a problem with

a CPT code or with a billing issue that DeVore could not resolve, she asked Mitrione. (Tr:1080)

## 2. M&A's Employees

In 1995, Mitrione and DeVore hired a number of non-physicians to provide services to their clientele. For example, they hired a social worker, Dana Ingram, and counselors Ron Havens and Cathy Walters. (Tr:1666-67) When those employees quit, defendants also hired Terry Kuethe Goff,<sup>s</sup> an unlicensed intern who was working to complete her requirements for an advanced psychology degree, and Walter Woods, a drug and alcohol counselor. (Tr:128-31,134,787,1256-57;Ex:24A)

Woods had been a director of Gibraltar, Ltd., a failing drug and alcohol rehabilitation center in Springfield. (Tr:752,785) Certain drug and alcohol centers qualify for a special certification from the State of Illinois similar to the provision for mental health facilities. (Tr:747) Through this certification, a center may submit billings for non-physician counselors working under the supervision of a

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physician. (Tr:747) During this time, however, there was a moratorium that precluded additional drug and alcohol certifications of this type in Sangamon County. (Tr:769)

Over the next several months, Mitrione, DeVore, and Woods made several attempts to secure the drug and alcohol licenses and billing privileges that belonged to Gibraltar, and to obtain similar licenses and billing privileges for their own practice. (Tr:752-54,791-92,795;Exs:16B-16C-1) The attempts were unsuccessful. The Gibraltar Medicaid certificate was ultimately terminated, and M&A was unable to obtain authority to bill Medicaid for non-physician drug and alcohol services. (Tr:757,769,1699)

Since Woods held only an Alcohol and Drug Counseling Certificate, he was not licensed to provide any other mental health services. (Tr:761-62,782-84,1257-58;Ex:24C) Both defendants knew that they could not bill the Medicaid program for Woods's services. (Tr:796-97,1702,1881) Nevertheless, shortly after the Gibraltar transfer was denied, Mitrione and DeVore expanded Woods's role by assigning him Medicaid clients. (Tr:796-801) Defendants also directed Woods to counsel patients with diagnoses other than drug and alcohol addiction. (Tr:279-280,801,1716-17;Ex:13B) Goff objected to both Mitrione and DeVore that Woods was acting far beyond his certification. (Tr:280-81)

Mitrione and DeVore also assigned Goff a full case load of Medicaid and

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Medicare clients, despite her lack of license and private clinical experience. (Tr:131-32)

## III. Upcoding (Counts 3, 4, 5, 11)

### A. The Scheme

Both IDPA and Medicare paid providers based on CPT codes. (Tr:454-56,943-44) In the psychiatric practice, the codes were based on, among other things, the amount of time the provider spent with the patient. (Tr:456) For example, the procedure code 90843 represents 20-30 minutes of psychotherapy, while 90844 represents 40-45 minutes of psychotherapy. (Tr:455)

Both Medicaid and Medicare anticipated that certain sessions with the doctor would be for medication checks only, and the CPT manual had a separate code, 90862, for "medication management" or "pharmacologic management. (Tr:166, 513-14) Medicaid paid less for medication management sessions than for the more time-consuming psychotherapy sessions. (Tr:480)

After Mitrione brought counselors and therapists into the practice, he used them to counsel patients. Mitrione provided "medication management" and referred the patients to the counselors for individual psychotherapy. (Tr:163-64)

Mitrione and DeVore billed Medicare several times for lengthy psychotherapy sessions when all that was provided was medication management. (Tr:166-71,174-76,261-63,267-73;Exs:3B-5-6,3B-7-12,3G-1-2,3H-6,11,5A,5B-2-7,10-11,5C-

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2,5E-1-2,5F-1-2,5G-1-2,5H2,4,6,10,13,15A)

### B. The Defense

Mitrione and Phillip Bornstein, a psychiatrist hired by Mitrione, testified that the upcoded sessions were consistent with more than minimal psychotherapy. (Tr:1457,1480,1767-69,1785) DeVore testified that the upcoded bills were errors that she had only recently discovered. (Tr:2074,2152-55,2215)

## IV. No Service Rendered – "Ghost Billing" (Counts 2,6,7,8,9,10,11)

### A. The Scheme

In addition to convictions for upcoding, defendants were convicted of charges

that they submitted claims for services that were not rendered at all. IDPA and Medicare would not pay for services provided over the telephone. (Tr:466,510,951) The psychiatric community commonly knew that all CPT codes required face-to-face contact. (Tr:511-12,520-22) Nevertheless, DeVore instructed Goff to document telephone sessions as if they were face to face, and defendants then billed for those sessions. (Tr:219-22;Ex:7B-14,7B-15)

IDPA and Medicare also refused to pay for missed appointments, cancelled appointments, letters, or other paperwork. (Tr:465,509,951) Cancellations and “no-shows” were common occurrences at M&A. (Tr:139) DeVore billed for sessions when the records established that the session did not occur. (Tr:160-63,182-87,223-24,227-31;Exs:2B-3-4,2B-7-8,2B-10-12,2E-3,7,10,3B-1-4,3H-1,3,4B-

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2,4D,6A,6B,6B1-3,6F-4,8,7B-19-22;7E-20,10B-3-6,7-8,11-14,10G-5,11,10G-13) Some clients saw both DeVore (for counseling) and Mitrione (for medication management) on the same date. (Tr:184-85,903-04) IDPA would not pay for two services on a single date. IDPA also did not pay for psychiatric treatment provided by non-physicians. (Tr:950) DeVore instructed her billing clerks simply to split the dates and to bill as if the client had been seen on two different dates by Mitrione. (Tr:1149,1185)

### B. The Defense

Mitrione and DeVore defended the charges of false or “ghost” billing by suggesting that the billings were due to incompetent billing clerks (Tr:98-99), their disorganized office (Tr:99-100), and/or numbers transposed by their billing computer. (Tr:97,2138-45,2662) DeVore consistently denied billing certain services. (Tr:2026,2030,2095,2155,2215-16,2219,2223-24,2226,2230,2252-54)

### V. Substitute Billing (Counts 12 and 14)

#### A. The Scheme

Finally, the defendants were convicted for substitute billing. They assigned Medicaid and Medicare patients to counselors and therapists for treatment, and then billed as though Mitrione either provided the service himself or directly supervised the others.

Shortly after she joined M&A, DeVore twice asked Sheryl Walters, a billing

¶ Although Illinois did not require that a counselor be licensed, Medicare reimbursed only for services provided by licensed individuals. (Tr:501)

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employee with MHC, how M&A could bill Medicaid for counselors’ or therapists’ services. (Tr:697-98) Walters twice explained that the practice could not bill for those services because it was not a licensed not-for-profit mental health clinic. (Tr:699) Shortly thereafter, Walters told Mitrione the same thing when he inquired about billing for therapists. (Tr:700) During an advanced IDPA seminar, which Mitrione attended in October 1996, it was confirmed that Medicaid would not pay for psychiatric services performed by non-physicians. (Tr:1038)

In the spring of 1996, the practice formed a therapy group for the survivors of sexual abuse (SOSA). The group consisted of women who had survived sexual trauma, molestation, or rape in their childhood. (Tr:188-89) Neither DeVore nor Goff, who initially ran the group, were licensed to practice in Illinois.¶ (Tr:1257;Ex:24B)

The first meeting of the SOSA group was held in May 1996. (Tr:191) Because of the abuse suffered by members of the group, they were often fragile and volatile. (Tr:189,1505-06) The discussions during the group sessions were at times personal and painful. (Tr:901,1262,1280) If not handled carefully, the group members could have been hurt further, according to a psychiatric expert.

