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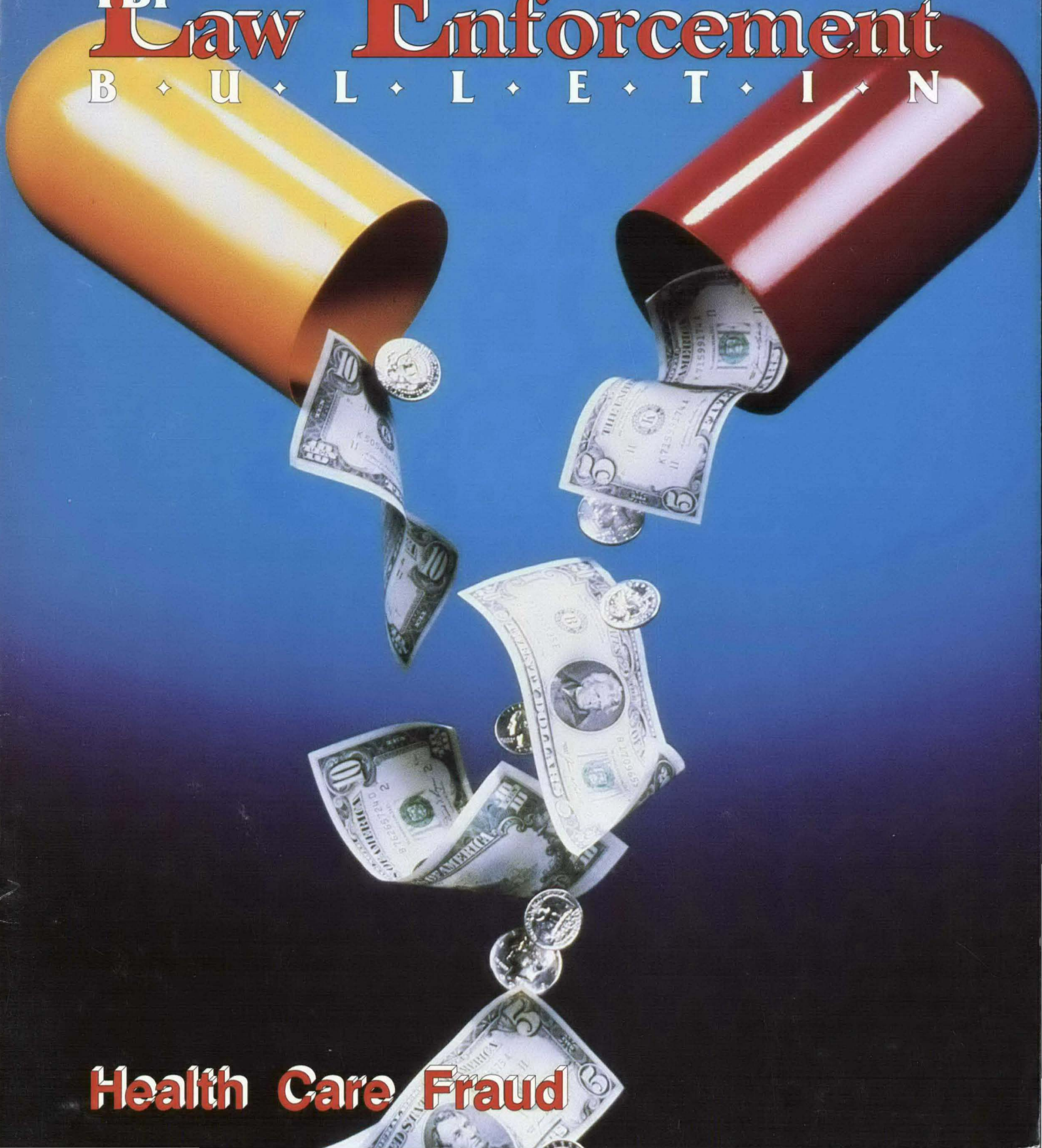

Health Care Fraud

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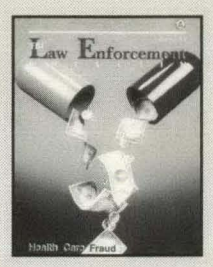
Features

Focus on Health Care Fraud

Departments



Cover: Health care fraud directly challenges law enforcement. This issue focuses on law enforcement's concerted efforts to strategically address this crime problem. (Cover photo © 1992, M. Simpson, FPG International Corp.)

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Director's Message

Throughout history, law enforcement has risen to meet the challenges brought about by the ever-changing needs of society. As the 21st century nears, law enforcement must be aware that crime problems continue to evolve. One such area that demands immediate attention is health care fraud.

The economic toll of health care fraud is staggering. The U.S. Chamber of Commerce estimates that between 5 and 15 percent of all paid health insurance claims are fraudulent. However, by working with the many facets of the health care profession, law enforcement, government, and private carriers can develop strategies to root out the schemes of fraudulent health care providers who not only threaten the financial well-being of citizens but in many cases also endanger the health of Americans.

In recent years, Federal, State, and local regulatory and law enforcement agencies embarked on a long-term aggressive campaign to combat health care fraud. With a substantial commitment of resources and a coordinated approach, these agencies identified fraud in almost every segment of the health care industry. Though this fact is disturbing, only a very small percentage of health care professionals were found to engage in the type of egregious and illegal procedures that warranted law enforcement's attention.

This summer, the first phase of Operation GOLDPILL, the largest health care fraud undercover operation in history, culminated in the filing of criminal charges, the mass execution of search warrants, and asset seizures. As a result of this 2-year investigation, over 200 subjects nationwide were charged and arrested, over 100 locations were searched, 11 pharmacies were seized, liens were placed on over 20 pieces of real property, and restraining orders attached to approximately 300 financial accounts.

In Operation GOLDPILL, the FBI worked with the Food and Drug Administration, the Drug Enforcement Administration, the Department of Health and Human Services, and the Postal Inspection Service, along with various State and local agencies in over 50 cities, to carry out the arrests and execute the search warrants. Millions of dollars worth of adulterated and illegal medications were taken out of circulation, and cash in excess of $1 million was seized.

Beyond investigative cooperation, law enforcement must develop training programs to address health care fraud and must strengthen working relationships with other investigative and regulatory agencies. Departments also need to expand their criminal intelligence base and make effective use of asset forfeiture in health care fraud investigations. Most importantly, however, criminal justice professionals must exhibit an increased determination to investigate and prosecute this crime.

This issue of the *FBI Law Enforcement Bulletin* focuses on law enforcement's campaign against this growing crime problem. The feature articles detail how local, State, and Federal agencies and Federal prosecutors work to curtail the activities of fraudulent health care providers.

Without question, the criminal justice community faces a formidable task in combating health care fraud. Yet, I am confident that law enforcement on all levels can meet the investigative challenges and take positive action against those who jeopardize the physical, mental, and economic well-being of Americans. ✦

William S. Sessions
FBI Director

Health Care Fraud
The Silent Bandit

By
JOSEPH L. FORD

Each second, Americans spend approximately $24,000 on health care,[1] making it the second largest industry in the United States, next to education.[2] In the time that it takes to read this article, Americans will spend an additional $12 million on health care. And these figures will continue to skyrocket.

The U.S. Chamber of Commerce estimates that by 1994, spending on health care will reach $1 trillion, and this amount will probably double again by the turn of the century.[3] In 1982, by contrast, expenditures on health care totaled just $280 billion.[4]

Unfortunately, this dramatic increase has been fueled, in part, by growing levels of fraud in the health care industry. While the vast majority of health care practitioners provide competent, equitable services, those who commit fraud cost this Nation significantly. While estimates vary, as much as 10 cents of every dollar spent on health care may be lost to fraud and abuses in the industry.[5]

To a large degree, this occurs because Americans tend to place their trust in health care professionals. People expect good health care and do not mind paying for services that will make them well. To them, cost does not matter when it comes to proper medical treatment for troubling health problems. At the same time, they assume that they will be billed correctly for the treatment received and will not be subjected to unnecessary treatments, tests, or drugs. Unfortunately, this is not always the case.

IDENTIFYING FRAUD

Investigators must remember that fraud affects every level of the health care system—from a doctor who charges exorbitant fees and authorizes unnecessary tests, to a hospital or nursing home that overbills Medicare, to a pharmacist dispensing generic drugs at brand name prices. In addition, another major component of the system easily defrauded by unethical providers includes durable medical equipment (DME) suppliers, who may conspire with other segments of the

health care system to commit a host of fraudulent activities.

Unfortunately, though, not all cases of fraud can be clearly defined. Because malpractice suits can destroy entire careers, the actions of many health care providers are governed by the need to protect themselves from liability. These practitioners believe it is better to perform a battery of tests and authorize extensive treatments rather than find themselves involved in a malpractice suit resulting in a multimillion-dollar settlement. While such cases may border on fraud, they can be considered more accurately as simple abuse of the system.

Fraud, on the other hand, encompasses clear and distinct activities by practitioners and businesspersons in the health care field to make money illegally, primarily by bilking patients, private insurers, or the Federal Government. For the most part, the audit systems established by the various Federal and State regulatory agencies do not detect this type of criminal activity. Law enforcement, then, must take action.

THE ROLE OF LAW ENFORCEMENT

Federal, State, and local law enforcement all must play a role in combating health care fraud. Jurisdiction, investigative expertise, and Federal and State laws govern the levels of involvement of the various agencies. However, success in curtailing the activities of fraudulent health care providers depends on closely coordinated efforts of the entire criminal justice community. No one agency can solve the problem of health care fraud independently; Federal agencies must work with those on the State and local levels to stem the tide of this devastating crime.

Federal Agencies

Several Federal agencies devote extensive resources and a vast number of workhours to health care fraud investigations. These include the Drug Enforcement Administration (DEA), the Food and Drug Administration (FDA), the U.S. Postal Service, the Department of Health and Human Services (DHHS), the U.S. Department of Labor, the Office of Personnel Management, and the Defense Criminal Investigative Service (DCIS). Each agency handles specific areas of health care fraud according to its jurisdictional and legislative mandates.

Health care fraud is also a top investigative priority within the FBI's White-Collar Crimes Program. As a combative measure, the FBI developed a national strategy to investigate incidents of health care fraud.

Because each of these agencies has well-defined investigative responsibilities, they can combine their specific resources to provide a comprehensive effort:

- Diversion units of the DEA monitor and investigate the diversion, misuse, and abuse of pharmaceutically controlled narcotic substances
- The FDA regulates the prescription drug market of noncontrolled prescription medications
- Postal Service investigators become involved in health care cases through jurisdictional mandates authorizing them to investigate fraud committed through the U.S. mail. Since the majority of claims filed by health care providers (as well as subsequent payments) flow through the mail, the investigative resources of the Postal Service can be invaluable in fraud investigations
- The Inspector General's Office of Health and Human Services audits and investigates health care providers accused of fraud against federally sponsored

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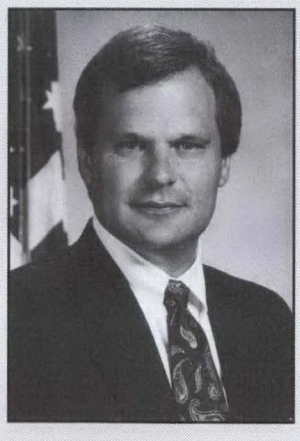


Special Agent Ford serves in the White-Collar Crimes Section of the FBI's Criminal Investigative Division in Washington, D.C.

programs, primarily Medicare and Medicaid

- The Inspector General's Office of the Department of Labor handles cases involving workmen's compensation claims or fraud in health plans administered by labor unions
- The Office of Personnel Management becomes involved when fraud is suspected in Federal employee health plans. Almost every Federal worker is enrolled in one of a number of health insurance plans, to which the Federal Government contributes billions of dollars annually. Fraud can be committed against Federal health plans as well as private ones
- The Defense Criminal Investigative Service seeks to ensure the integrity of all Department of Defense programs, including the military health care system. In 1991, the cost of medical care to military personnel, both active and retired (and their dependents), reached approximately $13 billion.

The FBI's National Strategy

Although the FBI began investigating incidents of health care fraud in the 1970s, the vast majority of these cases targeted single providers. During the past several years, however, the FBI developed a more comprehensive national strategy against health care fraud and redirected its efforts and resources in this area.

Health care frauds have evolved from single offenders operating in one State to multiple offenders operating throughout several States. The FBI has focused its investigations on these loosely knit, complex conspiracies. In many cases, groups of individuals operate fraud schemes in several different States at the same time. Once detected, these offenders simply move on to other locations within the country to conduct their illegal practices. As a result, the FBI now looks at local problems on a national level and coordinates its investigations accordingly.

> ***"Health care frauds have evolved from single offenders operating in one State to multiple offenders operating throughout several States."***

Simply stated, the FBI's national strategy takes a holistic rather than parochial view of health care fraud. This perspective is essential because the crimes committed against private insurers and Government-sponsored programs often cross State lines. Single defendant prosecutions have given way to multidefendant conspiracy indictments.

Moreover, rather than reacting to isolated allegations, the FBI's current initiative includes deploying unique and sophisticated proactive investigative techniques. Gathering evidence through extensive financial record reviews has given way to the use of undercover operations, electronic surveillance, cooperating witnesses, and consensual monitoring.

In the early 1980s, many prosecutions were lost because of such defenses as "the Government rules were too complicated" or "the bookkeepers didn't know what they were doing." Now, undercover operations and consensual monitoring provide direct evidence of providers' criminal intent.

Within this framework, the FBI established a national intelligence base and trained investigative personnel to handle these types of cases. In addition, white-collar crime squads in seven FBI field offices—Baltimore, Chicago, Detroit, Los Angeles, Miami, New York, and Philadelphia—now focus exclusively on health care fraud cases.

State Regulatory and Law Enforcement Agencies

The current system places most responsibility for regulating the health care industry with the States. For this reason, investigators at all levels should consider working closely with certification boards and other State regulatory entities when developing cases.

Regulatory agencies house important records and can provide relevant information to investigators. State boards can verify whether a suspected offender possesses a license to practice or whether criminal charges have been brought against a suspect in another part of the State.

The decision to bring regulators into a case rests with the investigating agency, but this step cannot be overlooked. Only State licensing

boards have the authority to suspend or revoke the licenses of health care providers to prevent them from operating in that State. And since every State sets its own regulations on license suspension and revocation, it is important to contact these boards at some point in the investigation.

