DEPARTMENT OF HEALTH AND HUMAN SERVICES
Departmental Grant Appeals Board
Civil Money Penalties Hearing Office

In the matter of:	)	Date: May 14, 1985
William J. Mayers, D.C., and	)	Docket No. C-4
Patricia M. Mayers,	)	DECISION # CR2
Respondents		

DECISION AND ORDER

This is a civil money penalties, assessments and suspension case arising from a determination by the Inspector General of the Department of Health and Human Services that the Respondents knowingly submitted false Medicare claims for reimbursement.

By letter dated May 3, 1984, the Deputy Inspector General for Civil Fraud notified the Respondents of the Inspector General's intent to impose civil money penalties and assessments against them in the amount of $2,900,000. The Deputy Inspector General also advised Respondents that she proposed to suspend each of them from participation in the Title XVIII (Medicare) and Title XIX (Medicaid) programs for a period of twenty-five years. She further advised Respondents that these actions were authorized by Sections 1128A and (b) of the Social Security Act (42 U.S.C. secs. 1320a-7a and 1320a-7(b)) as implemented by 45 C.F.R. sec. 101.100 et seq.

Respondent Dr. William J. Mayers is a chiropractor. Respondent Patricia Mayers is his wife. They have operated clinics in the vicinity of Fort Myers, Florida. They are charged with submitting claims in violation of Section 1128A of the Social Security Act. The alleged violations generally involve claims for Medicare reimbursement submitted by Respondents for services ostensibly rendered by medical doctors who were employed by them.

The Inspector General specifically charged that from June 1982, through January 1984, Respondents submitted and/or caused to be submitted for Medicare reimbursement 307 claims, containing 2,729 items or services, which represented that such items or services were performed or ordered by medical doctors employed by clinics owned and operated by Respondents. She further charged that Respondents claimed reimbursement of $147,406 for these items or services. The Inspector General has amended these allegations to assert that the claims in question involve 2,702 items or services, with the amount claimed being $145,550.

The Inspector General charged that at the time these claims were submitted, Respondents had reason to know, and, indeed, knew that the items or services for which reimbursement was sought were not provided as claimed since

they were neither rendered by nor ordered by physicians employed by them. The Inspector General further asserted that in reliance upon Respondents' false representations, Blue Cross and Blue Shield of Florida, the Medicare Part B Carrier for the State of Florida, reimbursed Respondents for many of these allegedly false claims. The Inspector General also asserted that substantial aggravating factors existed which justified the proposed penalties, assessments, and suspensions. These alleged factors included: the large volume of items or services rendered over an extended period of time, a pattern of false claims of which the items specifically charged were but a small part, and submission of false claims by Respondents after they had specifically been warned against such submissions by an agent of the Department of Health and Human Services. The Inspector General also asserted that the vast majority of the claims at issue were represented by Respondents to have been rendered by their physician employees on dates which either preceded or followed their employment by Respondents.

On May 31, 1984, counsel for Respondents replied, denying the allegations made by the Inspector General. Counsel also requested a hearing before an Administrative Law Judge. The matter was assigned to me for hearing and decision. A hearing was held in Fort Myers, Florida, from October 29 to November 8, 1984. Nineteen witnesses testified on behalf of the Inspector General, and seventeen testified on behalf of Respondents. Four hundred and eight written exhibits were offered as evidence by the Inspector General and were made part of the record of this proceeding. Thirty written exhibits were offered as evidence by the Respondents and were made part of the record. Two joint exhibits were also received into evidence. As a consequence of a post-hearing motion by the Inspector General, I permitted the record to be reopened for the limited purposes of receiving testimony from one of Respondent's witnesses, who offered to substantially recant her previous testimony, and for receiving relevant rebuttal evidence. Pursuant to my Order reopening the record, a day of additional testimony occurred in Tampa, Florida, on January 29, 1985, at which time the witness in question testified on behalf of the Inspector General. Two rebuttal witnesses testified on Respondents' behalf. Subsequent to the hearing, both parties filed briefs and reply briefs, and proposed findings of fact, and oral argument was held on April 9, 1985.

ISSUES

The principal issues are:

1) Whether Respondents submitted claims for items or services that they knew or should have known were not provided as claimed, as defined by the Social Security Act and implementing regulations.

2) If Respondents submitted claims for items or services in violation of the law, whether the amount of the proposed penalty, assessment and suspension is reasonable and appropriate under the circumstances of this case and within the intent and meaning of the Act and regulations.