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(Tr:1506-07)

Shortly after the group started, DeVore had a falling out with Goff and quit working with the SOSA group. (Tr:190,801-803,2231) DeVore and Mitrione then assigned Woods to co-facilitate the group. (Tr:195-96,199-201,801-05,1708-09) When Goff objected to defendants that Woods was unqualified to co-lead the group therapy, they reminded Goff that she was a “supervisee,” that is, an intern who needed Mitrione’s supervision for her doctorate and eventual license. (Tr:128,201-03) Goff nevertheless complained weekly to Mitrione that Woods’s actions and demeanor in the group were inappropriate. (Tr:203-07,281-83) Mitrione responded that Goff should continue to work with the group, and that she had no choice. (Tr:200-03)

Woods too told both DeVore and Mitrione that certain therapy sessions were beyond his ability levels, though he continued with them. (Tr:818-19) Defendants

even assigned some of the group members to Woods for individual therapy. (Tr:811-14,881-84)  
Several times Woods handled the SOSA group without Goff. (Tr:209,236,806-07;Exs:12B-3,12C-2,14A,14B-1-2) For example, Goff and Mitrione (who was accompanied by DeVore) both attended a medical conference in Texas from November 12-14, 1996. (Tr:231,1745;Exs:17A,26) During this time, Woods facilitated the SOSA group, and saw some of those group members for individual

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therapy sessions. (Tr:232,811-12;Exs:14A,14B-1) Defendants then billed as if Mitrione had provided the service. (Tr:796,1879-81,2251-52;Exs:21A,21B, 37A,37B) Some of the billings for Woods were signed and submitted by DeVore. (Exs:14B-2;21B-1,21B-2;Tr:234,1852)

In addition to billing IDPA, Mitrione and DeVore billed Medicare for Woods's work with the SOSA group and counseling of clients. (Ex:4B-5;Tr:477-78) Medicare would not have paid for the service had it been aware that the group was being run by a drug and alcohol counselor with no other licensing, certification, or education. (Tr:477) Even if Goff had been in the group with Woods, Medicare would not have paid because Goff was not licensed and Mitrione was not present in the office suite and available to intervene. (Tr:478-79)

### B. The Defense and the Government's Response

Unlike the defendants' defense to the ghost billing and upcoding charges, *i.e.*, that they were simply inept billers, defendants defended the substitute billing charges by claiming ignorance of the rules. Mitrione claimed that he did not receive the physician's handbook, or received only a portion of it, or threw it away without reading it. (Tr:1677,1801-06,1836-37) DeVore, on the other hand, claimed that she was unaware that the handbook existed. (Tr:2250) In addition, Vaughn died prior to the start of the trial.

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both Mitrione and DeVore claimed that Gary Vaughn, an IDPA representative, told them that the substitute billing practice was acceptable. (Tr:1671-72,1815, 2049)

The evidence demonstrated that Mitrione received the physician's handbook (which contained the billing prohibition) at least three times: (1) when he first enrolled as a provider (Tr:929); (2) when the ombudsman trained Mitrione and Cecilia on the handbook (Tr:657); and (3) when he attended the IDPA seminar in October 1996. (Tr:1029) Additionally, Mitrione pointed to the manual in his office when interviewed by investigators. (Tr:1386)

Moreover, neither defendant mentioned to the investigators that Vaughn had sanctioned their substitute billing practices. (Tr:1323,2347) In December 1999, Mitrione phoned the IDPA Office of Inspector General to inquire about the investigation, and to try to convince investigators that any billing issues were the result of a former employee. Mitrione never suggested at that time that Vaughn had sanctioned the improper billing. (Tr:1816-25) Nor could Mitrione explain why the issue even came up with Vaughn, since DeVore and he claimed that they did not know about the prohibition against billing for non-physician services. (Tr:1680,1805-06,2050)

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### VI. Summary Witnesses

Prior to trial, the government and defense exchanged exhibits, including proposed summary exhibits. Both parties objected to the use of summaries by the other. (PretrialTr:7-10)

Government's Exhibit 20A was a spreadsheet that reflected information an IDPA auditor compiled from all of the Medicaid and Medicare files subpoenaed from the defendants. Defendants complained that the exhibit included matters not strictly relevant to the issues in the trial, such as claims resulting from patients seen at the hospital. (PretrialTr:28-29) DeVore objected: ". . . I think included in some of these is treatment that was given in hospitals that we don't have the records for . . . I have no indication that the Government has ever gotten the records for those." (PretrialTr:28-29)

The district court precluded the government from using the summary exhibit in its case-in-chief. It then ruled that "to the extent that the government's summary exhibit . . . rebuts defendants' summary exhibit, the government, upon a showing of a proper foundation, may introduce its summary exhibit into evidence as rebuttal evidence." (docket entry 8/14/01)

At trial, the defense called David Parker to introduce their summary exhibit of certain services contained in defendants' patient files. (Tr:1930-2002) At the completion of defendants' case, the government called Deanna Statler, an IDPA

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auditor. (Tr:2300-35) Statler testified that she reviewed about 800 of the files produced by Mitrione and DeVore pursuant to subpoena. (Tr:2301-02) She looked in the files for notes or other indications of service, compared them with the billings, and recorded her findings on a spreadsheet. (Tr:2302-04) She explained that, in doing so, she eliminated from consideration those services performed at the hospital, as she did not have the hospital records.

(Tr:2304,2306,2315-16) Because Statler was looking solely at whether documentation existed to support claims, she included and counted in the spreadsheet the dates in which service was provided by a "therapist."

(Ex:20A;Tr:2327)

She concluded that there was no documentation for claims 28% of the time, while only 9% of the time notations of service were reflected with no claim filed.

(Tr:2305,2310-12,2323;Ex:20B)

### VII. The Verdicts

On September 13, 2001, following a jury trial, Mitrione was convicted of Counts 1-6, 9-12, and 14, and acquitted on Counts 7 and 8. (docket entry 9/13/01; R:132) DeVore was convicted on Counts 1, 3-5, 9-12 and 14, and acquitted on Counts 2, and 6-8. (docket entry 9/13/01;R:133)

### VIII. Motion For New Trial Based Upon Closing Argument

On September 27, 2001, defendants filed motions for judgments of acquittal or

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for new trial, which the district court denied. (R:146,R:147,R:149) In their respective motions, both defendants argued, in part, that the prosecutor's closing argument was improper.

In his closing, the prosecutor commented briefly on the terrorist attacks of the previous day, September 11, 2001, and encouraged the jurors to remain focused on the trial. The defendants argued that the prosecutor compared the terrorist attacks to the allegations of Medicare and Medicaid fraud against defendants and that this reference prejudiced them. The court rejected this argument, found that the prosecutor never made that comparison, and held that the prosecutor's remark was proper. (R:149)

### IX. Motion For New Trial Based Upon Newly Discovered Evidence

On April 10, 2002, defendants filed a motion for new trial based upon newly discovered evidence. The government responded, and the district court held a hearing on the motion starting July 8, 2002. (R:165,R:187;docket entry 7/8/02)

At the hearing, Statler testified that she did not in fact remove all claims that indicated the service was performed at the hospital. Despite her earlier testimony to the contrary, she relied on others to ensure that the spreadsheet was limited in time and place of service, and to assist her in adding the numbers. (NewTrialTr: 29-34) Finally, contrary to her trial testimony, she failed to verify that all claims found in the files had been submitted for payment. (Tr:2313;NewTrialTr:42)

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The district court found that Statler's trial testimony was false, and that it "might" have affected the convictions in all of the counts that had an element of "ghost billing" and "upcoding" as a foundation (even though some of those counts also alleged substitute billing). (RulingTr:8) The court found that the prosecutor was unaware that the testimony was false. (RulingTr:17)

The court explicitly distinguished Counts 12 and 14, which were based solely on "substitute billing" or the billing for the services of a non-physician, Woods, as the defense to these counts did not rely on confusion by billing clerks or computer error. (RulingTr:18-20) Instead, defendants defended these counts on the ground that they were unaware of the IDPA prohibition, and had been given permission to substitute bill by the IDPA representative, Gary Vaughn. The court stated:

Counts 12 and 14 . . . are of a different category. These are charges arising from bills submitted to Medicaid for Dr. Mitrione when the services were provided by Walt Woods in leading the SOSA group, a group he wasn't professionally qualified to lead . . . . And they were for services at a time when defendants were either in Texas or had just returned home from Texas and were not in the office and wouldn't have been available to intervene, because . . . they didn't know the particular session was even occurring.

\* \* \*

Both Defendants knew Woods was leading or co-leading the group. Both reviewed the monthly reimbursements from Public Aid and the allocation to particular therapists. There was no evidence on these counts . . . to

support a confusion in billing for one therapist when another provided the services here or a mistake on the date of billing with respect to these

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counts.

The issues raised by the summary exhibits and summary witnesses did not go to [Counts 12 and 14].