However, State involvement in health care extends beyond regulation to include investigative and statutory responsibilities. State Bureaus of Investigations, State Police, and other State-level law enforcement agencies are generally quite familiar with health care fraud investigations and can provide valuable assistance to local departments developing their own investigative initiatives. Forty-two States operate special Medicaid Fraud Control Units. These units are the frontline in Medicaid fraud enforcement and can provide relevant information to local agencies or work with them to conduct undercover operations.[6]

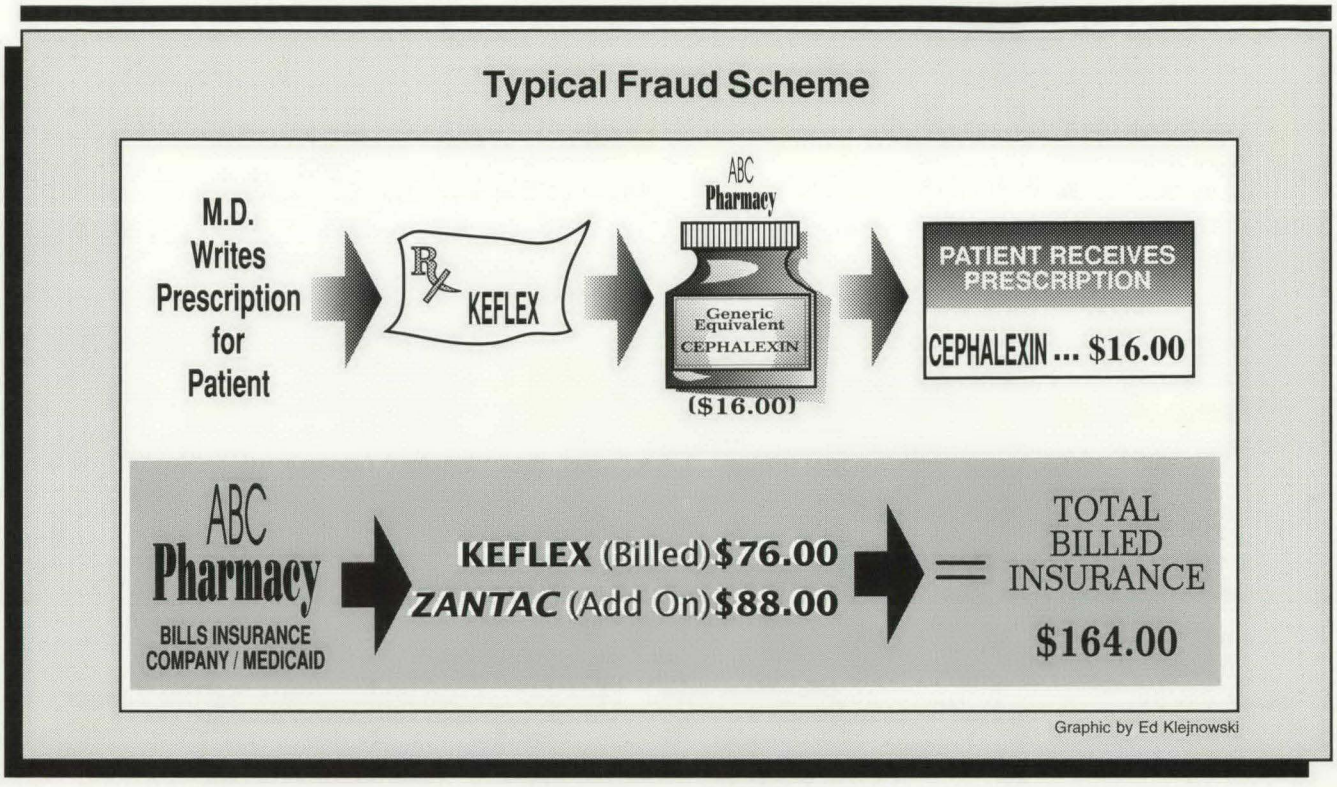
Local Law Enforcement

Often, local police agencies are the first to receive fraud allegations, usually brought to them by patients who suspect that their health care providers are involved in illegal activities. When allegations surface, local agencies can conduct an investigation or notify the appropriate State or Federal agency of possible fraud and patient abuse problems within their jurisdictions.

If police departments decide to conduct their own investigations, they need to develop a plan to gather the information needed to arrest and prosecute the offender(s). Agencies should initiate surveillance, use undercover operatives to verify the al-

Health Care Fraud Investigative Guidelines

- Ensure that the provider is clearly committing fraud, e.g., billing for services not rendered, billing for treatment not administered or for which there is no apparent need, supplying equipment not required by patient, etc.
- Make liaison contacts with other law enforcement agencies, insurance companies, local and State regulatory boards, and Federal entities responsible for investigating health care fraud. Undercover contacts with any health care professional or provider should always be well predicated.
- Remember when analyzing billing data that there may be well-founded reasons for a provider's billings to be high. As an example, pharmacies located close to oncology clinics could easily explain high percentages of controlled narcotics dispensed. Billings by providers should be compared with their peer group instead of all doctors in the metropolitan area. A chiropractor's billing will often be different when compared to a heart surgeon or ENT specialist.
- During undercover operations, use individuals who do not have known illnesses. If diagnosed as being ill, confirm with a reputable provider that the undercover operative is, in fact, well and that the diagnosis has been fabricated.
- Ensure that undercover operatives seek treatment for illnesses that mirror the fraudulent activity. That is, if patients are billed for generic/brand substitutions for pharmaceuticals, the undercover operative should not have a prescription for a drug that has a generic equivalent available at a considerably lower price.
- Compare billings with treatments received and track billings from one central repository. Use fraudulent billings as probable cause for search warrants to seize other documents, either from insurance carriers or Government-sponsored programs. By law, certain patient records are protected. Search warrants should be closely coordinated with the assistant U. S. attorney or district attorney.
- When conducting investigations, do not overlook those who provide ancillary services in the medical profession, e.g., nursing homes, laboratories, medical equipment suppliers, pharmacies, etc.



legations, and elicit corroborating testimony from other patients.

Even on the local level, investigators should take a global approach to health care fraud. If individuals are committing fraud against one program, they are also likely to defraud other programs subscribed to by their patients. As an example, when investigating primary care providers (doctors), it is important to look at all of the doctors' insurance claims (Medicaid, Medicare, private insurers, etc.). In addition, many providers may work in concert with pharmacists, clinics, hospitals, laboratories, and medical equipment suppliers to commit fraud.

Local law enforcement agencies should also contact local professional boards to see if other complaints have been registered against the suspected offender. If these local boards received previous complaints, this corroborating information can form the basis for predication to continue the investigation.

Because proving the *intent* to defraud is extremely important, investigators should attempt to catch offenders in the act of committing fraud. Departments need to show a pattern of criminal activity to get a search warrant and to file criminal charges. Accordingly, suspected offenders should not be able to claim billing errors or administrative mistakes as reasons for their behavior.

Other potential, but often overlooked, sources of assistance to local law enforcement are the private insurance carriers. Annually, these companies pay approximately $400 billion in claims. Their files may contain detailed information concerning allegations of fraud against health care providers.

A number of private insurance carriers operate Special Investigation Units (SIUs) that can work with law enforcement agencies to investigate and prosecute these health care fraud cases. The majority of personnel in SIUs have previous law enforcement experience, and their assistance can prove invaluable in developing successful cases.

PUNITIVE ACTIONS

Because health care fraud is becoming increasingly lucrative, it is not uncommon for a health care provider to be convicted in one State and then begin practicing in another, without even a lapse in defrauding the system. Currently, no law or Federal regulation specifically prohibits such actions. Thus, law enforcement agencies at the Federal, State, and local levels must use every available means to stop these criminals. Strategies may include

securing lengthy jail terms for offenders or seizing offender assets in order to prevent them from establishing fraudulent practices in other jurisdictions.

While State regulatory agencies can suspend or revoke licenses of health care providers, the Inspector General of Health and Human Services can bar offenders from submitting claims against Medicare and Medicaid for a minimum of 3 years up to life. Defrauders can also be subjected to civil action according to false claims statutes, and they can also be civilly fined for their criminal activity.

While these punitive actions impact on health care fraud, asset forfeiture may remain the most effective means to curtail the illegal activities of providers. Since individuals convicted of health care fraud rarely serve significant time in jail (because most are seen as first-time offenders), asset forfeiture is often the only form of punishment applied.

Forfeiture strips accused offenders of their ill-gotten gains and deprives them of their primary motivator—the acquisition of wealth. And, without capital or collateral, defrauders find it difficult to relocate and continue their illegal practices.

Generally, fraudulent claim forms and subsequent payments are either mailed or electronically transferred. When this occurs, violations of Federal mail fraud and wire fraud statutes are committed because the means of transmittal facilitates the fraud scheme. These statutes have been designated as "specified unlawful activity" under the Federal Money Laundering statute. Investigators should remember that the money laundering statute can be used to seize assets, both civilly and criminally.

Once investigators identify a fraud scheme, they should act quickly to freeze, or if possible, seize the tainted assets of the accused. Failure to do so may allow offenders to transfer funds and property so they do not retain outright ownership to anything of value. All too often, law enforcement agencies delay initiating forfeiture proceedings only to find that the accused has transferred bank accounts to offshore financial institutions or has signed over businesses, property deeds, and titles to a spouse or child.

> ***"...law enforcement agencies at all levels must actively investigate allegations of fraud in the health care system."***

The decision to seize assets civilly or criminally rests with the assistant U.S. attorney or the local district attorney. After this decision has been made, investigating agencies then follow their established forfeiture process. The insurance programs harmed as a result of the fraud scheme have an opportunity to make a claim against the forfeited assets. Also, under Federal forfeiture regulations, State agencies working together on the investigation can make a claim to those assets through sharing procedures of forfeiture law.

CONCLUSION

Health care fraud not only squanders national and personal resources but it also places the physical and emotional well-being of millions of Americans in jeopardy. As defrauders divert money away from legitimate services, research efforts, and programs into their own pockets, everyone who accesses the health care system pays for their crimes. For these reasons, law enforcement agencies at all levels must actively investigate allegations of fraud in the health care system.

Through combined and comprehensive efforts, law enforcement and regulatory agencies can have a significant impact in reducing fraudulent activity. Simply by establishing and publicizing an aggressive and effective effort, agencies can succeed in disrupting existing fraud schemes and discouraging new ones. When fraud is detected, every effort should be made to investigate all leads and to secure the strongest penalties possible against offenders.

Understanding that fraud may exist at any level in the health care system is an essential caveat for investigators to remember. Not all criminals wear masks—but some still do.✦

Endnotes

[1] "U.S. Industrial Outlook 1992," U.S. Department of Commerce, Washington, DC, 1991.

[2] Ibid.

[3] Ibid.

[4] Ibid.

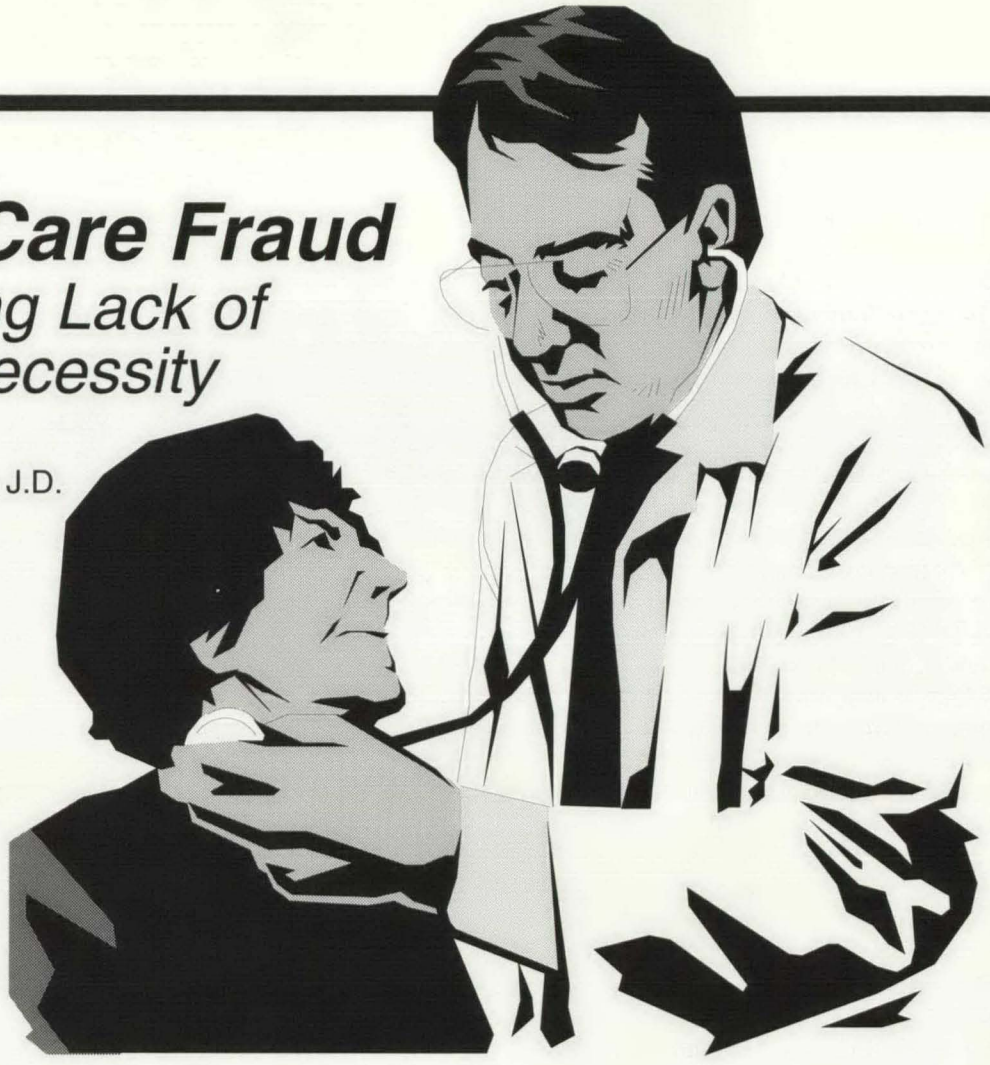
[5] Ibid.

[6] Larry L. Bailey, "Medicaid Fraud," *FBI Law Enforcement Bulletin*, 7, July 1991, 21-23.

Health Care Fraud

Prosecuting Lack of Medical Necessity

By
ANDREW GROSSO, J.D.



Health care providers who authorize unnecessary treatment, services, or supplies commit fraud against their patients and against insurance carriers that cover those pateints. Law enforcement, however, may be reluctant to give adequate attention to this type of fraud.

Reasons for such relunctance vary. Some believe that such targets are "too insulated." Others say that the prosecutions are "too risky" or that the investigations are "too resource intensive." These views, if they result in refusals to act, would permit the smartest criminals to continue to defraud the health care system of billions of dollars, while small-time and less-sophisticated offenders are prosecuted.

Law enforcement should not hesitate to pursue such challenging criminal schemes. Not only can such cases be successfully prosecuted, but the magnitude of the resulting deterrence effect can be enormous, producing benefits that more than justify the resources expended. The case account presented here is but one concrete example of the success that prosecutors can experience by bringing these criminals to justice.

Background

During 1988, Oswaldo Mora founded a small company in Tampa, Florida, called Osmomedic, Inc. This business supplied durable medical equipment (DME) to elderly people on Medicare. The company specialized in one particular type of DME—transcutaneous electrical nerve simulators, also known as TENS units. A TENS unit uses pulsating electrical currents to ease the suffering of chronic pain, such as that caused by arthritis.