SUMMARY OF THE ARGUMENTS

These principal issues subsume numerous affirmative allegations and defenses. The Inspector General asserts that the items or services at issue are a minor part of a scheme by Respondents to unlawfully obtain Medicare reimbursement. Respondents are alleged to have employed physicians primarily for the purpose of affixing their signatures and Medicare reimbursement numbers to claims for services rendered at Respondents' clinics. The Inspector General asserts that these physicians' involvement with patients at Respondents' clinics was tangential; consisting primarily of performing brief physical examinations, without rendering subsequent treatment or supervising treatment by clinic staff. The Inspector General also asserts that the items or services at issue were attributed to specific medical doctors when Respondents knew that these physicians could not have rendered or supervised provision of the items or services, inasmuch as these physicians were not employed by Respondents' clinics when these items or services were allegedly rendered. Moreover, many of the items or services in question allegedly consist of items or services that were never actually rendered--office visits with physicians which were routinely billed every time a patient visited one of Respondents' clinics, regardless whether that patient actually consulted with or was examined by a medical doctor. Respondents are charged with continuing to bill Medicare for such visits even after they were expressly warned to cease doing so by a representative of the Part B Carrier. Finally, the Inspector General charges that Respondents engaged in an orchestrated coverup of their unlawful activities when it became apparent that they were under investigation. Respondents allegedly manufactured documents which purport to show that physician employees ordered and supervised tests and therapies which they never actually ordered or supervised.

Respondents concede that the physician employees on whose accounts reimbursement for the 2,702 items or services was claimed were not employed by Respondents on the dates when these items or services were allegedly rendered. But they argue that this concession does not establish the claims to be false. They assert that all services and tests in question were actually provided by a "physician"--either a medical doctor or a chiropractor. They argue that relevant law, regulations, and policy statements do not distinguish between chiropractors and medical doctors for supervisory or rendering services ordered by a medical doctor. And, since chiropractors and medical doctors are asserted to be equally "physicians" for Medicare reimbursement purposes, Respondents claim that there is neither a statutory nor regulatory prohibition against a chiropractor receiving reimbursement for rendering or supervising a service or test previously ordered by a medical doctor. This is ostensibly the case even where the medical doctor has left Respondents' employ and the tests and treatment ordered by him continued under the auspices of a chiropractor. Thus, according to Respondents, the claims for reimbursement for the 2,702 items or services at issue constitute lawful claims. Respondents argue further that even if their interpretation of applicable law and regulations is incorrect, it is nontheless plausible, given allegedly confusing regulations and guidelines and the novel situation of a chiropractor employing medical doctors--a business relationship which, according to Respondents, was simply not anticipated by the agencies who

administer the Medicare laws. From this they assert that any incorrect interpretation which Respondents may have made was made in good faith, and therefore, the claims they submitted were not false pursuant to Section 1128A of the Social Security Act.

Respondents make other arguments to explain their actions or as proof in mitigation. They argue that they diligently sought to ascertain their obligations, but were impeded by the Carrier's failure to adequately advise them of their responsibilities or to promulgate a clear statement of Respondents' duties. They assert that the Carrier deliberately withheld critical information from them, causing them to submit arguably false claims for items or services which they otherwise would never have submitted. They deny that the items or services in question were part of a pattern of unlawful conduct. Respondents argue that their physician employees had a much closer relationship with patients and clinic activities than is alleged by the Inspector General. They assert that medical doctors actively supervised the tests and treatments rendered at Respondents' clinics. They assert that evidence to the contrary is inaccurate or untrue. Respondents suggest that adverse testimony by witnesses who were called by the Inspector General was either motivated by these witnesses' animosity toward Respondents, or was coerced by agents of the Inspector General. Respondents also assert that in any event, no damages were occasioned by the claims they submitted because the items or services in question constituted legitimate chiropractic treatments under applicable State law and did not harm patients. They argue that the items or services at issue represent only a tiny fraction of Respondents' business activities. They argue that given all of this, coupled with their view of statutory and regulatory intent and meaning, the penalties, assessments and suspensions proposed by the Inspector General are inappropriate. Finally, Respondents aver that I did not afford them a fair and impartial hearing--that I deprived them of the opportunity to present relevant evidence and displayed bias through overly zealous questioning of certain witnesses.[1]