(RulingTr:18-19)

### **X. The Sentencing Hearing**

#### **A. Amount of Loss**

The government presented evidence establishing that the amount of loss due to the “substitute billing” scheme to IDPA was \$40,119. (SentTr:64) After adding additional categories of Medicaid loss (such as ghost billing and phone sessions) the total loss to IDPA was \$52,274.63. (SentTr:66;Ex:S-7)

The government also presented evidence of loss to Medicare totaling \$14,611.74. (SentTr:81;Ex:S-8A) The loss included: (1) claims totaling \$8,181.25 for services provided by an unlicensed or unsupervised person (SentTr:81); (2) claims totaling \$2,580.27 for services not provided on the date claimed (SentTr:81); (3) claims totaling \$447.13 for non-reimbursable phone sessions (SentTr:81); and (4) services totaling \$3,403.09 for sessions falsely billed as “incident to” the physician’s service. (SentTr:80)

The court found that: (1) IDPA’s plan lawfully limited the payment of psychiatric services to physicians (SentTr:151-53); (2) Woods was totally unqualified to run the SOSA group (SentTr:153); (3) Goff’s and DeVore’s services

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prior to their licensure could not be claimed “incident to” the care of the doctor (SentTr:156); and (4) the value to IDPA and Medicare for the services of the nonphysicians was “zero.” (SentTr:158)

The sum of the Medicaid and Medicare losses was \$54,730.74. The district court, however, limited the amount of loss to the amounts that were verifiably free of Statler’s testimony. (SentTr:161-62) The court, in ruling that “there should be some sanction that carries over to sentencing for the use of false testimony,” chose to ignore the Medicaid loss entirely, and to look only at the Medicare loss. (SentTr:162-64) The court likened the loss findings and figures to a Guidelines downward departure. (SentTr:173-74) It concluded that the loss to Medicare was \$11,255.65. (SentTr:164)

#### **B. Obstruction of Justice**

The court also found that both Mitrione and DeVore testified falsely. (SentTr:169-73) Specifically, the court found that DeVore’s testimony that she was involved neither in billing nor in Woods’s assignment to co-lead the SOSA group was false. (SentTr:169-72) The court found Mitrione’s testimony that he never received the IDPA provider handbook to be likewise false. (SentTr:172-73) Accordingly, the court imposed a two-level enhancement on both defendants for obstruction of justice. (SentTr:172)

#### **C. The Sentences**

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After finding that both defendants were responsible for the harm caused to their SOSA group members as “vulnerable victims” (SentTr:164-66), and finding that Mitrione abused a position of trust (SentTr:167-68), the court sentenced Mitrione to a term of 23 months (SentTr:187-88) and DeVore to a term of 15 months. (SentTr:190)

The court also ordered both defendants to pay \$11,255.65 in restitution to Medicare. (SentTr:188,190)

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### **SUMMARY OF THE ARGUMENTS**

The defendants together challenge their convictions on six grounds. All six are without merit.

First, they argue that the Illinois statutes underlying their convictions for Medicaid and Medicare fraud are in conflict with, and therefore preempted by, federal law. The district court properly rejected this argument, as it ignores both basic rules of statutory construction and the State of Illinois’s discretion to adopt standards for its medical assistance programs.

Second, defendants argue that the prosecutor, who delivered a closing argument one day after the September 11, 2001, terrorist attacks, inflamed the passions of the jury by suggesting that the jury should find defendants guilty because the United States needed protection. Actually, the prosecutor merely acknowledged the attacks and urged the jurors to remain focused on the trial. The district court correctly found that defendants distorted what the prosecutor

said and found the comment to be proper.

Third, defendants argue that the district court abused its discretion in declining to grant their motion for new trial on Counts 12 and 14. They argue that the false rebuttal testimony of a government witness infected not only the ghost billing and upcoding counts vacated by the district court, but the pure substitute billing counts as well.

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Defendants, however, did not satisfy any of the three requirements for a new trial on those counts. The false testimony was not material to the substitute billing counts because it rebutted a defense that defendants advanced only on the ghost billing and upcoding counts. Since the false testimony was simply irrelevant to the substitute billing counts, the jury would not have reached a different conclusion absent the false testimony. Finally, the defendants could not have been surprised by the false testimony because the nature of the testimony and the summary exhibit in support of the testimony were both revealed to defendants weeks before trial.

Fourth, DeVore argues that the district court erred in imposing an obstruction of justice enhancement based on its finding that she testified falsely. The district court found that DeVore willfully testified that she was neither the biller at M&A, nor involved in the decision to appoint Woods as co-leader of the SOSA group. While DeVore claims that her testimony was true, the court found that several witnesses contradicted DeVore's testimony, implicitly found those witnesses more credible, and concluded that DeVore testified falsely on matters material to the counts of conviction. The court's findings, far from being clearly erroneous, enjoy ample support in the record.

Fifth, defendants argue that the district court, in calculating the loss amount for sentencing purposes at close to \$12,000, failed to credit them for services

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provided by non-physicians of M&A. The district court found, however, that IDPA and Medicare were unwilling to pay for the services of unlicensed nonphysicians, and that therefore the value of those services was zero. Accordingly, the court properly refused to offset the loss amount.

Finally, defendants argue that the district court ordered them to pay restitution to the wrong victim. According to defendants, Medicaid, not Medicare, was the victim of their fraud. This argument ignores that under the Mandatory Victim Restitution Act, when the counts of conviction involve a scheme, as they do here, the restitution may be ordered for all of the harm caused by the defendants' criminal conduct in the course of that scheme. Defendants' crime included a scheme to defraud Medicare and Medicaid. Therefore, the district court was authorized to order the defendants to pay restitution to Medicare as well as Medicaid.

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### **ARGUMENTS**

#### **I. The District Court Properly Refused To Dismiss The Indictment Because, Contrary To Defendants' Claim, Their Conduct Violated The Law**

Defendants first argue that the district court erred when it refused to dismiss the indictments against them. *United States v. Mitrione*, 160 F.Supp.2d 990, 993 (C.D. Ill. 2001). Specifically, they claim that they were improperly convicted of a violation of an informal policy statement that is preempted by federal law. (MitrioneBr:11)

##### **A. Standard of Review**

This Court reviews a district court's denial of a motion to dismiss an indictment de novo. *See United States v. Aldaco*, 201 F.3d 979, 982 (7<sup>th</sup> Cir. 2000).

##### **B. The District Court Properly Rejected the Defendants' Argument that 89 Ill.**

Admin. Code § 140.413 is Contrary to – and Therefore Preempted by – Federal Law

89 Ill. Admin. Code § 140.413 provides in relevant part that IDPA will pay for psychiatric services only when provided by a physician. Defendants argue that the district court erred in ruling that this provision is consistent with – and therefore not preempted by – federal law. (MitrioneBr:14) Specifically, defendants argue that Illinois Medicaid must cover “physician” services provided by or under the personal supervision of Mitrione because federal law requires states to cover services provided under the supervision of a physician.

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(MitrioneBr:14-15)

The basis for this sweeping contention is purportedly the Social Security Act,

which requires, among other things, that any state accepting Medicaid money must cover “physician services.” (MitrioneBr:12-15) Defendants take this simple contention and ask this Court to rule that since a state Medicaid fund must cover “physician services,” it is required to cover all such services, no matter who performs the service, no matter what service is performed, and no matter where the service is performed.

Under defendants’ argument, the provider may dictate what services are provided, and by whom, under the heading of “physician services,” and the state is powerless to do anything but pay these claims, no matter how unreasonable. Further, the state Medicaid system, according to defendants’ reasoning, may neither regulate the services provided by physicians nor set reasonable utilization controls. Such a ruling would leave the states with no discretion to limit, regulate, or oversee the services for which it must pay. This argument finds no support in law or logic.

The Social Security Act, which created Medicaid (also known as Title XIX) requires that state Medicaid plans establish “reasonable standards . . . for determining . . . the extent of medical assistance under the plan which . . . are consistent with the objectives of [Title XIX].” *Beal v. Doe*, 432 U.S. 438 (1977)

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(quoting 42 U.S.C. § 1396a(a)(17) (1970 ed., Supp. V)). The Supreme Court has explained that this language in Title XIX “confers broad discretion on the states to adopt standards for determining the extent of medical assistance” offered in their Medicaid programs and requires only that such standards be “reasonable” and “consistent with the objectives” of the Social Security Act. *Id.* at 444.

In *Beal*, the State of Pennsylvania accepted Medicaid funds and was, therefore, subject to the same provisions as the State of Illinois in this case. The Pennsylvania state agency responsible for Medicaid promulgated a rule that denied financial assistance for any services (which would necessarily include physician services) that were part of non-therapeutic abortions. *Id.* at 441. The plaintiffs argued, as defendants do here, that these services must be covered under the Medicaid regulations. *Id.* at 441-42.