Most Medicare beneficiaries, who are usually elderly, suffer from arthritis. Osmomedic used a sales force to seek out these beneficiaries, telling them that they were working with Medicare and that Medicare wanted them to have TENS units. Many beneficiaries gave their

names, addresses, and insurance identification numbers to the sales representatives, who then relayed the information to Osmomedic. For their efforts, the sales people received between $80 and $150 for each unit eventually prescribed and sold.

Osmomedic bought these units wholesale at $65 apiece, and then billed Medicare $685 for each TENS unit sold. In turn, Medicare "reimbursed" Osmomedic $484 per unit.

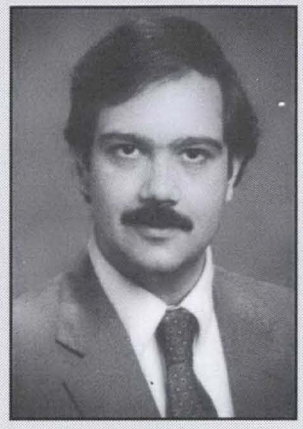
Clearly, Osmomedic and its owner had an incentive to maximize the number of units prescribed. To do this, the owner enlisted the aid of medical doctors, in addition to the services of Osmomedic's large corp of sales representatives.

Osmomedic would give the name and address of each Medicare beneficiary to one of three medical doctors—Nelson Ramirez, Betty Bertonicini, and Felix Cruz. Then, one of these doctors would visit a beneficiary at home. While there, the doctor would examine the patient, find that the person suffered from arthritis, and then prescribe a TENS unit.

Osmomedic made no payments to the doctors, because the doctors billed Medicare separately for their services. During a 6-month period, Medicare paid Osmomedic and these doctors more than $500,000.

The activities of Osmomedic came to the attention of law enforcement when Medicare beneficiaries in elderly care facilities began complaining that Osmomedic's sales representatives were making unsolicited calls and were pressuring the senior citizens to order TENS units. These complaints eventually reached the Inspector General's Office of the U.S. Department of Health and Human Services in Clearwater, Florida. This agency, together with the State Medicaid Fraud Control Unit and the Inspector General's Office of the U.S. Railroad Retirement Board, opened the criminal investigation.

> ***"...health care providers who engage in fraud are merely con artists who believe they can outsmart the system because of their medical expertise."***



Mr. Grosso is an assistant U.S. attorney in the Criminal Division, District of Massachusetts in Boston, Massachusetts.

Actions Taken

In February 1990, a Federal grand jury returned a 29-count indictment charging Osmomedic, Oswaldo Mora, Nelson Ramirez, Betty Bertoncini, and Felix Cruz with conspiring to defraud the Medicare Program by prescribing and billing for medically unnecessary services and supplies. Both Osmomedic and Oswaldo Mora pleaded guilty.

After a 2-week trial, at which Mora testified for the government, Nelson Ramirez and Betty Bertoncini were convicted of multiple counts and were sentenced, respectively, to 42 months and 30 months imprisonment. Dr. Cruz fled to Ecuador, his native country, prior to trial and was subsequently indicted for flight from prosecution. He remains a fugitive. Oswaldo Mora received a 24-month prison sentence, and Osmomedic, Inc., has since been dissolved.

Prosecuting the Crime

The gravamen of what the defendants did in this scheme is simple: They gave physical exams to Medicare beneficiaries, ordered TENS units that weren't necessary, and then billed Medicare for these exams and units. The problem facing the prosecution team was how to prove to the unanimous satisfaction of a jury, beyond a reasonable doubt, that Oswaldo Mora, his company, and the medical doctors engaged in a scheme to defraud Medicare by ordering and billing for examinations and TENS units that were not medically necessary.

Each Medicare claim form contains a statement requiring certification that the item being billed is medically indicated and necessary.

When there is no medical indication or necessity, signing this form constitutes a lie. Such a lie can be prosecuted under various statutes of Title 18 of the U.S. Code.

However, to minimize the extent to which the trial would become a battleground for experts, prosecutors approached these false statements from a slightly different angle. The primary thrust of the indictment was that *all* TENS units and exams had been provided in *conscious disregard* of medical necessity, not that any single unit or exam had been medically unnecessary.

For the most part, prosecutors relied on the general conspiracy statute (sec. 371) and the mail fraud statute (sec. 1341) of Title 18, U.S. Code, to charge this fraud scheme. Specifically, prosecutors used a clause in sect. 371, which makes it an offense to conspire to defraud the United States.

The Trial

At the trial, the prosecution presented 12 Medicare beneficiaries in support of its case. When called to the stand, these beneficiaries all testified that they had their own personal physicians, whom they saw regularly, and that they had no need to be examined by another doctor. They stated that they allowed Osmomedic's doctors to see them only because the sales representatives told them (falsely) that Medicare would be sending doctors to examine them. Prosecutors also demonstrated that in no case had a beneficiary's personal physician (who knew the medical condition of the patient far better than Osmomedic's doctors) ordered a TENS unit for that individual.

The prosecution then entered testimony that focused on the specific practices of each of the defendant doctors. The doctors employed various tactics to commit the fraud.

Dr. Ramirez was the most active participant, and perhaps, the greediest of the three doctors indicted. He examined some 300 patients. For each beneficiary, with very few exceptions, Dr. Ramirez performed a routine physical, an electrocardiogram (EKG), and a holter monitor exam. Each claim submitted by Ramirez to Medicare for these three exams totaled over $500, excluding the separate bill for the TENS unit submitted by Osmomedic.

The fact that 300 patients received identical tests raised the question as to whether these tests were truly necessary. The prosecution addressed this issue by calling experts to the witness stand to explain the purpose of a holter monitor and how a physician conducts an exam using this device.

A holter monitor is a device that records the electrical activity of the heart. In order to interpret the record produced by the monitor accurately, a patient wears the device for 24 hours and maintains a diary to show what the patient was doing at various times of the day (walking, sitting, sleeping, etc.). The patient also notes any chest discomfort experienced. Without such a diary, holter monitor results cannot be interpreted and are virtually worthless.

During the trial, prosecutors pointed out that Dr. Ramirez never asked his patients to keep a diary. This fact demonstrated that he provided the holter monitors without any intentions of using the results recorded. Further, Dr. Ramirez interpreted *all* 300 holter monitor recordings as being "normal."

Toward the end of the government's case, prosecutors called an expert cardiologist to testify. Prior to trial, this cardiologist examined the physical exam reports, the EKG results, and the holter monitor reports.

To begin his testimony, this expert explained to the jury how a holter monitor works and when use of one is indicated. He then gave his opinion as to the medical necessity of holter monitors for 80 randomly selected Medicare beneficiaries from the 300 patients seen by Dr. Ramirez.

As a basis for his opinion, the cardiologist used Dr. Ramirez's own medical files, which contained the results of the physical exams and the EKGs. The cardiologist found that holter monitors were not medically necessary for an overwhelming number of those 80 patients.

Dr. Bertoncini was somewhat more sophisticated than Dr. Ramirez. She varied the tests given to Medicare beneficiaries to fit their medical needs more closely.

Sometimes, she performed only a physical exam, for which she billed Medicare a mere $90. Other times, she performed the same tests as Dr. Ramirez and more. For these services, Medicare was billed in excess of $1,000.

In addition, however, Dr. Bertoncini took 12 kickbacks, totaling $600, from one sales representative. The indictment charged her with 12 felony counts under 42 U.S.C. sec. 1320a-7b for those kickbacks. These charges were in addition to the fraud counts filed under Title 18 of the U.S. Code.

"Medical Necessity" of TENS Units

The prosecution also addressed the medical necessity of the TENS units, focusing on the fact that Medicare requires a trial period and that Osmomedic and the doctors ignored this requirement. Prosecutors showed that most, but not all, of the beneficiaries either never used or stopped using the units for various reasons.

Some beneficiaries claimed they received no relief when using the units. Others stated that they didn't know how to use the units because the doctors failed to explain how the device worked. In addition, a few patients said that they feared the sensations of the electrical currents and refused to use the units for this reason. Since the doctors failed to conduct the required trial periods, they did not learn of these problems.

Simply stated, the doctors prescribed TENS units without taking simple steps to ensure that the beneficiaries could make use of the device. This fact buttressed the allegation that the units were prescribed "in conscious disregard" of any medical necessity.

Another important point was that the prescription forms, signed by the doctors and submitted to Medicare, contained false statements that indicated the doctors successfully conducted trial periods. The prosecution used these prescription forms as the basis for additional counts charging false statements (sect. 1001) and false claims (sect. 287).

> ***"...criminals...continue to defraud the health care system of billions of dollars...."***

To strengthen its case even more, the prosecution called a research scientist to testify as an expert in pain and pain relief. This witness explained to the jury the physical nature of pain, how a TENS unit works, and what is necessary for such a unit to be medically indicated. He then gave his opinion, as an expert, that without conducting a trial period, a physician could not truthfully certify that a TENS unit was medically necessary.

Furthermore, this expert went on to describe how a TENS unit can be adjusted with regard to the frequency and intensity of its pulses, and how the human body adapts to these pulses. The research scientist then explained that for this reason, the unit must be continuously adjusted during the trial period so as to identify the combination of frequency and intensity that best eases the pain of the patient once the adaptation process stabilizes. According to the expert, without such adjustments, the medical value of prescribing a TENS unit for chronic pain would be, at best, dubious.

Deterrence Effect

Prior to the indictment, the practice engaged in by Osmomedic and the doctors was common in central and south Florida. Two much larger companies, named as co-conspirators during the trial, each grossed several million dollars yearly in the DME market

Prosecution of Osmomedic had a salutary effect on the industry. In the aftermath of the Osmomedic indictment, the yearly disbursement by Medicare alone for TENS units in Florida dropped from more than $10 million to approximately $500,000.

Points for Prosecutors and Investigators

The keys to a successful prosecution of a medical necessity case, such as Osmomedic, can be summed up as follows:

1) Understand the technology and medical conditions involved

2) Identify how the suspects misused or ignored a crucial requirement of the technology involved (If suspects prescribed unnecessary medical equipment or services, this factor will definitely be present.)

3) Avoid a head-on collision of medical experts by using a "conscious disregard" theory rather that one of outright "no medical necessity" (Again, focus on suspects' misuses of technology and work that misuse into a pattern.)

4) Hit suspects from multiple directions (Call beneficiaries to the stand, demonstrate patterns of abuse by introducing charts that summarize the physicians' own medical records, have experts explain the technology, ask witnesses for their expert opinions as to the presence or lack of medical necessity, etc. In other words, leave the defendants with no safe grounds on which to rest the defense.)

5) Search for and exploit minor but clear-cut offenses, e.g., Dr. Bertoncini's 12 kickbacks of $50 apiece (Offenses too minor, in and of themselves, to prosecute criminally can help in the context of a medical necessity case. These offenses can convince a jury that the suspects exhibited the fraudulent intent necessary for a finding of guilt on the overall scheme.)

Conclusion

Investigators and prosecutors should remember that health care providers who engage in fraud are merely con artists who believe they can outsmart the system because of their medical expertise. Your jobs are to prove these criminals wrong. ✦

Police Practices

The One-A-Day Plan for Drug Dealers

The mass arrest of criminals indicted on drug charges is common practice among police agencies. Usually, the officers gather at a central location where they are briefed on the details of the operation, given their assignment, and moved into position to make the arrest.[1] Generally, the unit commanders schedule mass arrests at a time when the suspects can be found at their residences, such as early in the morning. The intended goal is to surprise them, while actively showing citizens that the police are working to stem the flow of drugs into the community.

This approach presents potential problems, including communication difficulties, safety concerns, and logistic dilemmas. Also, in many cases, arrest warrants from other jurisdictions are not served, or investigators do not obtain sufficient information.

To lessen the impact of such problems and to provide added safety to officers, a multiagency drug enforcement unit developed an alternative to the mass arrest technique. Undercover officers proposed what is now known as the "one-a-day" plan, which brought about lasting changes and immediate results in curtailing illegal drug sales.

Arrest Procedure

Under the one-a-day plan, investigators select one individual each day from among those indicted by a grand jury. The indictments remain sealed throughout the seizure process to prevent public disclosure of the suspects.

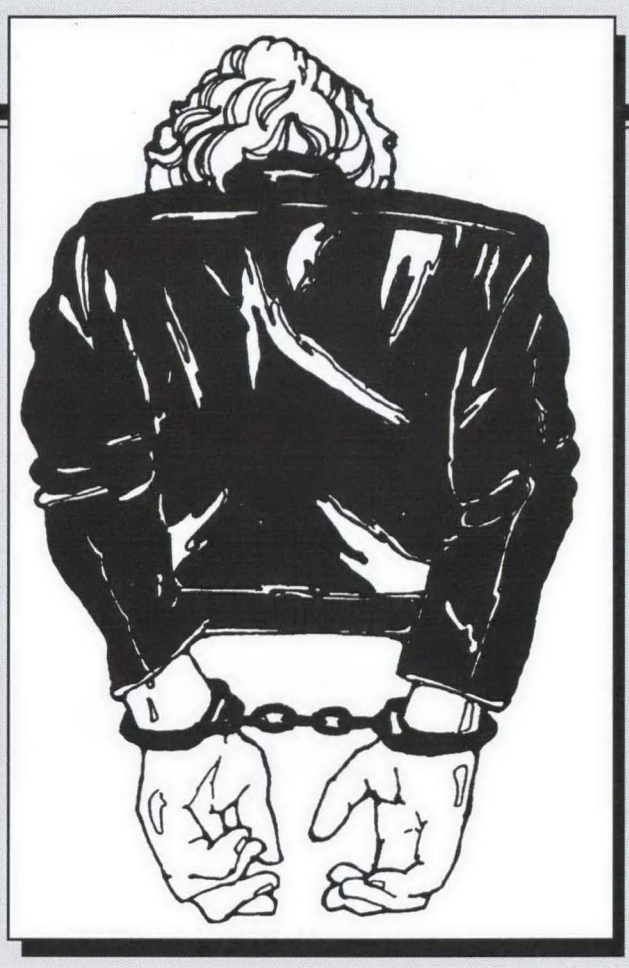
By using this procedure, the lead investigator no longer needs to assemble a large number of officers. Selecting one individual for capture each day not only reduces the number of officers needed but also increases the safety of those involved. Assignment of personnel to arrest teams, determination of radio frequency assignments, and issues of command and control no longer represent major considerations. Investigators now make arrests at the time and place they believe the maximum outcome can be achieved. Preplanning of arrests reduces dangers to officers, allows prosecutors to provide legal input, and results in efficient police action.

Media Involvement

Prior to implementation of the program, members of the unit met with the police reporter for the local newspaper. The newspaper expressed a willingness to track each defendant through the entire court process, from arrest through conviction and sentencing. The program received maximum press coverage through front page articles accompanied by pictures and lists of pending charges.