The Supreme Court disagreed. It held that “. . . nothing in [Title XIX] suggests that participating states are required to fund every medical procedure that falls within the delineated categories of medical care.” Indeed, as the Court noted, the statute expressly provides that “[a] State plan for medical assistance must . . . include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which . . . are consistent with the objectives of this [Title] . . . . 42 U.S.C. § 1396a(a)(17)(1970, Supp. V).” *Id.* at 444. Defendants ignore the discretion that clearly lies with the State of Illinois to adopt standards

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for its medical assistance programs.

Defendants’ remaining arguments ignore basic rules of statutory construction and, as a result, rest on misinterpretations of the relevant statutes. They mistakenly argue that 42 U.S.C. § 1396d(a)(5)(A) requires Illinois to pay for all “physician services” as those services are defined by state licensing law.

(MitrioneBr:14-15) The district court properly rejected this argument, recognizing that defendants were confusing this provision with § 1396d(a)(5)(B), which covers dentists’, not physicians’, services. The court stated “[t]he medical assistance covered by 42 U.S.C. § 1396d(a)(5)(A) refers to physician services furnished by a *physician*, whether furnished in the office, the patient’s home, a hospital, a nursing facility, or elsewhere.” (R:238,p.4)

Section 1396d(a)(5)(B), on the other hand, requires states to cover: “medical and surgical services furnished by a *dentist* . . . to the extent such services may be performed under State law by a doctor of medicine or by a doctor of dental surgery or dental medicine and would be described in clause (A) if furnished by a physician.” The district court held that the “performed under state law” clause modifies Section (5)(B), which refers to a *dentist*, and not Section (5)(A), which refers to a *physician*. (R:238,p.4-5)

As the district court properly concluded, “[t]he placement of the language, context of the language, and lack of comma after dentist all indicate the language

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on which Defendants rely modifies services furnished by a *dentist*. Dental services are not involved in this case.” (R:238,p.5)

Nor, as defendants argue, do the IDPA regulations discriminate against physician services based solely on mental diagnosis, illness, or condition.

(MitrioneBr:20-21) As the district court found, the Illinois rule does not restrict

coverage of physician services; rather, it protects patients by requiring that the provider be qualified. (R:238,p.5) The court concluded that “the Illinois plan has logical restrictions on payment in an area that is ripe for abuse, as evidenced by the facts and pleadings in this case.” (R:238,p.5)

So, while defendants may have been permitted to delegate responsibility for providing service to other personnel (including individuals who were neither licensed nor qualified under Illinois law), nothing in federal or state law required the Medicaid program to pay for the services those employees provided. To the contrary, the State of Illinois is empowered to make reasonable rules and regulations regarding medical necessity and utilization control. The limitations put on mental health services by IDPA are reasonable.

C. The District Court Properly Found that 89 Ill. Admin. Code § 140.413 Requires that a Physician Personally Provide Psychiatric Services Before Medicaid Will Reimburse

Defendants next argue that the government based its case on the IDPA Medical Assistance Program Handbook § A-210.7, which restricts payment for

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psychiatric services. (MitrioneBr:12) That section provides, “The provision of psychiatric services is limited to those services and associated procedure codes listed . . . and must be *personally* provided by the physician who submits charges. Services provided by a psychologist, social worker, etc. are not reimbursable.” Defendants argue that this restriction does not carry the effect of law, and is in conflict with federal law.

True, as the district court found, the Handbook does not carry the import of the law itself. However, its “interpretation conforms to the language of the Illinois Administrative Code (Code), which does carry the force of law.” *United States v. Mitrione*, 160 F.Supp.2d at 993.

Section 140.411 of the Code provides, in relevant part, that physicians will be reimbursed for services *not otherwise excluded* that are provided by the physician or by a member of the physician’s staff under the physician’s direct supervision. Section 140.413 of the Code is entitled “Limitation of Physician Services.” As noted above, it provides, in relevant part:

(a) When provided in accordance with the specified limitations and requirements, the Department shall pay for the following services . . .

(4) Psychiatric Services

(A) Treatment – when the services are provided by a physician who has been enrolled as an approved provider with the Department

....

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Defendants argue that the general provision for physician reimbursement (§ 140.411) modifies the limiting clause for reimbursement for psychiatric services (§ 140.413). In so doing, defendants reason that since psychiatrists are physicians, the reference to “services provided by a physician” in § 140.413 encompasses work done by members of the psychiatrist’s staff under his direction, as provided in § 140.411. (MitrioneBr:16-17) The district court properly rejected this argument, noting that “if that were the case, then there would be no need for this provision under Section 140.413.” *Mitrione*, 160 F.Supp.2d at 994. As the court found, the plain language of the Code indicates that § 140.413 limits § 140.411. *Id.* See *First Bank of Oak Park v. Avenue Bank and Trust Co. of Oak Park*, 605 F.2d 372 (7<sup>th</sup> Cir. 1979)(rules of statutory construction provide that specific provisions control over general provisions).

Defendants also argue that the Medicaid and Medicare claim forms provide no place to designate whether the service was provided personally by a physician or by a staff member. This absence must mean, say defendants, that billing for services provided by the doctor’s staff using the doctor’s provider number is authorized. (MitrioneBr:25) As the district court noted, “[t]he forms cannot change the requirements of law, however.” *Mitrione*, 160 F.Supp.2d at 995. Thus, the district court properly found that “[f]or Medicaid reimbursement for psychiatric services, Illinois requires that the services actually be provided by the

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physician and not by members of his staff under his direct supervision.” *Id.* Accordingly, the district court properly refused to dismiss the indictment.

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II. The Prosecutor, In His September 12, 2001, Closing Argument, Properly Encouraged The Jurors To Continue To Focus On The Trial

Closing arguments began one day after the September 11, 2001, terrorist

attacks on the United States. DeVore argues (DeVoreBr:29) that the following remark by the prosecutor in closing argument “inflamed the passions of the jury”:

Ladies and Gentlemen. Good morning. Our job just got harder in the last 24 hours. We’re already facing an incredibly difficult task as we’ve done for the last three and a half weeks trying to sort this out. It’s now made more difficult by the events of yesterday, the devastation that terrorism has brought to our country. But that’s why we need to do this today. That’s why we got out of bed today and came here. The very institutions that these people seek to undermine must continue.  
(Tr:2535)

#### A. Standard of Review

While DeVore claims that “the defense objected to the suggestion that the jury should find defendants guilty because the United States needed protection,” the record tells a different story. (DeVoreBr:30) First, DeVore did not object; Mitrione did. (Tr:2535) Second, Mitrione simply objected as follows: “Objection, Your Honor, this is going far beyond anything that’s in evidence.” (Tr:2535) That is simply not the same point DeVore makes here, *i.e.*, that the statement “inflamed the passions of the jury.” See *United States v. Hardamon*, 188 F.3d 843, 848 (7<sup>th</sup> Cir. 1999)(to preserve issue for appellate review, a party must make a

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proper objection that alerts the court and opposing party to the specific grounds for the objection).

Because DeVore failed to object to the prosecutor’s comment, and Mitrione objected on a basis different from the one now advanced, both defendants have forfeited the issue. This Court, therefore, will review the comment only for plain error. *United States v. Young*, 470 U.S. 1, 6 (1985).

#### B. Legal Framework

This Court, in analyzing claims of prosecutorial misconduct during closing argument, first looks at the disputed remark in isolation to determine if it was proper. *United States v. Butler*, 71 F.3d 243, 254 (7<sup>th</sup> Cir. 1995). Only if this Court finds the remark to be improper will it look at the remark in light of the entire record to determine if it deprived defendants of a fair trial. *Id.*

#### C. Analysis

The prosecutor’s statement was entirely proper. While defendants characterize the comment as a comparison of “the charges to the heinous acts of terrorism” (DeVoreBr:30), that characterization is not borne out by the record. As the district court found, “there was nothing in [the prosecutor’s] remarks that could be construed as comparing the conduct of defendants to the September 11 acts of terrorism. In context, the remark about the institutions that ‘these people seek to undermine,’ was clearly a reference to the terrorists and not to

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defendants.” (R:149,p.10)

Indeed, even a cursory review of the transcript reveals that at no time did the prosecutor compare the allegations of Medicaid and Medicare fraud to acts of terrorism. Nor did the prosecutor suggest that defendants were related to or responsible for those acts. As the district court found, “the government did not compare the September 11 acts to those of Defendants; Defendants’ argument . . . distorts what the prosecutor said.” (R:149,p.9)

On September 11, 2001, after reciting its instructions to the jury, the court (with the agreement of all parties) informed the jury of the terrorist attacks, and cancelled the closing arguments. The court rescheduled the arguments for the following day. (R:149,p.11) As defendants themselves recognize, “thousands died in the worst terrorist attack in the history of America.” (DeVoreBr:30) It would have been highly peculiar for anyone to have carried on with the business of the day with no acknowledgment of the previous day’s events.

After the district court overruled Mitrione’s objection, the prosecutor appropriately sought to remind the jury that the American system of justice must carry on, and that the trial still required their full attention and participation:

One of those systems is the system of justice. And that’s one of our most important systems in this country. And that’s something that we’ve all been a part of the last three and a half weeks. Every one of us. And that’s why we need to redouble our efforts today to concentrate, to stay on task, to get back to pay attention to the evidence, no matter how hard it is after

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yesterday.  
(Tr:2535-36)

Viewed in context, the prosecutor's comments were not designed to inflame the passions of the jury, but to do just the opposite, *i.e.*, to encourage the jurors to set aside any grief, anger, or distress that may have been prompted by the previous day's events, and concentrate on the task before them.

While defendants claim that "the district court overruled [their] objection, stating that defendants could respond in their closing arguments" (DeVoreBr:30), the district court actually said, "I'm going to overrule the objection. You may all comment on the events of yesterday briefly." (Tr:2535) And indeed, both DeVore and Mitrione did. In fact, DeVore's counsel virtually parroted the prosecutor's comments. (Tr:2638) She should not now be heard to complain.

There was no error here, plain or otherwise. In light of the tragedy of September 11, the remarks were necessary, measured, and proper. As the district court found, "[e]ven if the remark were deemed improper, however, the record viewed as a whole supports the conclusion that defendants were given a fair trial." (R:149,p.11)

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### III. The District Court Properly Denied Defendants' Motion For New Trial On Counts 12 And 14 Because Those Counts Were Unaffected By The False Testimony

Defendants argue that the district court abused its discretion in declining to grant their motion for new trial on Counts 12 and 14, the two counts based exclusively on substitute billing. They argue that the false rebuttal testimony of a government witness infected not only the ghost billing and upcoding counts vacated by the district court, but the substitute billing counts as well. (MitrioneBr: 31;DeVoreBr:20) Defendants, however, did not satisfy the requirements for a new trial on the purely substitute billing counts.

The defendants defended the ghost billing and upcoding, in part, on the grounds that they were inept record-keepers and billers. (Tr:76-78,101-02,425,843-44,2597,2630) To rebut that defense, Statler testified that the defendants submitted bills for which there was no service three times more often than they declined to submit a bill when service was provided, thus suggesting that they were not inept, but intentional defrauders of the system. Statler's false testimony rebutted *only* the defense of *accidental* erroneous billing.

With respect to Counts 12 and 14, which involved billing for the services of non-physician Woods as if a physician had provided the service, defendants never claimed that the billing was an accident, due to their ineptness. To the contrary, they claimed that they *intentionally* billed services of therapists, such as

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Woods, because they believed IDPA rules permitted it. (Tr:72,92,103,1672,1677-80,2049-50) Statler's rebuttal testimony had no bearing on that claim. Given the strong evidence that defendants knew they could not bill non-physicians as physicians, they would have been convicted on Counts 12 and 14 absent Statler's false testimony.

### A. Standard of Review

This Court reviews a district court's denial of a motion for new trial for an abuse of discretion. *United States v. Westmoreland*, 240 F.3d 618, 636 (7<sup>th</sup> Cir. 2001). *See also United States v. Williams*, 81 F.3d 1434, 1440 (7<sup>th</sup> Cir. 1996) ("Having watched the jury as they listened to the testimony, having listened to the testimony and arguments himself, having his finger as it were on the pulse of the trial . . . the district judge was in a better position than we to weigh the imponderables involved in a judgment of prejudice.").

### B. Legal Framework

In determining defendants' motion for new trial in this case, the district court used a standard announced by this Court in the 1928 case of *Larrison v. United States*, 24 F.2d 82 (7<sup>th</sup> Cir. 1928). Under this standard, a new trial will be granted when: (1) the court is reasonably well satisfied that the testimony given by a material witness is false; (2) the jury *might* have reached a different conclusion absent the false testimony or if it had known that testimony by a material witness

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was false; and (3) the party seeking the new trial was taken by surprise when the false testimony was given and was unable to meet it or did not know of its falsity until after the trial. *Id.* at 87-88; *United States v. Reed*, 986 F.2d 191, 192-93 (7<sup>th</sup> Cir. 1993).

Several courts of appeal have questioned and rejected this standard. Those courts instead hold that – regardless whether the testimony was false or perjurious, absent a finding that the prosecutor knowingly sponsored the false

testimony – a new trial will be granted only when (looking backward) the jury would *probably* have reached a different verdict absent the testimony, or when (looking forward) a new trial would *probably* produce an acquittal. See e.g., *United States v. Williams*, 233 F.3d 592 (D.C. Cir. 2000) (a defendant must show that a new trial would “probably produce an acquittal”); *United States v. Huddleston*, 194 F.3d 214, 217 (1<sup>st</sup> Cir. 1999) (same); *United States v. Provost*, 969 F.2d 617, 622 (8<sup>th</sup> Cir. 1992) (same); *United States v. Petrillo*, 237 F.3d 119, 123 (2<sup>nd</sup> Cir. 2000) (defendant must show that “but for the perjured testimony, [he] would most likely not have been convicted”); *United States v. Sanchez*, 969 F.2d 1409, 1413 (2<sup>nd</sup> Cir. 1992); *United States v. Krasny*, 607 F.2d 840, 844-45 (9<sup>th</sup> Cir. 1979); *United States v. Sinclair*, 109 F.3d 1527, 1532 (10<sup>th</sup> Cir. 1997). But see, *United States v. Lofton*, 233 F.3d 313 (4<sup>th</sup> Cir. 2000); *Gordon v. United States*, 178 F.2d 896, 900 (6<sup>th</sup> Cir. 1949).

The government urges this Court to revisit the *Larrison* standard, and adopt

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instead the more commonly used “probability” standard. In *United States v. Manzzanti*, this Court recognized the widespread disagreement with *Larrison*, and noted that *Larrison* might need to be revisited “in a case in which the application of the tests would make a difference.” 925 F.2d 1026, 1029-30 & n.3 (7<sup>th</sup> Cir. 1991). The courts that have rejected *Larrison* have found that it sweeps too broadly: It would be an unusual case in which newly discovered evidence of false testimony “might” not pave the way for an acquittal. In practice, therefore, *Larrison* comes perilously close to creating a per se rule that mandates a new trial whenever the government unwittingly uses perjured testimony. See [*United States v.*] *Krasny*, 607 F.2d [840], 843-844 [9<sup>th</sup> Cir. 1979] (warning that *Larrison*, read literally, requires reversal even with respect to relatively minor instance of perjury . . .).

*Huddleston*, 194 F.3d at 214. The First Circuit concluded that the *Larrison* test “casts a leaden weight on the scales and severely hampers efforts at nuanced, case-by-case evaluation.” See also, *United States v. Stoisky*, 527 F.2d 237 (2<sup>nd</sup> Cir. 1975) (“the [*Larrison*] test, if literally applied, should require reversal in cases of perjury with respect to even minor matters . . .”).

Supreme Court authority rendered subsequent to the *Larrison* decision also casts doubt on the continuing viability of its rule. In *United States v. Agurs*, the Court ruled that convictions based on the *knowing* use of perjured testimony could be overturned only if there is a “reasonable likelihood” that the false testimony affected the verdict. 427 U.S. 97 (1976). As the First Circuit observed in *Huddleston*, “[i]f courts must scrutinize the *knowing* use of perjured testimony

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under this standard, there is no principled justification for treating the government more harshly . . . when its use of perjured testimony is unintentional.” 194 F.3d at 220.

There is simply no reasoned basis for treating the government’s unwitting use of perjured testimony any differently than other types of newly discovered evidence. We ask this Court to hold that when a defendant grounds a motion for new trial in a criminal case on a claim that he has newly discovered that the government unwittingly sponsored perjury, the conviction nonetheless should stand unless the force of that evidence is such that an acquittal *probably* would result upon retrial.