This had two important effects. First, the public interest generated by the media unified the court system, creating a force that

pushed for higher bail, longer jail terms, and reduced incidents of plea bargaining. Second, it generated community interest in the program. Citizens discussed the prosecution of individuals whom they never suspected of being involved in drugs. The community continued to express approval of the program as it evolved into a highly successful operation.



Community Response

As public awareness increased, local businesses and firms sought help from the police and sheriffs' departments to reduce the presence of drugs in their work environments. Frequently, officers made an arrest at the defendant's place of employment, with the support or assistance of management. This impacted strongly on others in the workplace who were either involved in the illegal activity or who knew of the arrestee's involvement.

In addition, the attention focused on police activities prompted a number of community organizations to help. Civic and fraternal organizations requested programs on various drug-related topics, such as abuse, prevention, and treatment. Citizens' groups initiated several public service announcements and organized awareness meetings, and the number of calls informing investigators of suspected illegal drug activity increased significantly.

Benefits

The new program allowed the agencies to process individuals at a less hectic pace. Proper identification was obtained and thorough inquiries conducted to seek outstanding arrest warrants in other jurisdictions. Investigators had time to interview defendants properly and complete the required reports, resulting in the opening of many new cases. Frequently, defendants furnished investigators with information about other drug dealers in hopes of reducing the severity of their charges.

Other benefits included less pressure on the magistrate, booking officers, and jail officials. Bail was set after a thorough review of the charges and the individual's criminal history. Additionally, the limited capacity of the jail was not overburdened with a large number of prisoners at one time, nor were the district attorney and the court burdened with several defendants appearing for deposition on the same day. Investigators were not overburdened with multiple cases. In general, the process allowed all segments of the justice system to function normally and to conduct business in an orderly manner.

Conclusion

The benefits of the one-a-day program are significant. The investigators and the courts are equally impressed with the results, and public support for the drug reduction efforts by the task force is overwhelming.

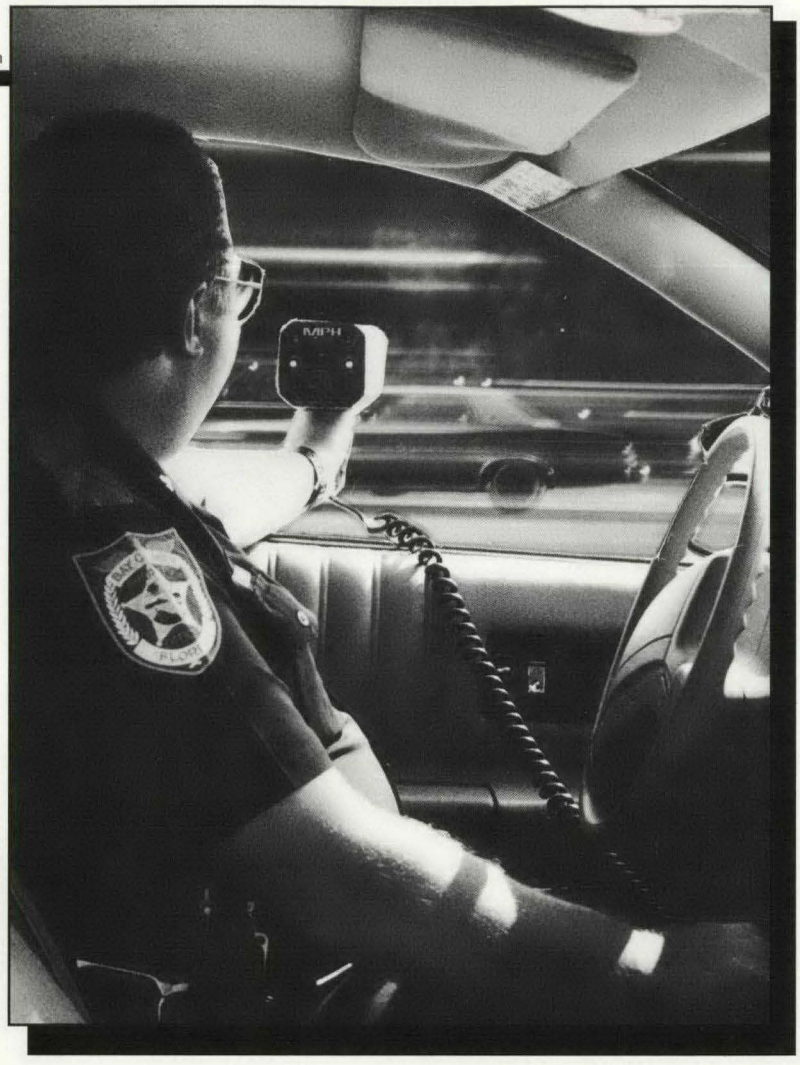
However, the level of success attained could not have been achieved without the cooperation of the press, which provided widespread coverage of task force activities. With the one-a-day plan, police officers, members of the press, and citizens worked as a team, fighting back against the presence of drugs in their community. ✦

Endnote

[1] David Romine, "Miami's Crack Attack," *FBI Law Enforcement Bulletin*, 60 (11), 1991, 11-16.

Dr. Richard C. Lumb, former chief of the Department of Public Safety, Morgantown, North Carolina, submitted the information for this column.

Photo by Kathy L. Morrison



Police Radar
A Cancer Risk?

By
JOHN M. VIOLANTI, Ph.D.

In recent years, many police officers and law enforcement agencies started to express concern about the possible link between police radar and cancer. As of 1991, individuals filed eight legal actions relative to this possible health hazard.[1] While the Food and Drug Administration's (FDA) Office of Science and Technology issued a release stating that no concrete evidence currently exists to verify that police radar guns cause cancer, the FDA did recommend that operators not place radar antennas within 6 inches of any part of the body.[2]

This article considers the debated "link" between police radar and cancer. Specifically, it discusses the characteristics and possible biological effects of radar electromagnetic fields (EMF) and studies that demonstrated possible associations between EMF and cancer. The articles also addresses the difficulties in determining causal relationships between radar EMF and cancer and what law enforcement agencies can possibly do to resolve this issue and protect police officers.

Characteristics of Radar Electromagnetic Fields (EMF)

Police radar operates generally on an ultrahigh frequency (UHF) band in the electromagnetic spectrum. This band is approximately midrange between ordinary electrical power sources and x-rays. The strength of an electromagnetic field can be measured with a device called a dosimeter, which calibrates milligauss (mG) units. The higher the milligauss reading, the stronger the electromagnetic exposure.

To date, it is not known what value of milligauss puts humans in danger of biological change. However, researchers determined that prolonged electromagnetic exposure increases the risk of cancer.[3] Thus, high frequencies, like police

radar, may increase the probability of biological harm.

Additionally, exposure to radar EMF from radar guns or devices used within an enclosed vehicle can exacerbate this risk. Operating police radar inside a patrol car with all the windows closed produces effects similar to those found in microwave appliances. The intensity of exposure increases greatly because radar EMF continuously permeates the officer and cannot escape from the police vehicle.

Cancer and EMF Exposure

Recently, a study of cancer deaths among 2,763 police officers indicated that there may be a possible link between exposure to EMF and cancer.[4] The resulting analysis indicated that the risk of brain cancer increased fourfold in officers with 20-29 years of police service over individuals in other occupations. Other officers experienced a fourfold risk of lymphatic and hemopoietic (blood-related) cancers. Although information on the types of assignments of these officers was unavailable, findings indicate a possible EMF-cancer association. And, the possibility still exists that EMF sources may even cause other types of cancer.

According to Dr. David Savitz of Johns Hopkins University, a common criticism of many EMF-cancer studies is that workers exposed have not been individually assessed as to the degree of such exposure.[5] Measuring radar EMF exposure in the police vehicle and at the radar site offers one possible solution to this problem. This could be accomplished by equipping several police vehicles with dosimeters, an instrument that effectively measures the strength of radar EMF, and then comparing exposure levels in those cars with known cancer-producing levels in other populations. If exposure of police officers ranks as high as those in other populations, then it may be necessary to take preventive measures to lower officers' radar EMF exposure.

Another criticism of EMF-cancer studies concerns the absence of information on other factors that might associate cancer with police officer exposure to radar EMF, such as lifestyle, diet, smoking, alcohol use, and exposure to chemicals. Certainly, these factors may confound any research on police radar and cancer, but interestingly, most of these other behaviors do not relate to the cancers associated with exposure to radar EMF.[6]

A third consideration that would help to clarify the association between radar and cancer involves measuring the amount of exposure time. Theoretically, cancer develops as a result of repeated EMF exposure over a long period of time. This makes studying police officers difficult because of their high mobility. However, according to Dr. Savitz, current exposure may be just as much a problem as exposure over time. In order to sort out this problem, officers should be studied over a period of years and have assessments made of their health and their exposure to EMF. Unfortunately, such studies require outlays of considerable time and money.

Managing the Risk

Although the association between radar and cancer remains inconclusive, based on existing evidence, present research certainly points to a possible link. Therefore, until researchers know more about this cause/effect relationship, departments should take precaution-

> ***"...departments should take precautionary steps to protect police officers from potential harm caused by radar units."***

Dr. Violanti is a professor in the Criminal Justice Department at the Rochester Institute of Technology in Rochester, New York, and a member of the Department of Social and Preventive Medicine, School of Medicine, University of New York at Buffalo.

ary steps to protect police officers from potential harm caused by radar units. This is not a call to "panic," nor does it mean that law enforcement departments should remove all sources of electromagnetic radiation. Such action impedes the proper enforcement of the law. However, departments should initiate procedures that would lessen exposure to radar EMF, such as mounting the radar units outside of the police vehicles. This would limit police officer exposure to highly focused, intense dosages of radar EMF in enclosed vehicles.

> ***"...high frequencies, like police radar, may increase the probability of biological harm."***

Additionally, many of the newer radar devices have an instant on/off feature that allows officers to turn the unit off when not in use. Such units reduce the time of exposure to radar EMF and presumably lessen the cancer risk. The older radar units do not have such a feature. If any departments still use older radar units, they should update their sets, if possible.

Conclusion

Despite technological advances, few ways exist to minimize police officer exposure to radar EMF. Either officers must limit their exposure to radar EMF or departments must completely remove radar devices from police vehicles. Unfortunately, law enforcement agencies may have to depend on future engineering advancements, such as EMF shielding and devices designed to narrow the radar beam and contain radar emissions, in order to dismiss this threat.

Today's police officers have enough risks to contend with in their daily activities without the added burden of exposure to possible cancer-causing radar EMF. To help ease this burden, law enforcement agencies should act to alleviate this unnecessary job-related hazard for law enforcement officers. ✦

Endnotes

[1] Three Connecticut officers with cancer, the widow of a Wisconsin State trooper who died of cancer, and several other officers have filed cases. Several types of cancer occurred in these officers, including testicular, thyroid, and bone cancers.

[2] The Food and Drug Administration (FDA) has set up a hotline to collect information concerning radar and its link to cancer. The hotline can be reached at 1-800-638-6725.

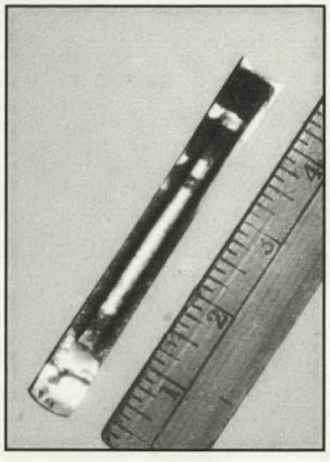
[3] J. Violanti, J. Vena, and J. Marshall, "Disease Risk and Mortality Among Police Officers: New Evidence and Contributing Factors," *Journal of Police Science and Administration*, 14, No. 1, 17-23.

[4] Ibid.

[5] D. Savitz, N. Pearce, and C. Poole, "Methodological Issues in the Epidemiology of Electromagnetic Fields and Cancer," *Epidemiological Reviews*, 11, 1989, 59-78.

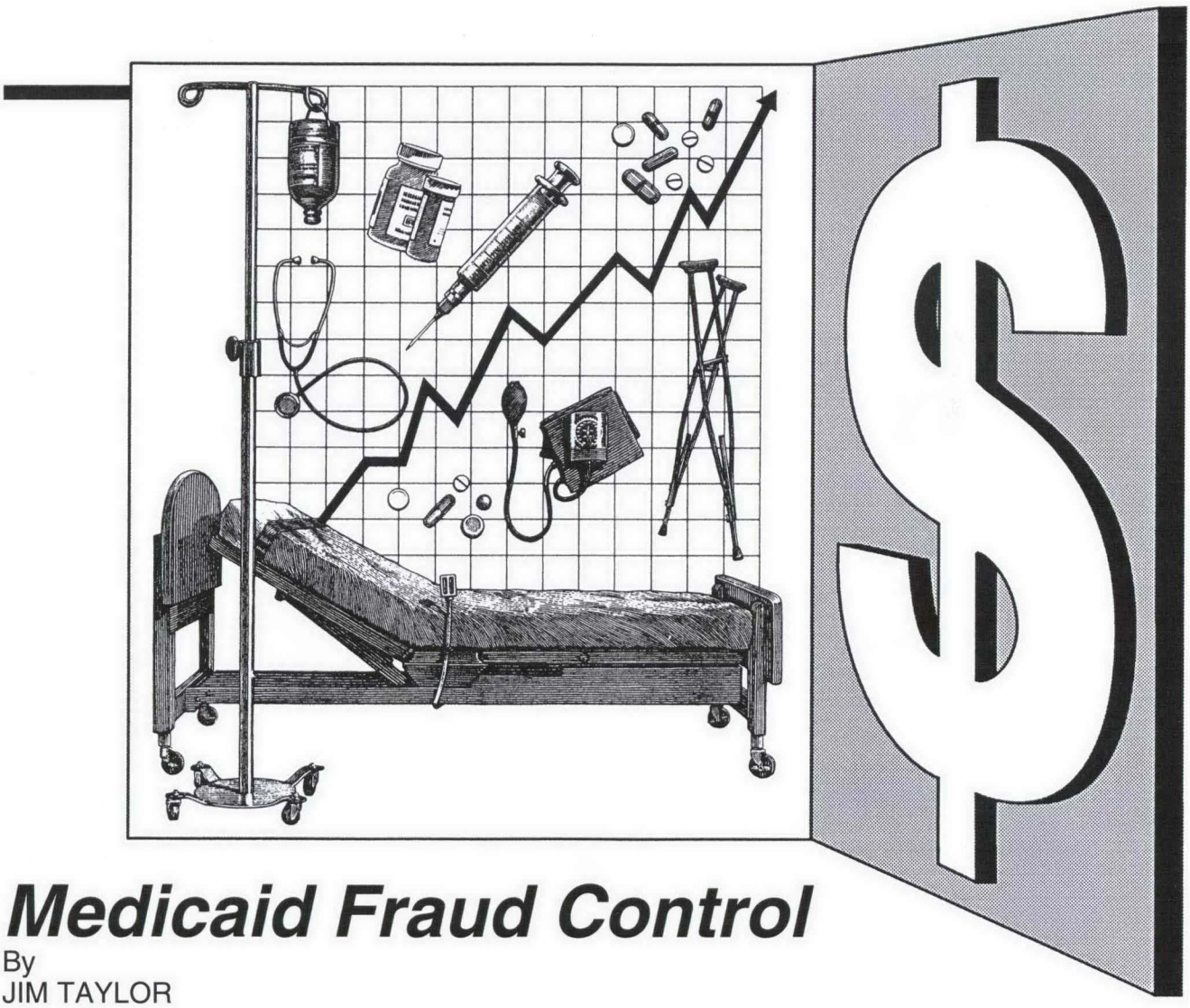
[6] Ibid.