#### C. Analysis

Even if this Court applies the *Larrison* standard to this case, defendants cannot prevail. Defendants advanced a different defense to the substitute billing charges than to the upcoding and ghost billing charges. As to the substitute billing charges, defendants argued that they were ignorant of the rules, and truly believed that they were allowed to bill for Woods’s services as though Mitrione had provided them. On the other hand, defendants defended against the ghost billing and upcoding charges on the theory that they were inept billers. They admitted that they made many mistakes in billing, but insisted that these mistakes were made unintentionally – certainly without the intent to defraud.

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DeVore testified in support of this defense, and also offered the testimony of David Parker. Parker presented a summary exhibit to suggest that, with respect to the patients specifically referenced in the indictment, the number of times that a bill was submitted without a documented service compared to the number of times that no bill was submitted although a service was documented, resulted in nearly a one-to-one ratio.

On rebuttal, Statler testified that she too reviewed the billing practices of M&A. Specifically, she testified that she compared all of the charges defendants submitted for reimbursement for undocumented services to all services documented in the patient files for which defendants could have submitted charges but did not. She concluded that, even counting the services provided by therapists, defendants submitted claims without a documented service three times more often than they delivered services but submitted no charge. At the conclusion of the hearing on defendants' motion for new trial, the district court found that Statler testified falsely about how she arrived at her figures. The court independently reviewed the data, and concluded that the ratio was much closer to the one-to-one ratio testified to by Parker. The court concluded that Statler's testimony was material on the ghost billing and upcoding charges because Statler was the only witness who refuted Parker's testimony. The court then specifically distinguished Counts 12 and 14 from the

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dismissed counts:

Counts 12 and 14 . . . are of a different category. These are charges arising from bills submitted to Medicaid for Dr. Mitrione when the services were provided by Walt Woods in leading the SOSA group, a group he wasn't professionally qualified to lead . . . . And they were for services at a time when defendants were either in Texas or had just returned home from Texas and were not in the office and wouldn't have been available to intervene, because . . . they didn't know the particular session was even occurring.

\* \* \*

Both Defendants knew Woods was leading or co-leading the group. Both reviewed the monthly reimbursements from Public Aid and the allocation to particular therapists. There was no evidence on these counts . . . to support a confusion in billing for one therapist when another provided the services here or a mistake on the date of billing with respect to these counts. The issues raised by the summary exhibits and summary witnesses did not go to [Counts 12 and 14].

(RulingTr:18-19)

The record demonstrates that defendants cannot clear any of the three *Larrison* hurdles.

1. The testimony, while false, was not material

First, Statler's testimony was not "material" to the charges in Counts 12 and 14. Statler's testimony and spreadsheet illustrated the number of claims submitted by M&A that were unsupported by documentation, and compared that to the number of documented services for which no claim was filed. The summary included the services rendered by non-physician therapists without

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regard for whether those services were ultimately reimbursable. The testimony, therefore, had no possible impact on the substitute billing charges, as it neither addressed nor commented on the issue of the propriety of substitute billing or defendants' knowledge that filing such claims was prohibited. It instead accepted the claims for therapists (as long as they were documented in the files) to address the ghost billing issues.

The district court correctly found that confusion or mistake in individual billings were the sole issues even potentially affected by Statler's testimony and, because defendants did not defend Counts 12 and 14 on this basis, Statler's testimony was not material on those counts. Defendants, therefore, did not meet the first element of the *Larrison* test.

2. The jury would not have reached a different conclusion absent the false testimony, or had it known that Statler's testimony was false

Second, because the jury would not have reached a different conclusion on Counts 12 and 14 absent the false testimony or if it had known that testimony was false, the district court properly exercised its discretion in refusing to grant a new trial on those counts.

Defendants argue that the district court erred because: (1) it could not have known upon which theory the jury convicted on Counts 12 and 14; and (2) Statler's testimony damaged their overall credibility and, absent her testimony,

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the jury would have acquitted them on Counts 12 and 14. (MitrioneBr:31; DeVoreBr:21) These arguments are easily answered.

First, there is no mystery to the jury's verdict. Defendants acknowledge that they defended Counts 12 and 14 on the ground that they believed they were

permitted to substitute bill. (DeVoreBr:28) Both defendants testified that they made the decision to substitute bill after thoroughly checking all of the facts, and being instructed to do so by Vaughn. (Tr:1668-1680,2044-54,2184-85)

Thus, the jury was presented with a clear choice: either believe the government's evidence that defendants were fully aware of the rules and intentionally defrauded IDPA and Medicare, or believe defendants that they were ignorant of the rules and honestly believed they could bill for Woods's services as though Mitrione had provided them. Obviously, the jurors believed the former.

Defendants also argue that the jury did not believe them because Statler's testimony demolished their credibility. (DeVoreBr:28-29) This argument fails on a number of levels. First, the jury acquitted them on some of the counts. DeVore was acquitted of Counts 2 and 6 and both DeVore and Mitrione were acquitted on Counts 7 and 8. These acquittals indicate that the defendants retained at least some credibility in spite of Statler's testimony.

In addition, defendants' testimony with respect to Counts 12 and 14 was

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simply incredible in light of the evidence. The evidence clearly demonstrated that both defendants were instructed numerous times, directly and indirectly, that they could not submit claims to Medicaid for services provided by therapists. See *United States v. Lanas*, 324 F.3d 894, 903 (7th Cir. 2003)(motion for new trial properly denied in mail fraud case when government presented so much evidence that the jury could easily have found defendants guilty even had star witness been impeached with newly discovered evidence that he testified falsely).

3. Defendants should not have been surprised by the false testimony and should have been able to counter

Finally, the record clearly established that prior to trial the defendants were aware of the substance of Statler's testimony, as well as the government's summary exhibit. The government notified defense counsel of the anticipated testimony before, during, and after the pretrial hearings in this case. The defendants, therefore, knew that the witness would testify that the ratio of false claims to unfilled services was greater than the defense had presented. See *United States v. Olson*, 846 F.2d 1103, 1112-13 (7th Cir. 1988) (the defendant could not meet the third element of the *Larrison* test as he could not have been surprised by the trial testimony that was consistent with prior testimony).

In this case, defendants themselves were in the best position to discover the

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errors in the summary exhibit. The vast majority of the errors on the spreadsheet (Exhibit 20A) and chart (Exhibit 20B) resulted from Statler including in the data patients that were apparently seen by Mitrione in a hospital or other non-office facility. Statler testified that all hospital visits were removed from the exhibit. Statler's misstatement should have been obvious to Mitrione and DeVore, who were familiar with the patients and the services. The district court found that over 50% of the patients listed on the spreadsheet were "out of office" patients. In fact, several of these patients were in fact *only* seen in the hospital. Either defendant could have identified the errors merely by looking at the face of the spreadsheet. (NewTrialTr:141)

Further, defendants' attorneys received Exhibit 20A weeks before it was introduced at trial. Indeed, the fact that the summary included hospital patients was pointed out by DeVore's attorney during the pretrial conference on August 9, 2001. He stated: ". . . I think included in some of these is treatment that was given in hospitals that we don't have the records for, that I have no indication that the Government has ever gotten the records for those." (PretrialTr:28-29) Thus, the fact that the chart included claims for patients treated in the hospital did not come to defendants' "knowledge only after trial" or take them by surprise.

Finally, the defense was clearly warned that this document was going to be 8 In granting the motion for new trial on some counts, the court found that the defense did not discover the falsity of the evidence until after trial and they were unable realistically to meet it at trial. (RulingTr:15)

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offered if they presented a summary. (PretrialTr:39;Tr:1967;docket entry 8/14/01) As the district court ruled following the trial, ". . . it was incredibly cavalier of the defense to inject summary exhibits into this without really understanding what was in the Government's exhibit, and knowing the high likelihood that if they used their summary exhibit the Government in all likelihood would get to use its

summary exhibit.” (RulingTr:16) “Defendants were the impetus for the admission of this evidence and cannot now complain that it was improper.” (R:149,p.11)

Thus, there was nothing presented that “could not have been discovered sooner had due diligence been exercised,” nor anything that defendants should not have been “able to meet” at the time of the testimony. *See United States v. Nero*, 733 F.2d 1197, 1204 (7<sup>th</sup> Cir. 1984).

As defendants did not meet the requirements necessary for a new trial on Counts 12 and 14, the district court properly denied their motions.