Bulletin Alert



Supporting Crime

While cleaning a cell block after the release of several prisoners, a maintenance worker found two steel strips left in a cell. Personnel in the Belleville, New Jersey, Police Department determined that the curved strips, measuring 4 1/4 inches by 1/2 inch, were actually arch supports found in many types of athletic and soft-soled shoes. The concave ends of the strips were sharp enough to be used as weapons. While the arches can be easily concealed from sight, metal detectors register an alert when scanning footwear containing these supports.



Medicaid Fraud Control

By
JIM TAYLOR

Until recently, few people paid much attention to one of the most lucrative crimes inflicted on American society—health care fraud. It wasn't until investigations of this crime began to take place across the country that the criminal justice system realized how widespread and profitable this crime is. Today, experts estimate that health care fraud costs taxpayers $50 to $80 billion a year.[1]

This article centers on the issue of Medicaid fraud and the various schemes used by those in the health care profession. It then covers the State of Tennessee's efforts to bring these criminals to justice and the problems encountered in Medicaid fraud investigations.

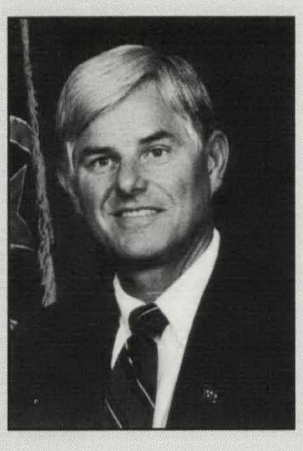
FRAUD SCHEMES

Health care fraud investigations typically center around six main schemes—upcoding, phantom billing, billing for unnecessary services, double billing, unbundling, and giving or receiving kickbacks. Investigators should recognize that Medicaid providers often engage in several such schemes, even though investigations may begin with indications of only one scam.

Upcoding

For the most part, upcoding occurs when health care providers bill for a more expensive service than the one they provide to the patient. However, upcoding can also come in the form of generic substitutions—filling a prescription with a less expensive generic drug, while billing Medicaid for the more expensive form of the drug.

Medical fraud investigators for Tennessee initiated one such case, "Operation Rx," because of a pervasive problem across the State with generic drugs being substituted for prescribed medicines. Investigators



> ***"Medicaid recipients deserve the best efforts of law enforcement in protecting their safety and welfare...."***

Special Agent-in-Charge Taylor is the Director of the Medicaid Fraud Control Unit of the Tennessee Bureau of Investigation, Nashville, Tennessee.

were concerned that health care providers were defrauding the State, since generic drugs tend to cost less than brand name drugs. However, an even greater concern was that these substitutions could seriously affect the health of the patients.

Therefore, investigators developed an investigative profile that targeted those pharmacies that did a given dollar amount of business with Medicaid each year and also obtained a certain percentage of payments from some 50 brand name drugs also available in the generic version. In most cases, the generics had not yet been approved for use in the State's Medicaid Program.

Once investigators decided which pharmacies to target, they obtained valid Medicaid cards for the areas in which the pharmacies were located, as well as valid prescriptions for the targeted brand name, noncontrolled drugs. Then, agents, posing either as patients or as friends or relatives of the patients, attempted to fill the prescriptions at the targeted pharmacies. After receiving the drugs, these agents checked the pharmacies' Medicaid billing information for any discrepancies.

As a result of the first phase of this operation, 33 pharmacists were convicted of Medicaid fraud. Each case involved a minimum of 10 felony counts gained through 4 months of undercover work. Each case also involved at least two different Medicaid "recipients."

At the conclusion of the first phase of Operation Rx, which covered middle and east Tennessee, the Medical Care Fraud Unit applied the same selection criteria to pharmacies in west Tennessee and found virtually no generic drug substitutions. Either the problem did not exist in that area of the State, which is unlikely, or the grapevine and resulting publicity proved to be an effective deterrent.

Phantom Billing

Phantom billings—billing for services not performed—also occur frequently in health care fraud cases. To address this fraud scheme, investigators revised the original investigative profile to identify a number of pharmacies in each part of the State that exceeded the State average cost per prescription by $4 to $20. Each of these stores dispensed a high number of expensive antibiotic, anti-inflammatory, or ulcer medicines. While not all of the pharmacies billed for medicines they did not dispense, several billed for more medicine than they dispensed. In addition, investigators found that several pharmacies either filled unauthorized refills and then billed Medicaid, or they billed for a more expensive medicine of the same class.

Other cases of phantom billing involve home health agencies that bill for services not received. For example, some of these facilities falsify records to show that LPNs or RNs made home visits to patients when the visits either did not occur or were performed by untrained, unlicensed individuals.

Billing for Unnecessary Services

Another type of health care fraud involves billing for unnecessary services. For example, some medical supply companies forge the signatures of physicians in order to certify that particular services are necessary. These same companies also bill for items that patients may not need at all, such as oxygen concentrators, hospital beds, or wheelchairs.

Physicians also engage in this type of scheme. One Tennessee physician billed the government for unnecessary services that were improperly performed, as well as services that were never performed. He put heart patients on treadmills without bothering to connect them to a monitor; he also billed for hundreds of other diagnostic tests with no medical value. Instead of the

hours needed to perform these tests properly, he completed the tests within minutes, which resulted in useless medical information.

In addition, this same physician falsified patient complaints to justify performing the tests, a common tactic among dishonest practitioners. He also billed for tests incompatible with a patient's age, such as performing pregnancy-related tests on a 60-year-old woman.

Some physicians also add unnecessary tests that they can perform in the office to their Medicaid billings. These tests—rarely detected by Medicaid—include routine blood tests, x-rays, and urinalysis tests. Therefore, when any single diagnostic test exceeds about 20 percent of a provider's billing (excluding services directly related to a specialist's practice), health care fraud investigators may want to examine the physician's billings.

If investigators suspect fraud, undercover visits may be useful in proving the case. However, undercover personnel should keep their complaints simple, and they should avoid allowing invasive medical tests.

Double Billing, Unbundling, and Kickbacks

Some home health care providers defraud the Medicaid Program through double billings. In one case, a home health care provider received over $1 million in payments from Medicaid after receiving payment for the same services from Medicare.

Health care providers also defraud the system by billing Medicaid twice in one month for the same services to the same patients. They bill Medicaid once at the beginning of the month and then again—for the same patients—at the end of the month.

The unbundling scheme used by some physicians involves billing Medicaid separately—as if they were performed on different days—for procedures that the doctor performed during one operation. For example, a physician may bill for procedures done on the right side of the patient and then bill separately for procedures done on the left side of the body.

> ***"To counter the escalating rate of health care fraud, States need to form special units to deal specifically with these crimes...."***

Another health care fraud scheme involves giving or receiving kickbacks. In this scheme, medical suppliers, home health care agencies, etc., give kickbacks to physicians who recommend their businesses to patients.

HEALTH CARE FRAUD UNITS

To counter the escalating rate of health care fraud, States need to form special units to deal specifically with these crimes, such as the Tenneesee Bureau of Investigation's (TBI) Health Care Fraud Unit. However, in order to increase their chances of successful prosecutions, health care fraud investigators must take certain steps.

First, investigative personnel in these units should familiarize themselves with the many schemes used in health care fraud. They also need to be familiar with regulations that govern the Medicaid Program. This not only helps to develop cases but it also helps investigators to avoid wasting valuable time on cases that are not prosecutable because of vague or nonexistent Medicaid regulations.

One particular challenge is common to most, if not all, health care fraud units. Simply put, in order to investigate fraud against the Medicaid Program, an agency frequently must first *find* the fraud. This problem exists primarily because:

- Most Medicaid recipients do not know what services their physicians bill in their names; therefore, fraud units receive few direct complaints of fraudulent billing
- The medical community rarely expresses suspicions about its own members
- Problems inherent in the Medicaid Program tend to keep to a minimum complaints of suspicious billings.

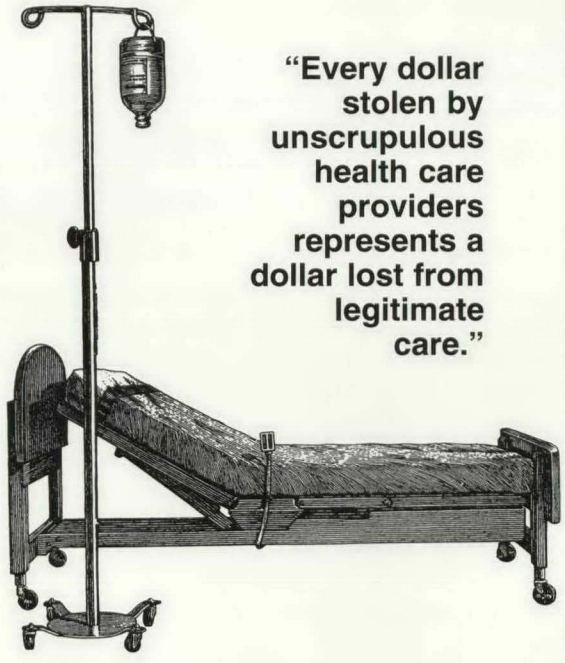
However, once investigators suspect fraud, they can initiate investigations in different ways.

INITIATING INVESTIGATIONS

Medical fraud unit investigators sometimes initiate cases based on complaints received from patients or from insurance companies. Insurance companies alert health

care fraud units when they discover fraud, because those who defraud health insurance companies also often defraud the Medicaid Program.

Other times, fraud units initiate cases based on investigative profiles. In these cases, investigators determine what criteria to use when targeting certain pharmacies, health care providers, or medical supply companies by examining computer printouts of billings to Medicaid.



"Every dollar stolen by unscrupulous health care providers represents a dollar lost from legitimate care."

Before initiating a case, investigators should be alert to any special investigative problems they may encounter. How investigators work the case may make the difference between success and failure.

INVESTIGATIVE PROBLEMS

While the State of Tennessee has several major urban areas, it remains primarily a rural State with many areas of extreme poverty. Because of this, Tennessee's health care fraud investigators deal with specific problems unique to these types of settings.

For example, health care providers sometimes use the defense that their offenses are merely business errors. In order to eliminate this possible defense, investigators often use multiple agents who make repetitive visits to a suspect provider. However, rural settings, where residents know one another well, make such operations difficult. Because this type of environment breeds clannishness, strangers stand out, and residents often suspect outsiders.

In addition, residents of these areas tend to protect the health care providers available to them. They know that the serious shortage of primary health care workers in many rural areas means that communities sometimes lose access to medical care for years if their local providers face criminal charges. Therefore, citizens often do not report suspected cases of health care fraud.

For the above reasons, developing medical fraud cases in rural areas tends to take longer than developing cases in urban settings. It may take several months to introduce two or three new "recipients" (undercover agents) to a pharmacy, physician, or clinic. After this, it takes on the average of three visits before any fraudulent billing appears, because well-publicized cases against health care providers make dishonest providers wary of submitting fraudulent bills for services provided to unfamiliar patients.

CONCLUSION

Even though Tennessee budgets only approximately $2 billion a year for Medicaid, the TBI encountered numerous schemes to defraud the system of substantial amounts of money. Not all of the schemes posed a direct threat to the health of the patients; however, they all impacted negatively on each recipient, as well as each taxpayer.

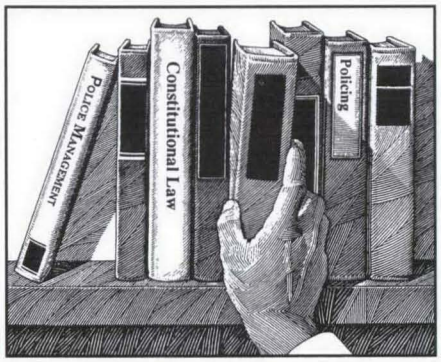
Every dollar stolen by unscrupulous health care providers represents a dollar lost from legitimate care. Health care fraud also impacts on programs that must go unfunded due to lack of money, such as eye and dental care for the elderly, or programs that must be limited, such as the monthly prescription limit for Medicaid recipients.

Every law enforcement agency *must* work to eliminate health care fraud. Medicaid recipients deserve the best efforts of law enforcement in protecting their safety and welfare, and taxpayers deserve the best efforts of law enforcement in reducing the escalating rate of health care fraud—the modern way to steal.✦

Endnote

[1] *U.S. News and World Report*, February 24, 1992, 34.

Book Review



Delinquent Gangs: A Psychological Perspective *by Arnold P. Goldstein, Research Press, Champaign, Illinois, 1991,* (217) 352-3273.

The law enforcement community recognizes the value of gathering intelligence on current and potential adversaries, including a thorough understanding of how criminals think and perceive their world. In short, law enforcement acknowledges the need to understand criminal psychology and how to apply these principles to street situations. Because of the burgeoning gang phenomenon, law enforcement must continue to examine criminal psychology in general and the psychology of gangs specifically.

The author of *Delinquent Gangs* draws from a wide variety of psychological and sociological resources to provide a comprehensive overview of relevant theory and research findings concerning gangs. The book presents a valuable perspective on the complexity of modern delinquent gangs.

In the first two sections, the author lays a literary foundation that focuses on definitional problems and theories of cause. He looks at the makeup of gangs from the turn of the century to the present and cautions against relying on a single definition of gangs. The discussion emphasizes the variability of gang structures and the complex psychological and social issues that lead to gangs and violent crime in general.

The third section focuses on intervention and presents alternatives to traditional police strategies that emphasize suppression, arrest, and incarceration. Instead, the author suggests a coordinated multidisciplinary approach to deal with the societal problems that create an environment in which gangs flourish.

Within this context, the author also discusses what he terms "prescriptive programming." This comprehensive treatment strategy recognizes individual differences among delinquent juveniles, and in a sense, predicts the potential for success of different intervention methods. The author analyzes the mixed results of traditional psychological therapies and attributes their uneven record, in part, to a lack of prescriptive programming. The end of this section highlights community outreach programs and reviews State planning initiatives. As examples of State programs, the author includes the report of the New York State Task Force on Juvenile Gangs (1989) and the executive summary of the final report by the California State Task Force on Gangs and Drugs (1990).

To understand why delinquent gangs continue to grow, those interested in solving the problem must go directly to the source and study the gang members themselves. In fact, this approach long ago became an integral feature of law enforcement's response to gangs. Perhaps the most helpful aspect of this book is that it offers alternative perspectives from other professional disciplines that attempt to understand why delinquent gang members do what they do.

Reviewed by
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Behavioral Science Services Unit
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Cincinnati's Pharmaceutical Diversion Squad

By
JOHN J. BURKE

In 1990, the Cincinnati, Ohio, Police Division formed a special squad to coordinate pharmaceutical diversion investigations. The pharmaceutical diversion squad (PDS) not only initiates investigations of health care providers suspected of pharmaceutical fraud but also works with Federal and State agencies to combat this growing, yet often overlooked, crime problem.

FORMING THE SQUAD

Early in 1990, top administrators in the Cincinnati Police Division recognized the need for an organized approach to pharmaceutical diversion investigations in the city. Accordingly, the division applied for a grant from the Governor's Office of Criminal Justice Services (GOCJS)—which administers Federal funds available to the State of Ohio—to form a new police squad specifically responsible for investigating these types of criminal offenses. The GOCJS approved the funding within months and the squad became operational in October 1990.

TRAINING

After securing equipment and supplies and selecting qualified personnel (four investigators, a commanding sergeant, and a secretary), administrators realized that the pharmaceutical diversion squad would deal in an area that most law enforcement officers knew little or nothing about. Fortunately, however, one of the investigators assigned to the new squad gained extensive investigative experience in diversion cases while working on a drug task force several years earlier. This officer provided most of the initial training to the squad.

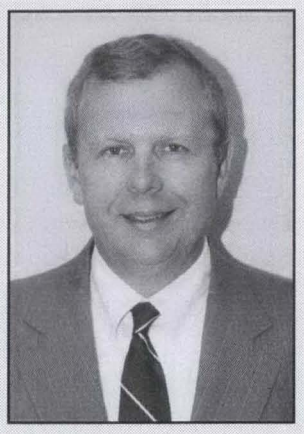
Because the other squad members had very limited background information regarding diversion cases, the officer kept the initial training very basic. He began with

an introductory discussion of controlled and noncontrolled substances and the drug scheduling system used by pharmacists. He then provided instruction on the various State criminal laws and pharmacy regulations.

After familiarizing squad members with how the system is *intended* to work, the officer showed them examples of forged and altered prescription forms. He also instructed them on how to recognize typical scams employed by individuals who seek to obtain drugs illegally.

In addition, members of the squad received instruction on the theft and abuse of drugs by health care professionals. Squad members learned the forms and the methods used to dispense drugs in health care facilities. And, they learned the techniques used by unscrupulous individuals in the health care system to steal drugs and substitute other substances for them. To augment this training, investigators also attended seminars offered by the Drug Enforcement Administration (DEA) and the National Association of Drug Diversion Investigators (NADDI).

> ***"The pharmaceutical diversion squad... works with Federal and State agencies to combat this growing, yet often overlooked, crime problem."***



Sergeant Burke commands the pharmaceutical diversion squad of the Cincinnati, Ohio, Police Division.

VISITING PHARMACIES

Within the first 3 months of the squad's operation, PDS investigators visited every pharmacy in Cincinnati. This preliminary step produced two important results. First, the visits provided investigators with valuable insights into the practices and procedures of the pharmaceutical trade. Second, the visits allowed investigators to alert pharmacy employees of the new operation and elicit their assistance in combating the problem of pharmaceutical diversion.

The visits gave investigators the opportunity to familiarize themselves with the generic names of drugs, as well as the more recognizable brand names. During the visits, investigators also requested that each pharmacy place the squad's business card in a prominent place within their stores and use the 24-hour phone number to report any suspicious prescription activity.

ROLL CALLS

In addition to visiting pharmacies, members of the pharmaceutical diversion squad attend roll calls in each of the city's five police districts on an ongoing basis. This gives PDS members an opportunity to instruct uniform patrol officers on how they can assist the PDS.

At roll call, squad members stress to officers the importance of notifying the pharmaceutical diversion squad whenever they arrest anyone possessing forged, altered, or stolen prescriptions. Often, in response to a radio call, officers arrest offenders involved in numerous diversion schemes. Investigators from the PDS can greatly expand investigations when they interview these individuals.

PDS members also encourage patrol officers to notify the squad when they come into contact with persons possessing large quantities of prescription drugs, especially controlled substances. Again, questioning these individuals concerning their supply source can help build additional criminal cases.

Further, PDS members request that patrol officers alert them of any contact with health care providers or health facility employees in illegal possession of prescription drugs or apprehended driving while under the influence of drugs. In many cases, health facility administrators willingly volunteer information concerning these individuals, since their actions may place patients and coworkers in jeopardy.

THE MEDIA

Another important aspect of the program includes using the media to

inform the public of the new squad's existence. Fortunately, in one particular case, the timely detection and prosecution of a small drug ring afforded the program and the new squad some very positive media exposure.

The case involved three offenders who forged medical records to indicate that they were suffering from AIDS in order to obtain mass quantities of the drug Dilaudid. By the time of their highly publicized apprehension, the suspects had obtained approximately $500,000 (street price) worth of the potent pain killer.

The local media coverage of the case alerted citizens and other criminal justice agencies to the extent and impact of pharmaceutical diversion in southwest Ohio. Also, during the coverage, television news reports broadcasted the phone number of the 24-hour PDS hotline.

INTERAGENCY COOPERATION

The GOCJS grant that funded the PDS mandated that the squad provide pharmaceutical diversion training to law enforcement agencies in southwest Ohio. To fulfill this requirement, and to further understanding of this crime problem among other criminal justice agencies in the State, the squad hosts 2-day seminars annually for all area police departments, prosecutors, and judges. These seminars not only alert attendees of the problem but also make them aware of the squad's mission and prepare prosecutors for the possible influx of pharmaceutical cases.

In addition, the PDS makes available to all law enforcement agencies information that it compiles from various sources. With computer programs it developed, the squad tracks suspects, cases, arrests, and the progression of court proceedings, as well as any related intelligence. The squad also monitors daily countywide arrest summaries and contacts suburban departments that have charged any individuals with diversion-type offenses.

TYPES OF CASES

Forged and False Prescriptions

A large proportion of the squad's cases involves forged and altered prescriptions. Although the stereotypical "street junkies" most often commit this type of offense, the squad also arrests offenders who are health care professionals, such as doctors, pharmacists, and nurses.

Often, legitimate pharmacists identify a problem involving illegal or forged prescriptions and then alert the police. However, as PDS squad members gained experience, they developed expertise in uncovering these types of cases even before pharmacists detected the illegal activity. Usually, in fact, PDS investigators discover offenses by simply reviewing pharmacy prescription files. During periodic squad meetings, members update each other on offenses being tracked, which may, in turn, lead to expanded investigations in cases found to be interrelated.

After PDS investigators identify illegal activity, they send confiscated fraudulent prescription forms to the latent print lab for processing. A recently acquired automated fingerprint identification system (AFIS) now makes these latent fingerprint searches faster and more accurate.

Handwriting examinations also prove invaluable. In a recent diversion case, a suspect mailed pharmaceutical drugs to a State correctional institute in hollowed out fruit pies. Investigators matched the handwriting on the packaging to known samples of the suspect. A subsequent search of the subject's apartment uncovered further incriminating evidence and led to several felony drug charges against the offender.

Doctor Shoppers

Another common offense involves persons who visit numerous physicians in order to obtain drugs. These "doctor shoppers" do not advise any of the health care providers that they also obtain prescriptions from other sources. Often, these offenders rotate among 10 to 20 doctors, as well as area hospital emergency rooms, to obtain prescriptions.

Usually, these individuals complain of illnesses or injuries that cannot be confirmed or refuted. They also generally provide correct identifying information (name, date of birth, etc.) to physicians when requesting medication. They then take these prescriptions to several different pharmacies, avoiding those linked together by computer. This serves to make investigations more time-consuming and difficult.

However, acquaintances of offenders often report these crimes to the PDS, out of concern for the individual. When this occurs, the investigative process generally moves more quickly.

When checking allegations, investigators must contact pharmacies by phone to determine whether the suspect tried to fill any prescription at a particular location. Then, investigators secure computer printouts from those pharmacies that the suspect visited. These printouts allow PDS investigators to compare the drugs prescribed and the names of the doctors involved.

After investigators uncover enough evidence to establish probable cause, they visit each doctor listed in the printouts to ensure that they were unaware that their patient saw other doctors. The dates of visits, types of drugs, and daily medication dosages prescribed must be noted when formulating a criminal case.

Medicaid Fraud

The pharmaceutical diversion squad also investigates cases of Medicaid fraud involving prescription drugs. These investigations may focus on physicians, pharmacists, or health care facilities that submit bills to Medicaid. Due to the complexity of the fraud schemes, however, these types of cases require considerable outlays of investigative hours.

In fact, physicians who defraud Medicaid often over prescribe drugs, such as pain killers, tranquilizers, and diet aids. However, while it is usually obvious that these offenders traffic drugs, the burden of proof placed on the prosecution in this type of case is extreme. Part of this burden requires that one or two doctors testify on the State's behalf against the suspected offender—something many doctors hesitate to do. The reluctance of doctors to testify is compounded by the possibility of a physician-patient privilege that prevents a doctor from presenting confidential information as testimony over the objection of a patient.

> ***"The problem of pharmaceutical drug diversion... should not be underestimated."***

Therefore, the PDS generally pursues Medicaid fraud charges—a felony in Ohio regardless of the amount—rather than trafficking charges in these types of cases. Usually, undercover police officers, not informants, make covert visits to targeted physicians during these investigations. State and Federal agencies also cooperate with the PDS by providing Medicaid information regarding suspected offenders.

Medicaid fraud offenses take many forms. In one case investigated by the PDS, an offending physician simply invented illnesses for patients and billed Medicaid for treatments not rendered.

Another fraud scheme frequently seen involves doctors who see patients only on their initial visits. During subsequent visits, patients receive their prescriptions without seeing the doctor, though the doctor charges Medicaid for an office consultation. Not only does this practice allow doctors to bill Medicaid for an unreasonable number of office visits, but it also attracts drug abusers.

Pharmacies may also defraud Medicaid. One investigation revealed that a local pharmacy billed Medicaid for vast amounts of potent and expensive drugs, even though the pharmacist did not dispense the drugs. By the time investigators apprehended the offender, he had defrauded Medicaid of thousands of dollars.

REGULATORY AGENCIES

The pharmaceutical diversion squad frequently works with various regulatory agencies. In addition to State and Federal agencies, the PDS also coordinates investigations with local regulatory boards. These boards serve as a ready source of information concerning the often-complicated issues involved in diversion investigations.

Field agents of the Ohio Board of Pharmacy work closely with the PDS on various investigations. The dental, medical, and nursing boards also assist the squad when health

professionals in their respective fields become suspects in possible criminal activity.

RESULTS

During the first calendar year of its existence, the pharmaceutical diversion squad made a considerable impact upon the drug diversion problem in southwest Ohio. The four PDS investigators opened 220 cases, which resulted in over 160 felony drug abuse arrests. Twenty-two percent of these arrests involved health care professionals. In addition, preliminary records for 1992 indicate that the number of cases may increase by approximately 40 percent this year.

CONCLUSION

The problem of pharmaceutical drug diversion may be easy to disregard, but it should not be underestimated. Like other assaults against the health care system, this "victimless" crime, in fact, affects everyone—through higher overall health care costs, dangerous proliferation of controlled substances, and the abuse of publicly funded programs designed to aid those in legitimate need.

However, a coordinated effort by the criminal justice community can have a tremendous impact on this crime problem. Even with limited resources, the Cincinnati Police Department's pharmaceutical diversion squad detected and prosecuted many offenders who attempted to misuse the system for their own purposes. Law enforcement agencies at all levels and jurisdictions can have a similar effect.✦

Bulletin Reports

Drug Testing Juveniles

Testing juvenile probationers and parolees for drug use requires effective, defensible, and credible operations. To this end, the American Probation and Parole Association (APPA), aided by the Office of Juvenile Justice and Delinquency Prevention, began a research project to explore drug testing and develop guidelines to assist juvenile probation and parole administrators, managers, and field staff. The information gathered as a result of this research project has been published in APPA's *Drug Testing Guidelines and Practices for Juvenile Probation and Parole Agencies.*

The guidelines identify the best practices of the field for drug testing to help juvenile probation and parole agencies develop and operate the most effective drug testing programs possible. The 142-page booklet serves as a resource manual. Some sections are policy-specific, while others are more technical. The majority of the guidelines are followed by commentaries to provide details that will assist in understanding them or to explain how the guidelines might be implemented.

To obtain more information, or to order a copy of this publication, write to the Juvenile Justice Clearinghouse, 1600 Research Boulevard, Rockville, Maryland 20850, or phone 1-800-638-8736.

Corrections Data

The Florida Criminal Justice Executive Institute recently released a monograph entitled "Improving Criminal Justice Information Systems Using Total Quality Management." The monograph discusses a program that provides corrections-based felon data to local law enforcement agencies. Using TQM principles, the information system focuses on the customer (local law enforcement), on teamwork, and on continual evaluation and system improvement.

Copies of the monograph can be obtained from the Florida Criminal Justice Executive Institute. For information or to receive an order form, contact Dr. Diane Zahm, P.O. Box 1489, Tallahassee, Florida 32302, or phone 904-487-4808.