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IV. The District Court Properly Enhanced DeVore’s Sentence For Obstruction of Justice Under USSG § 3C1.1

The district court imposed a two-level obstruction of justice enhancement under USSG § 3C1.1 on both defendants after finding that they testified falsely at the trial. (SentTr:172-73) DeVore contends that she did not testify falsely, and therefore the district court clearly erred in imposing the enhancement.

(DeVoreBr:33-38) Mitrione adopts the arguments in DeVore’s brief; DeVore’s brief, however, neither mentions Mitrione’s obstruction enhancement nor argues that it was improper.

A. Standard of Review/Waiver

This Court’s review of a district court’s imposition of an obstruction of justice enhancement is “very limited.” *United States v. Ramunno*, 133 F.3d 476, 480 (7<sup>th</sup> Cir. 1998). The district court’s determination that DeVore obstructed justice is a factual finding that this Court will not disturb unless it is clearly erroneous. *Id.* To meet this standard, DeVore must convince this Court “to a certainty that the district court’s factual findings were incorrect; merely suggesting the possibility of error is not enough.” *Id.* at 480-81 (citing *Anderson v. City of Bessemer City*, 470 U.S. 564, 573 (1985)). This is an especially daunting task for a defendant if the district court’s factual finding, as in this case, is based on an assessment of credibility because this Court gives special deference to the district judge’s

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credibility determinations. *Id.* at 481. *See United States v. Barnett*, 939 F.2d 405, 408 (7<sup>th</sup> Cir. 1991)(obstruction of justice enhancement upheld where the district court “made a credibility determination” that defendant lied “which we will not reconsider”); *United States v. Hickok*, 77 F.3d 992, 1007 (7<sup>th</sup> Cir. 1996)(district court is in best position to determine whether defendant committed perjury and this determination enjoys a presumption of correctness).

Mitrione does not argue that the district court erred in finding that he obstructed justice; instead, he merely adopts the arguments in DeVore’s brief.

DeVore’s brief, however, neither mentions Mitrione’s obstruction of justice enhancement, nor argues that it was improper. It is well-settled that a perfunctory and undeveloped assertion is inadequate to raise a separate basis for appeal. *United States v. Andreas*, 150 F.3d 766, 769-70 (7<sup>th</sup> Cir. 1998). This Court is not responsible for researching and constructing legal arguments available to a party. *Head Start Family Educ. Program, Inc. v. Cooperative Educ. Serv. Agency 11*, 46 F.3d 629, 635 (7<sup>th</sup> Cir. 1995).

Because Mitrione makes no argument with respect to this issue, he has waived his right to have that portion of the district court’s sentencing order reviewed on appeal. *See Tyler v. Runyon*, 70 F.3d 458, 465 (7<sup>th</sup> Cir. 1995)(“if a defendant fails to make a minimally complete and comprehensible argument for each of his claims, he loses regardless of the merits of those claims . . .”).

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B. Legal Framework

Section 3C1.1 of the Guidelines authorizes the district court to enhance the defendant’s offense level by two levels if it finds by a preponderance of the evidence that the defendant willfully obstructed or impeded the administration of justice during the prosecution of the offense of conviction. USSG § 3C1.1. *See United States v. Williams*, 272 F.3d 845 (7<sup>th</sup> Cir. 2001). The notes to that Guideline list “committing, suborning, or attempting to suborn perjury” as examples of conduct warranting the enhancement. USSG § 3C1.1, comment. (n.1).

Consequently, when a defendant testifies falsely at his own trial concerning a material matter with the willful intent to provide false testimony rather than as a result of confusion, mistake, or faulty memory, the court may apply the enhancement. *Williams*, 272 F.3d at 864.

C. Analysis

At trial, DeVore repeatedly testified that she was not the biller for M&A.

(Tr:2026,2030,2095,2155,2215-16,2219,2223-24,2226-2230) The district court found that DeVore testified that, prior to 1997, she played no role in billing except to fold, mail, and sign the bills. (SentTr:171)

The district court found that DeVore's testimony was contradicted by several witnesses at trial, implicitly found those witnesses to be more credible, and concluded that DeVore testified falsely. (SentTr:169-71) Rather than argue that

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her statements at trial were mistaken or the result of confusion, DeVore maintains that her testimony was truthful and claims that the government presented no contrary testimony. (DeVoreBr:34-37) The record belies DeVore's claim.

As the district court found, several witnesses, including McGowan, Goff, Woods and others, established through their testimony that DeVore in fact "orchestrated the billing processes throughout that office." (SentTr:171) These witnesses testified that DeVore instructed them on how to: (1) bill; (2) interpret codes; (3) resubmit bills that had been rejected; and (4) change the listed service date on a bill to avoid rejection of a bill for a second service on one date. (Tr:1148-49,1185;SentTr:169-71)

So, while DeVore maintains that her testimony was true, her claim simply cannot be squared with the evidence. In light of the testimony, the district court properly found that DeVore's statements that prior to 1997 she played no significant role in billing were false.

The district court also properly found that the testimony was material to the counts of conviction because it was willfully intended to mislead the jury into thinking DeVore had no decision-making authority in billing when clearly she did. (SentTr:171) See *United States v. Freitag*, 230 F.3d 1019, 1025 (7th Cir. 2000) (district court's finding that Medicare fraud defendant's testimony was " . . . a

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creative revision of what had happened" sufficiently found intent required to support perjury-based sentence enhancement).

DeVore also claims that the district court clearly erred in finding that she testified falsely that she did not participate in the decision to have Woods lead the SOSA group. (DeVoreBr:37-38) While DeVore baldly states that "no contrary testimony was offered" (DeVoreBr:38), the district court in fact found that DeVore's testimony was contradicted by Woods, Mitrione, and Goff. (SentTr:171-72)

Mitrione testified that the decision to have Woods participate as a co-therapist was a group decision. (Tr:1708-10) Woods testified that DeVore told him the group ran better with him, and she and Mitrione did not see anything wrong with him running the group. (Tr:806) Goff testified that both Mitrione and DeVore told her that Woods would be a co-therapist for the group and that Woods was qualified. (Tr:199-201) Thus, the district court properly found that DeVore's statement that she was not involved in the decision to have Woods participate in the second SOSA group was knowingly false, made with the willful intent to mislead the jury, and material to the issues on Counts 12 and 14. (SentTr:171-72)

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V. The District Court Properly Calculated The Loss Figure At Sentencing Defendants argue that the district court, in calculating the loss amount for sentencing purposes at \$11,943.05, failed to credit them for services provided by non-physicians of M&A. (MitrioneBr:45-52)

The district court found, however, that the value to IDPA and Medicare of those services was zero (SentTr:158), and therefore properly refused to offset the loss amount.

A. Standard of Review

A district court's calculation of the loss amount under the guidelines is a question of fact, which this Court reviews for clear error. *United States v. Freitag*, 230 F.3d 1019, 1025 (7th Cir. 2000). A defendant appealing a loss calculation faces the heavy burden of showing that calculation was not only inaccurate, but also outside the realm of permissible computation. *United States v. Hassan*, 211 F.3d 380, 383 (7th Cir. 2000).

B. Legal Framework

In fraud cases, a defendant's sentence depends in part upon the amount of loss involved in the defendant's crime. See USSG § 2B1.1. An application note to USSG § 2B1.1 provides that where a defendant fraudulently renders services to a victim by posing as a licensed professional, the loss must include the amount paid for the services rendered, with no credit provided for the value of those

9 The district court thoroughly analyzed and calculated defendants' sentences under the 2001 version of the guidelines, in effect at the time of sentencing, and under the 1995 version, in effect at the time defendants committed their crimes. The court concluded that the 2001 version of the guidelines benefitted defendants more. (SentTr:159) Defendants do not challenge that decision on appeal.

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services. USSG § 2B1.1, comment. (n.2(F)(v)).9 This provision was added as a result of the precise situation facing the Court in this case. The Sentencing Commission explained that this application note was necessary to reverse case law that allowed credit for services provided by people posing as medical personnel:

This rule reverses case law that has allowed crediting (or exclusion from loss) in cases in which services were provided by persons posing as . . . medical personnel. See *United States v. Maurello*, 76 F.3d 1304 (3rd Cir. 1996). . . . [T]he seriousness of these offenses and the culpability of these offenders is best reflected by a loss determination that does not credit the value of the unlicensed benefits provided. In addition, this provision eliminates the additional burden that would be imposed on courts if required to determine the value of these benefits.

Supplement to Appendix C, November 1, 2001, Amendment 617.

### C. Analysis

As the district court emphasized, the loss determination of approximately \$11,000 is conservative given the scope and duration of defendants' fraud. (R:238) The court limited the amount of loss to amounts calculated independently of Statler's testimony. In computing the amount of loss, the court considered only the evidence of Medicare billings for services of Goff, DeVore, Ingram, and

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Woods prior to the time they were licensed, when they performed services well beyond their qualifications. (R:238)

Defendants argue that the district court should have credited them for nonphysician services provided by M&A. (MitrioneBr:44-52) Their argument ignores the application note to USSG § 2B1.1, and rests on a faulty premise, *i.e.*, that the government was willing to pay for those services. The district court found the opposite to be true. IDPA was never willing to pay for services rendered by Goff, DeVore, Ingram, and Woods because their services did not qualify as "physician services." (SentTr:158) Moreover, Medicare was unwilling to pay for those services, because they were neither rendered by licensed professionals nor provided incident to the physician's services. (SentTr:158) *United States v. Frost*, 281 F.3d 654 (7th Cir. 2002) (willingness to pay for the services is a key factor in determining whether credit should be given).

The cases cited by defendants are inapposite. First, *United States v. Hayes*, 242 F.3d 114 (3rd Cir. 2001), was a direct result of the Third Circuit applying *Maurello* to a social worker. As discussed above, the Sentencing Commission specifically intended to reverse the rule set forth in *Maurello*. Thus, *Hayes* likewise has no precedential value.

*United States v. Vivit*, 214 F.3d 908 (7th Cir. 2000), is also distinguishable because the insurance companies there were willing to pay for the services

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provided, just not for the excessive charges. Thus, the question in *Vivit* was not whether services were provided by someone other than the doctor, but whether services were provided at all. *Id.* Here, by contrast, Medicare was unwilling to pay anything for the services at issue.

Finally, defendants cite *United States v. Frost*, 281 F.3d 654 (7th Cir. 2002), a case that supports the government's position. In *Frost*, a pre-2001 guidelines case, defendants asked the court to offset the "value of education" provided to the students from the amount of the fraud and argued that the sentencing guidelines called for a calculation of net loss, not gross loss. *Id.* at 659. This Court held that because defendants concealed material facts from the agency, they prevented the government victims from making an informed decision on whether to pay for the service. *Id.* This Court, therefore, refused to lower the loss by the "value" of the service defendants claimed, because the government agency was unwilling to pay for the service allegedly rendered. Here, it is likewise clear that neither IDPA nor Medicare would have paid the claims had they known the facts.

Defendants argue that many of the patients DeVore treated at M&A had previously received treatment from her when she worked at MHC. She then argues that while she "is not suggesting that Mitrione's license was equivalent to

MHC's . . . the amount billed by MHC for precisely the same services [should] serve as a benchmark to set the value of the services rendered by Mitrione and

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his staff." (MitrioneBr:49) The district court rejected defendants' argument that the amount of loss should be offset by DeVore, Goff, and Ingram's work as if they were working at a mental health center. In so doing, the court found, "The short answer is they weren't. Mitrione and Associates was not a Mental Health Center. Different rules apply for Mental Health Centers." (SentTr:159)

The district court, therefore, properly refused to offset the loss because the Sentencing Guidelines prohibit crediting in this situation and Medicaid and Medicare were unwilling to pay for the services.

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VI. The District Court Properly Ordered Restitution To Be Paid To The Medicare Program

Defendants argue that the district court erred in ordering them to reimburse Medicare, because, according to them, the victim of their fraud was Medicaid. (DeVoreBr:32-33)

A. Standard of Review

At sentencing, defendants did not object to the restitution order on the ground that they now advance, *i.e.*, that Medicaid – not Medicare – was the victim of their fraud. Instead, they argued that the district court improperly calculated the amount of restitution owed. In fact, defendants contended that the total loss to Medicare was \$2,144.58 and that Medicaid should be paid nothing.

(DevorePSRAddendum,p.34;MitrionePSRAddendum,pp.31-34) Defendants therefore forfeited this issue, and this Court will review only for plain error. *United States v. Randle*, 324 F.3d 550, 555 (7<sup>th</sup> Cir. 2003).

B. Legal Framework

Since defendants were convicted of fraud, the district court's authority to impose restitution is governed by the Mandatory Victim Restitution Act codified at 18 U.S.C. § 3663A and 18 U.S.C. § 3664. The relevant portions of the MVRA provide:

(A)(1) Notwithstanding any other provision of law, when sentencing a defendant the court shall order, in addition to . . . any other penalty

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authorized by law, that the defendant make restitution to the victim of the offense.

(2) For the purposes of this section, the term "victim" means a person directly and proximately harmed as a result of the commission of an offense for which restitution may be ordered including, in the case of an offense *that involves as an element a scheme . . . any person directly harmed by the defendant's criminal conduct in the course of the scheme . . .*

18 U.S.C. § 3663A(a)(1)-(2) (emphasis added).

Thus, while restitution is limited to the counts of conviction, when the counts of conviction involve a scheme, the restitution may be ordered for all of the harm caused by the defendant's criminal conduct in the course of the scheme. See *Randle*, 324 F.3d at 556; *United States v. Martin*, 195 F.3d 961, 967 (7<sup>th</sup> Cir. 1999).

C. Analysis

Based upon the district court's finding that the total loss caused by defendants' fraud was \$11,255, the district court ordered defendants to pay restitution in that amount. Defendants here do not dispute the amount of restitution ordered. Instead, they claim that the district court picked the wrong victim. They argue that Medicaid – not Medicare – was victimized by their fraud. (DeVoreBr:32) They are half right. Actually, as the district court found, both Medicaid and Medicare were victimized by their fraud. (SentTr:160-61) The statute does not, as defendants argue, limit restitution to only those individuals harmed by the conduct that formed the basis for a conviction. To the

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contrary, the statute defines the term "victim" as any person directly harmed by the defendant's criminal conduct in the course of the scheme. *Martin*, 195 F.3d at 967. See *United States v. Randle*, 324 F.3d at 557 ("restitution is authorized under the MVRA . . . to a victim who is directly harmed by the offender's conduct in the course of committing an offense that involves "as an element a scheme . . .") (emphasis in original); *United States v. Jackson*, 155 F.3d 942, 949 (8<sup>th</sup> Cir. 1999) ("the district court may order restitution to every victim directly harmed by the defendant's conduct in the course of the scheme . . . that is an element of the offense of conviction, without regard to whether the particular criminal conduct

of the defendant which directly harmed the victim . . . was even charged in the indictment.”).

In this case, defendants were convicted of one count of mail fraud in violation of 18 U.S.C. § 1341 (Count 12) and one count of filing false claims in violation of 18 U.S.C. § 287 (Count 14). These counts adopted parts of Counts 1 and 2, which charged defendants with devising a scheme to defraud the Medicaid and Medicare programs of the State of Illinois and the United States. (R:1;SentTr:188-189) See *United States v. Bennett*, 943 F.2d 738, 740 (7<sup>th</sup> Cir. 1991)(“Because a scheme to defraud is an element of the offense of mail fraud, a conviction pursuant to that statute allows restitution for all victims of that scheme.”). Defendants were convicted of offenses that triggered the broad definition of

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“victim” under the MVRA (and thereby authorized the district court to order restitution for all of the victims of the scheme), regardless of whether defendants were convicted of that specific conduct. See *Martin*, 195 F.3d at 969.

Thus, because defendants’ crime included a scheme, and there is evidence that the scheme directly harmed a victim, *i.e.*, Medicare, other than the victim mentioned in the counts for which defendants were convicted, *i.e.*, Medicaid, the district court did not err, plainly or otherwise, in ordering that the defendants pay restitution to Medicare. See *United States v. Smith*, 218 F.3d 777, 784 (7<sup>th</sup> Cir. 2000)(“As long as the court can adequately demarcate the scheme, it can order restitution for any victim harmed by the defendant’s conduct during the course of that scheme.”).

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#### **CONCLUSION**

For the foregoing reasons, the judgments including sentences of the district court should be affirmed.

Respectfully submitted,

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#### **CERTIFICATE OF COMPLIANCE**

This brief complies with the type-volume limitation of Fed. R. App. P.

32(a)(7)(B) because this brief contains 13,870 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

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#### **CERTIFICATE OF SERVICE**

I certify that on 7<sup>th</sup> day of May, 2003, I served two copies of the Consolidated Brief of Plaintiff-Appellee, and a copy in digital media format, upon defendants-Appellants herein, by mailing them to counsel of record as follows:

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