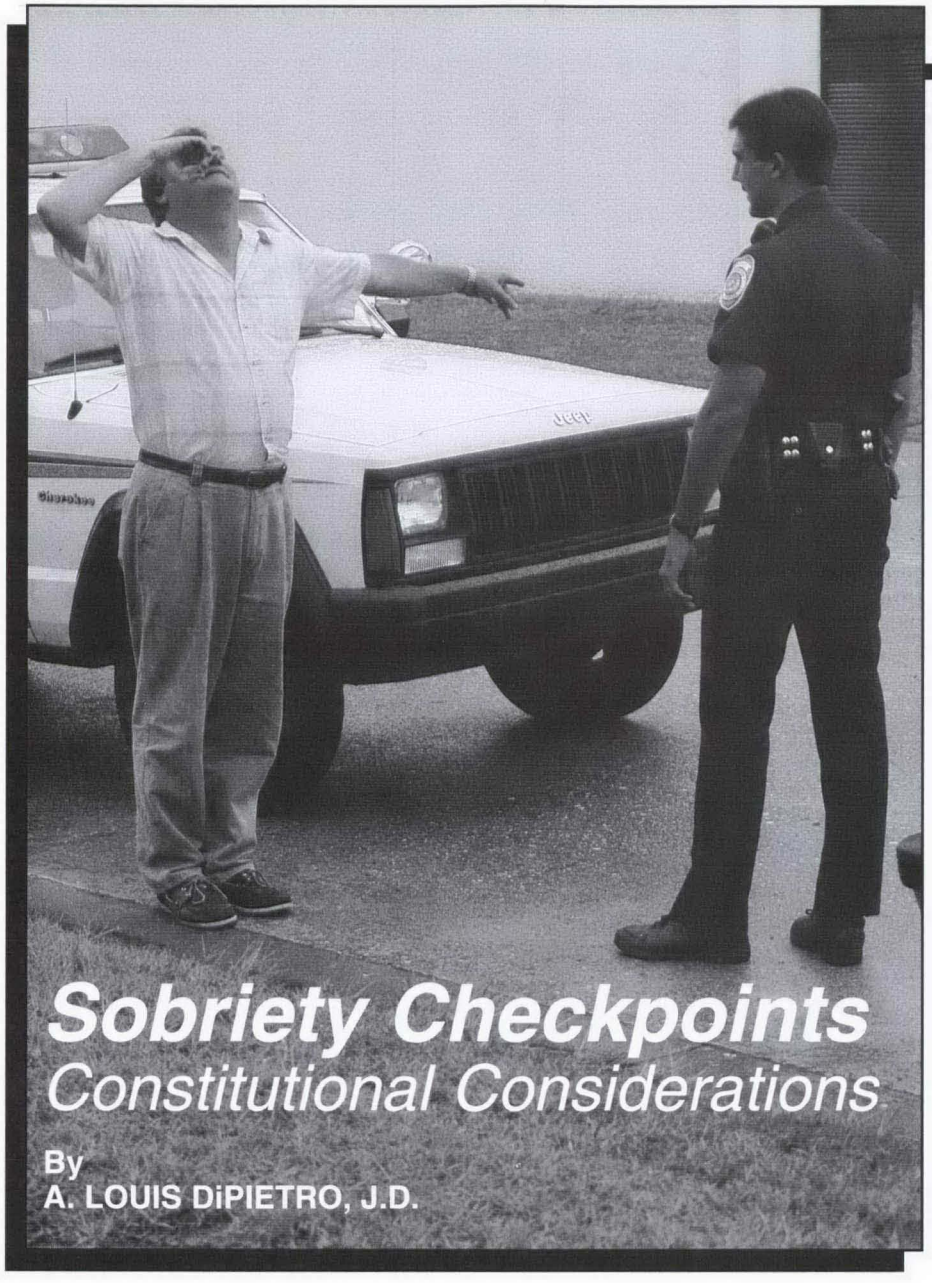


Photo by Kathy L. Morrison

Sobriety Checkpoints
Constitutional Considerations

By
A. LOUIS DiPIETRO, J.D.

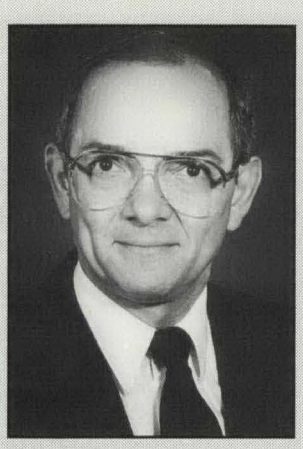
Assume that your community experienced a spate of alcohol-related auto accidents during the past year, several of which involved fatalities or serious injuries. Also assume that the police department has come under mounting pressure to "do something" to get drunk drivers off the road. Although special vigilance for drunk driving violators during routine patrol produced some driving-under-the-influence (DUI) arrests, a high alcohol-related accident rate continues unabated. Therefore, the department considers implementing a sobriety checkpoint program to attack this stubborn problem.[1]

This article addresses general fourth amendment principles applicable to roadblock stops in the context of *Michigan Department of State Police* v. *Sitz*,[2] in which the U.S. Supreme Court approved a sobriety checkpoint. Specific recommendations relevant to checkpoint legality are offered to ensure that sobriety checkpoints comply with fourth amendment reasonableness standards.

FOURTH AMENDMENT PRINCIPLES GOVERNING ROADBLOCK STOPS

When police stop a vehicle and detain its occupants, a fourth amendment seizure occurs, regardless of the reason for the stop or the length of the detention.[3] Courts determine the reasonableness of any seizure by balancing the intrusiveness of that seizure against its promotion of legitimate governmental interests.[4]

As a general rule, police may not conduct an investigatory stop of a vehicle without individualized or founded suspicion that the occupants are involved in criminal activity. However, roadblock stops designed to address special governmental needs, such as license and sobriety checks, can be deemed constitutionally reasonable in the absence of individualized suspicion.[5] In determining whether a particular sobriety checkpoint seizure is constitutional, courts employ a three-prong balancing test that involves a weighing of 1) the gravity of the public concerns served by the seizure, 2) the degree to which the seizure advances the public interest, and 3) the severity of the interference with individual liberty.[6]



> ***"Any sobriety checkpoint stop should be carried out pursuant to specific departmental guidelines that carefully limit officer discretion and the degree of intrusion of motorists' liberty."***

SA DiPietro is a legal instructor at the FBI Academy.

SUPREME COURT APPROVES SOBRIETY CHECKPOINTS

In *Michigan Department of State Police* v. *Sitz*,[7] the U.S. Supreme Court upheld the constitutionality of a sobriety checkpoint.[8] In that case, the director of the Michigan Department of State Police appointed State and local police officials, prosecutors, and transportation researchers from the University of Michigan to a Sobriety Checkpoint Advisory Committee, which created guidelines governing site selection, publicity, and police procedures for conducting sobriety checkpoints.

Under the guidelines, checkpoints would be set up at selected sites, and all drivers passing through the checkpoints would be stopped and briefly examined for signs of intoxication. Drivers would be allowed to proceed unless checkpoint officers detected signs of intoxication. In these cases, drivers would be directed out of the traffic flow for a license and registration check, and if warranted, further sobriety tests. If the tests suggested intoxication, an arrest would be made.

Pursuant to these guidelines, the checkpoint at issue in *Sitz* was operated for 1 hour and 15 minutes, during which the State police stopped 126 individuals for an average delay of 25 seconds each. Officers detained two drivers for field sobriety testing, one of whom they arrested for DUI. A third motorist, who drove through the checkpoint without stopping, was pulled over by an officer in an observation vehicle and arrested for DUI.

The two DUI arrests amounted to approximately 1.5 percent of the stopped drivers. To analyze the constitutionality of the sobriety checkpoint in *Sitz,* the Supreme Court applied the three-prong balancing test, which focused on 1) the gravity of the public concerns addressed by the checkpoint, 2) the effectiveness of the checkpoint, and 3) the severity of the checkpoint's interference with individual liberty.[9]

Gravity of Public Concerns

The Court found a significant State interest in reducing drunk driving based on the legion of media reports of alcohol-related death and mutilation on the Nation's roads and statistics comparing the slaughter on the highways to battlefields. The Court concluded that the magnitude of the problem and the State's interest in eradicating it could not seriously be disputed.

Checkpoint Effectiveness

The Michigan courts examined the degree to which the checkpoint advanced the public interest in getting drunk drivers off the highway and concluded that it failed the "effectiveness" prong. The Supreme Court, however, held that although experts in police science might disagree over which method of apprehending drunk drivers is most effective, the choice of implementation should be with law enforcement officials who have the understanding of, and the responsibility for, the allocation of limited police resources. The Court considered the 1.5 percent arrest rate (two drivers out of 126 vehicles stopped) adequately demonstrated that the checkpoint advanced the State interest and was a reasonable law enforcement technique to combat a serious public danger.

Severity of Interference With Individual Liberty

To measure the severity of the checkpoint's interference with personal liberty, the Court examined the level of "objective" and "subjective" intrusion on the motorist. The Court assessed the objective intrusion by examining the duration of the seizure and the intensity of the investigation. Except for differences in the nature of the questions asked, the Court found the level of objective intrusion of the *Sitz* sobriety checkpoint to be the same as highway checkpoints for detecting

illegal aliens, which the Court previously approved.

The subjective intrusion of a checkpoint is gauged by its potential to generate fear and surprise in a motorist. Obviously, a motorist who has recently been drinking would naturally experience surprise and fear upon encountering a DUI roadblock. However, the Court cautioned that "the 'fear and surprise' to be considered are not the natural fear of one who has been drinking over the prospect of being stopped at a sobriety checkpoint but, rather, the fear and surprise engendered in law abiding motorists by the nature of the stop."[10]

The Court found, by analogy, the level of subjective intrusion involved in a checkpoint stop to be appreciably less than in a roving patrol stop. The Court reached this finding because a motorist approaching a traffic checkpoint 1) can see that other vehicles are also being stopped, 2) may not be surprised because of prior publicity regarding the checkpoint's location, 3) can see visible signs of the officer's authority, and 4) is much less likely to be frightened or annoyed or have the substantial anxiety often generated from a roving patrol stop.[11]

SPECIFIC RECOMMENDATIONS RELEVANT TO CHECKPOINT LEGALITY

A department desiring to establish a sobriety checkpoint program should carefully consider the following recommendations. These recommendations help to ensure that any sobriety checkpoint challenged in the courts will withstand scrutiny under fourth amendment reasonableness standards.[12]

Establish Specific Operational Guidelines

Since most DUI roadblock stops are made on a suspicionless basis, they should be carried out pursuant to written departmental guidelines that explicitly set out procedures directing officers' conduct at the checkpoint. The guidelines should be promulgated by high-ranking law enforcement or governmental officials who have the ultimate responsibility for managing and allocating police resources.[13] A predicate to the guidelines should recite the severity of the drunk driving problem and set out the goals and specific objectives of the sobriety checkpoint program.

> ***"...written guidelines for conducting DUI roadblock stops...should significantly minimize officer discretion...."***

Limit Officer Discretion

The written departmental guidelines for conducting DUI roadblock stops should set forth specific rules governing the who, when, where, and how for setting up and operating a sobriety checkpoint. These guidelines should significantly minimize officer discretion to ensure that an individual motorist is not subject to an arbitrary stop.

The lack of such policy constraints on an officer's decision to stop a particular motorist substantially increases the likelihood of a successful judicial challenge.[14] For example, the guidelines should set forth specific stopping procedures, such as every vehicle, every third vehicle, every vehicle until a backup of four occurs, or some similar objective criteria, so that the officers operating the roadblock have limited discretion concerning which vehicles to stop.

Establish Objective Site Selection Criteria

The location of DUI roadblocks should not be left to the discretion of officers in the field, but instead, should be decided by management officials responsible for the allocation of limited enforcement resources. For example, in *Hall* v. *Commonwealth*,[15] the Court of Appeals of Virginia invalidated a traffic checkpoint despite departmental guidelines that 1) limited troopers discretion in choosing a site to 1 of 54 locations in the county previously approved by the first sergeant, 2) permitted troopers to conduct such details only when assigned by a supervisor; each week, one or two troopers were ordered to conduct a checkpoint, and 3) permitted individual troopers in their sole discretion to determine the time for conducting the checkpoint based on work-related criteria.

The court was critical of the fact that not only was the time left to troopers' discretion but also that the troopers could select from 1 of 54 sites. This was not an effective limitation on officer discretion, since a police officer who decided to stop a particular person arbitrarily could do so within these guidelines by

ascertaining when that person would travel through a particular intersection and establishing a roadblock accordingly. Thus, the court held that even though the guidelines did contain some limitations on the exercise of officer discretion, the considerable discretion left to officers concerning the time and location of the checkpoint exceeded the limitations permitted by law.

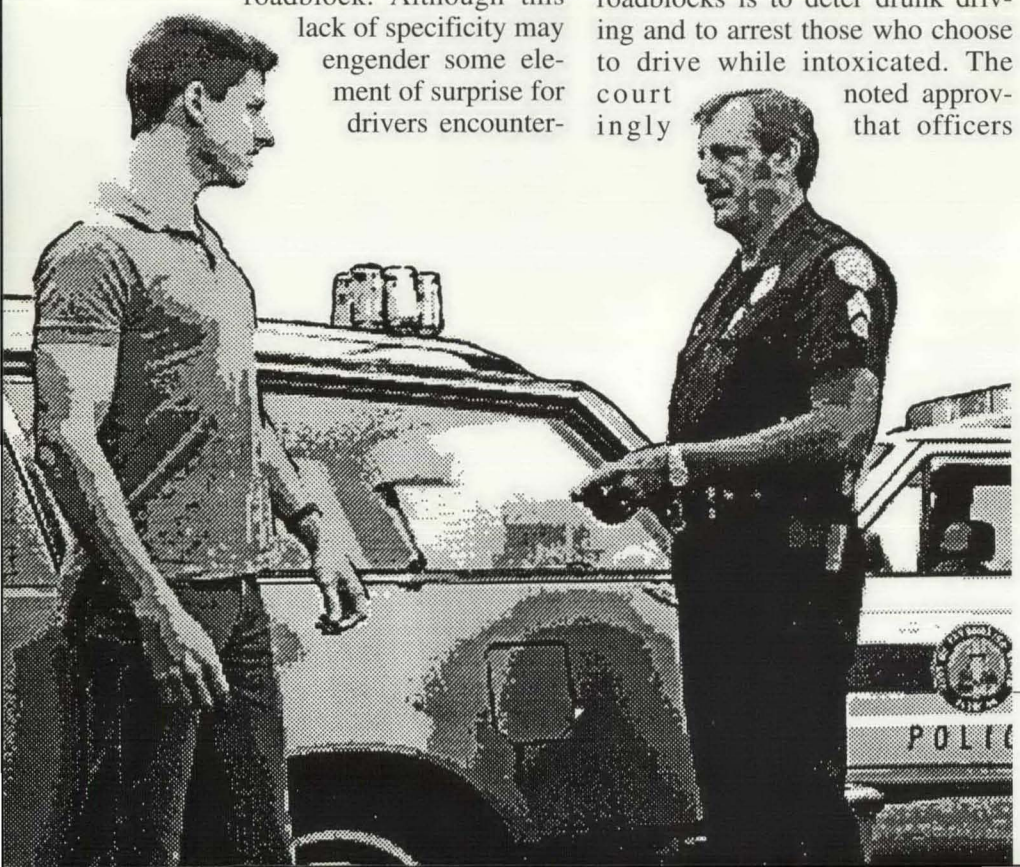
Notify the Public of Sobriety Checkpoint Program

Public notice of the use of DUI roadblocks serves two purposes. First, public awareness that law enforcement intends to employ sobriety checkpoints might discourage some intoxicated persons from driving, which should be a primary goal of the program. Second, advance publicity in the form of press releases, public notices, and media announcements will reduce the amount of anxiety felt by motorists who encounter a DUI roadblock.

The notice need not specify the precise time and location of the roadblock. Although this lack of specificity may engender some element of surprise for drivers encountering a checkpoint, public notice that a sobriety checkpoint program is in effect and the concomitant potential for being stopped at a checkpoint should substantially diminish any anxiety caused.[16]

For example, in *Christopher* v. *State*,[17] a Georgia appellate court considered a prior warning as an important factor in upholding the constitutionality of a sobriety checkpoint. The decision to set up the checkpoint on a particular road was made only after officers had been called at 11 p.m. to investigate a complaint of a loud party at a residence on that road. After police warned the host of the party that drivers leaving his house would have to pass through a sobriety checkpoint, all vehicles traveling that road past the checkpoint for the next two hours were stopped, including one operated by Christopher, who was a guest at the party.

The court held that it was not unreasonable to locate a roadblock where drunk drivers would be expected, since the purpose of such roadblocks is to deter drunk driving and to arrest those who choose to drive while intoxicated. The court noted approvingly that officers actually warned the host of the party of the checkpoint prior to its implementation.



Narrow the Scope of the Intrusion

Duration

The lawful stop of a motorist at a validly constituted sobriety checkpoint must be limited in scope to the objectives of deterring and apprehending drunk drivers. The duration of the stop should last no longer than necessary to ascertain indications of intoxication, with the average stop lasting 2 to 3 minutes.[18]

Questioning

Moreover, officer discretion to question a motorist should be circumscribed. Inappropriate questioning about matters unrelated to drunk driving increases the subjective intrusion and may engender fear and resentment in otherwise law-abiding citizens, who expect to be detained briefly for the sole purpose of determining their sobriety.[19]

Intrusiveness

Finally, departmental guidelines should limit unnecessary intrusions on a motorist's liberty and ensure uniformity in the investigative techniques employed, such as when to require drivers to produce their license and vehicle registration, answer certain questions, or perform other conduct. The Court in *Sitz* suggests that officers may be granted limited discretion to send certain vehicles selectively to secondary areas out of the traffic flow for expanded field sobriety tests, based on objective

criteria that restricts the officer's discretion.[20]

Establish Procedures for Handling Avoidance Maneuvers

A policy decision should be made in advance and set forth in departmental guidelines concerning whether and under what circumstances officers should pursue and detain a motorist who deliberately avoids the checkpoint without violating any traffic law. Some courts hold that avoidance of confrontation with the police at a checkpoint does not, without more, create reasonable suspicion to justify an investigatory stop.[21] These courts follow the rule that to justify the stop of a vehicle *not passing through* a roadblock checkpoint, the officer must have reasonable and articulable suspicion that the occupants are engaged in criminal activity.

Some courts have held that DUI roadblock guidelines need not provide an opportunity for motorists to avoid the checkpoint. These courts would likely uphold a sobriety checkpoint program that alerts motorists that all vehicles coming within a reasonable area of proximity to the checkpoint will be stopped, if necessary, by a police pursuit vehicle.[22]

Other courts analyze the specific facts of each case to determine whether avoidance of a roadblock constitutes reasonable suspicion in that particular case.[23] In view of this diversity of opinion in the courts, police administrators would be well advised to consult with their legal advisor and prosecutor before establishing departmental policy for handling avoidance maneuvers as part of a sobriety checkpoint program.

CONCLUSION

Although DUI roadblock stops constitute a fourth amendment seizure, the Supreme Court in *Sitz* approved their use without a showing of individualized suspicion, based on a balancing of governmental and individual interests.[24] Any sobriety checkpoint stop should be carried out pursuant to specific departmental guidelines that carefully limit officer discretion and the degree of intrusion on motorists' liberty. Sobriety checkpoints operated in accordance with the foregoing principles provide a powerful tool in the law enforcement arsenal to both deter and apprehend motorists who choose to drive the public roads while intoxicated.✦

> ***"The lawful stop of a motorist at a validly constituted sobriety checkpoint must be limited in scope to the objectives of deterring and apprehending drunk drivers."***

Endnotes

[1] National statistics of DUI accidents reveal that many people are willing to take the risk of driving under the influence of alcohol despite the fact that they are more likely to drive carelessly, resulting in severe injury or death, apparently because they believe there is only a slight chance of causing an accident. It is possible that an individual, who is not inhibited by the fact that particular acts are against the law and demand stiff sentences, may be inhibited by the very real possibility of detection. *Jones* v. *Murray*, 763 F.Supp. 842 at 846, n.7 (W.D. Va. 1991).

[2] 110 S.Ct. 2481 (1990).

[3] *Delaware* v. *Prouse*, 440 U.S. 648 (1979).

[4] *Id.* at 654. For a pre-*Sitz* discussion of drunk driving roadblocks, *see* Campane, "The Constitutionality of Drunk Driving Roadblocks," *FBI Law Enforcement Bulletin*, July 1984.

[5] For cases involving other special government needs justifications, *see New Jersey* v. *TLO*, 469 U.S. 325, 351 (1985) (school searches); *Griffin* v. *Wisconsin*, 483 U.S. 868, 873 (1987) (search of probationer's home); *Skinner* v. *Railway Labor Exec. Assn.*, 489 U.S. 602, 619 (1989) (drug testing railroad workers); *National Treasury Employees Union* v. *Von Raab*, 489 U.S. 656 (1989) (drug testing Customs Service employees).

[6] *Brown* v. *Texas*, 443 U.S. 47 (1979).

[7] 110 S.Ct. 2481 (1990).

[8] This article uses the terms "DUI roadblock" and "sobriety checkpoint" interchangeably to refer to police stops of traffic at fixed locations to check briefly for indications of drunk driving.

[9] *Sitz* addresses only the initial stop of each motorist passing through the checkpoint and the associated preliminary questioning and observation by checkpoint officers. The Court cautioned that detention of particular motorists for more extensive field sobriety testing may require satisfaction of an individualized suspicion standard.

[10] 110 S.Ct. at 2486.

[11] *United States* v. *Martinez-Fuerte*, 428 U.S. 543 (1976).

[12] Judicial disagreement on the legality of roadblocks for purposes other than identifying drunk drivers is beyond the scope of this article. In *State* v. *Everson*, 474 N.W. 2d 695 (N.D. 1991), the court held the State could validly conduct a checkpoint for the purpose of apprehending drunk drivers on the grounds it is a societal harm at least equal in magnitude to drunk driving. However, in *Galberth* v. *United States*, 590 A.2d 990 (D.C. Ct. App. 1991), the court said police may not use roadblocks to make suspicionless stops to detect crimes related to "violence, drugs and guns."

[13] Sobriety checkpoints were invalidated by the Texas Court of Appeals in two cases, because the guidelines were not the product of a legislatively developed scheme. *King* v. *State*, 816 S.W.2d 447 (Tex. App. 1991) and *State* v. *Wagner*, 821 S.W.2d 288 (Tex. App. 1991).

[14] *See, e.g., United States* v. *Walker*, 941 F.2d 1086 (10th Cir. 1991).

[15] 406 S.E.2d 674 (Va. App. 1991).

[16] *See International Brotherhood of Teamsters* v. *Department of Transportation*, 932 F.2d 1292 (9th Cir. 1991) (suspicionless random drug testing—notice is a relevant consideration, and in a particularly close case, could help tip the scales.)

[17] 413 S.E.2d 236 (Ga. App. 1991).

[18] While the average delay in *Sitz* was 25 seconds, lower courts have approved average delays in the 2- to 3-minute range. *See Chock* v. *Commissioner of Public Safety*, 458 N.W.2d 692 (Minn. Ct. App. 1990) (2-3 minutes); *People* v. *Rister*, 803 P.2d 483 (Colo. 1990) (3 minutes); *Cahill* v. *State*, 595 So.2d 258 (Fla. App. 2 Dist. 1992) (3-4 minutes).

[19] In *United States* v. *Walker*, 941 F.2d 1086 (10th Cir. 1991), the court held such questioning to be more than a "mere inconvenience" and declared the detention unreasonable under the fourth amendment.

[20] 110 S.Ct. at 2485.

[21] *See, e.g., State* v. *Powell*, 591 A.2d 1306 (Me. 1991) (no reasonable and articulable suspicion arose from officer's observation of a vehicle turning around 70 yards before the roadblock).

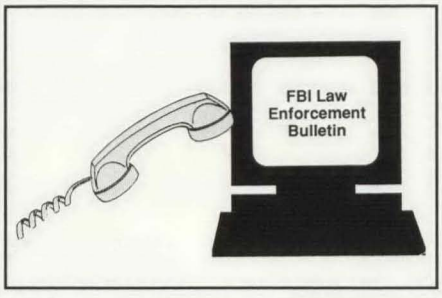
[22] *State* v. *Hester*, 584 A.2d 256 (N.J. Super A.D. 1990).

[23] *See, e.g., State* v. *D'Angelo,* 605 A.2d 68 (Me. 1992); *State* v. *Paterson*, 582 A.2d 1204 (Me. 1990).

[24] After the U.S. Supreme Court found the sobriety checkpoint in *Sitz* to be constitutional, the Michigan Court of Appeals decided that the Michigan constitution provides greater protection against suspicionless stops at sobriety checkpoints than does the fourth amendment. Accordingly, the Michigan court held that the roadblock in *Sitz* violated the State constitution, which requires "some facts constituting the basis for a particularized suspicion" to justify an investigative stop of a vehicle and that suspicionless stops at drunk driving roadblocks are impermissible under State law. *Sitz* v. *Michigan Department of State Police*, 485 N.W.2d 135 (Mich. App. 1992).

Law enforcement officers of other than Federal jurisdiction who are interested in this article should consult their legal advisor. Some police procedures ruled permissible under Federal constitutional law are of questionable legality under State law or are not permitted at all.

Dial-the-Bulletin

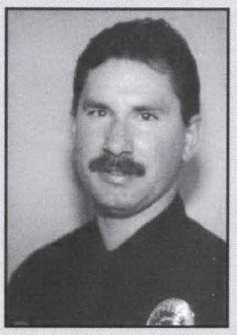


The *Bulletin* is now available via three computer dial-up services. Authorized law enforcement practitioners and related professionals who have a personal computer and a modem can access, download, or print current issues of the *Bulletin* in their own home or offices by contacting these services. These computer bulletin board services can be reached by dialing the following telephone numbers directly:

- SEARCH Group, Inc. (916) 392-4640
- IACP NET 1-800-227-9640
- CompuServe 1-800-848-8199 (Ask for Representative 346. The *Bulletin* is available only through their restricted law enforcement library.)

The Bulletin Notes

Law enforcement officers are challenged daily in the performance of their duties; they face each challenge freely and unselfishly while answering the call to duty. In certain instances, their actions warrant special attention from their respective departments. The *Bulletin* also wants to recognize their exemplary service to the law enforcement profession.



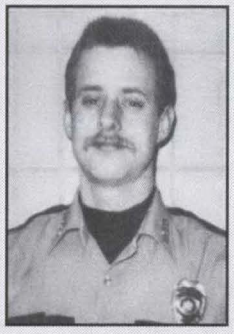
Officer Speckman

On his two-way radio, Officer Matt Speckman of the Turlock, California, Police Department overheard a communication dispatching rescue units to a residence where an infant had stopped breathing. Within 1 minute, Officer Speckman responded to the home and began life-saving procedures, which cleared the infant's airway. As a result of Officer Speckman's decisive actions, the infant resumed normal breathing.

Detective Conrad

A neighbor informed Detective Ashley Conrad of the Elizabeth, New Jersey, Police Department that an unstable man was brandishing a 16-inch knife. After requesting backup, Detective Conrad confronted the man and ordered him to drop the weapon. The subject refused and fled into a darkened basement. When Detective Conrad followed in pursuit, the subject jumped out and attempted to stab him. Detective Conrad fended off the attack and shot the suspect, thus neutralizing a dangerous assailant who placed an entire neighborhood in jeopardy.

Officer Adams



Officer Feskanich

During the early morning hours, Officer David Adams of the Elk City, Oklahoma, Police Department observed flames from a house fire. As Officer Adams requested the assistance of emergency units, Officer David Feskanich of the same department arrived at the scene. When the officers realized that three small children were still inside the residence, they entered the burning home and rescued the children, who received slight burns but were treated and released from an area hospital.

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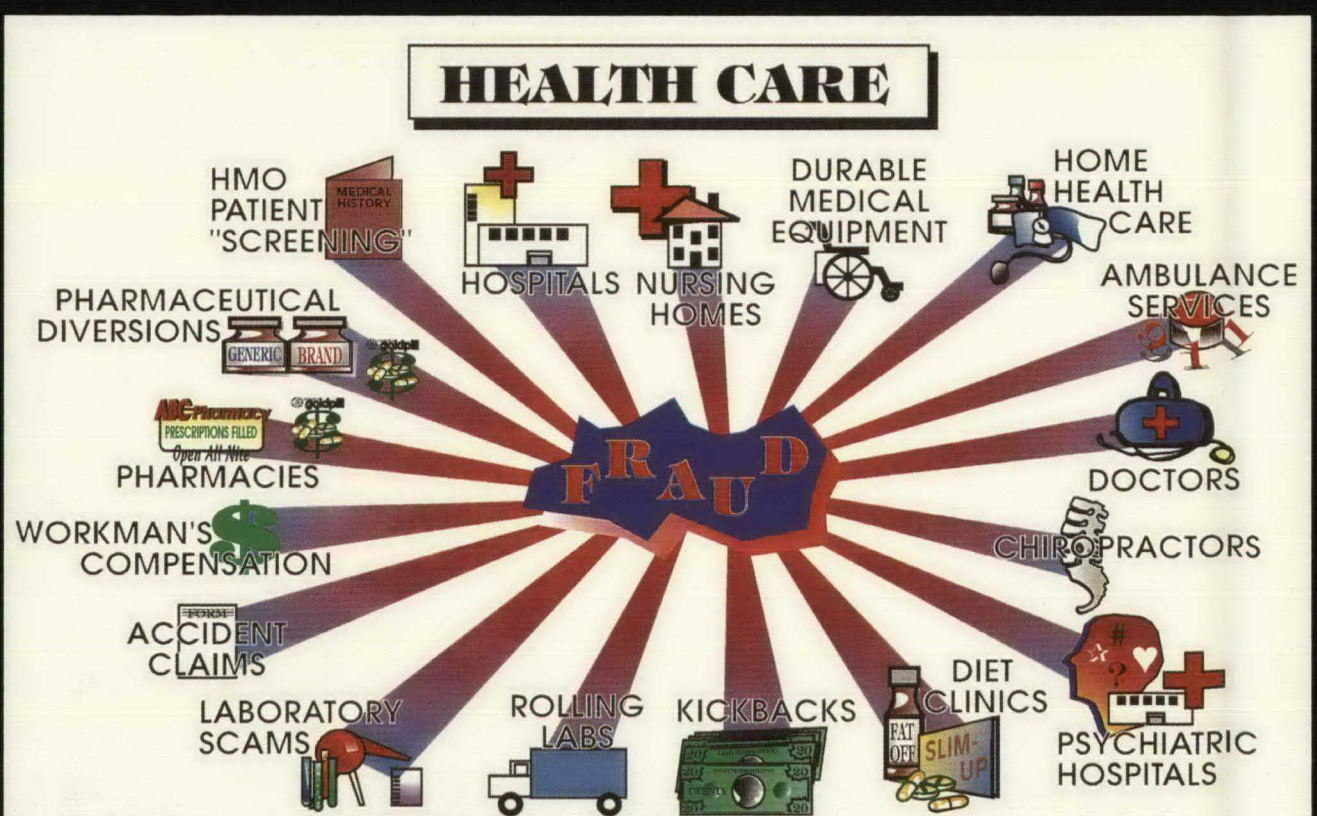

Graphic by Ed Klejnowski