FINDINGS OF FACT AND CONCLUSIONS OF FACT AND LAW

Based on my review of the applicable laws and regulations and the relevant evidence, I conclude that the Inspector General has established that claims for reimbursement for the 2,702 charged items or services constitute

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1/ In their response to the Deputy Inspector General's May 3, 1984 letter and in a motion seeking partial summary judgment, dismissal of administrative penalties and other appropriate relief dated April 9, 1985, Respondents assert that Section 1128A is a "penal statute" and that they are therefore entitled to a trial in United States District Court. This argument effectively challenges the validity of the statute and regulations providing for a hearing before an administrative law judge. I do not have authority to decide this issue. 45 CFR sec. 101.115(c). Respondents have also moved that this proceeding should be dismissed because the Inspector General has not established that the proceeding is authorized pursuant to 42 U.S.C. sec. 1320a 7A(b)(1). The Inspector General has supplied proof of authorization. Consequently, Respondents' motion is denied in its entirety.

violations of Section 1128A of the Social Security Act. I conclude further that these false claims were but a small element of a pattern of unlawful behavior by Respondents. I find that substantial additional aggravating factors exist, including the patent falseness of the claims at issue in this case, and Respondents' efforts to conceal from investigating agents the nature and scope of their unlawful activities. I conclude that no mitigating factors exist. Therefore, I find that the Inspector General has established grounds for imposition of substantial penalties, assessments, and suspensions. I have determined that an assessment of $291,100 and a penalty of $1,500,000 coupled with a 25 year suspension from the Medicare and Medicaid programs are appropriate in this case. These conclusions are premised on the following findings of fact and conclusions of fact and law.

1) Respondent Dr. William J. Mayers is a chiropractor. Respondent Patricia Mayers is his wife. Tr. 11/5 at 4-5.[2] Together they have owned and operated several chiropractic clinics in the vicinity of Fort Myers, Florida. These include the Del Prado Chiropractic Center, the Lee County Medical and Professional Center, and the Lee County Chiropractic and Medical Center. Tr. 11/8 at 97-100. At these clinics, Respondents have treated patients who are entitled to Medicare Part B health insurance benefits, and have submitted claims for reimbursement to Blue Cross and Blue Shield of Florida, the Medicare Part B Carrier for the State of Florida. These claims have included both claims for reimbursement for chiropractic services and for services allegedly rendered by medical doctors. See IG Ex. 1, 3, 5.

2) The statutes which govern Part B Medicare reimbursement provide that certain "medical and other health services" rendered to eligible beneficiaries are reimbursable 42 U.S.C. sec. 1395K(a)(1). The term "medical and other health services" includes certain "physicians services." 42 U.S.C. sec. 1395x(S). The statutory term "physician" is defined to mean a doctor of medicine or osteopathy legally authorized to practice medicine or surgery under relevant state licensure laws, and a chiropractor similarly licensed but "only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by x-ray to exist)." 42 U.S.C sec. 1395x(r). A chiropractor is therefore not a "physician" for Medicare reimbursement purposes except in those circumstances narrowly defined by law. Furthermore, "physicians" services are not reimbursable under Part B except where they are actually furnished by a physician or where they are furnished as an "incident to" a physician's professional service, 42 U.S.C. sec. 1395x(S); 42 C.F.R. sec. 405.321(a) and (b). The plain meaning of the term "incident to" is that physicians' services not personally rendered by a physician must at least have been ordered and personally supervised by a

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2/ Citations to the transcript and exhibits are in the following form:

Transcript	Tr (date) at (page)
Respondent's Exhibit	R Ex. (exhibit number)
Inspector General Exhibit	IG Ex. (exhibit number)
Joint Exhibit	J Ex. (exhibit number)

physician. This statutory meaning is restated by the Secretary of Health and Human Services at secs. 2050.1 and 2050.2 of the Medicare Part B Carriers Manual. It is also incorporated as part of the certification language contained in standard Medicare claims forms utilized by physicians for billing for Medicare reimbursement. Copies of such claims forms were present at Respondents' clinics, and Respondents executed many claims forms. IG Ex. 196, 243; Tr. 11/1 at 26, 78, 108-109; 11/5 at 192.

3) Thus, services rendered at Respondents' clinics to Medicare beneficiaries are reimbursable under Part B of Medicare only if they constitute the very limited category of chiropractic physicians' services defined in 42 U.S.C. sec. 1395x(r), or if they constitute services actually rendered by or ordered and supervised by an appropriately licensed doctor of medicine or osteopathy. The mere employment of medical doctors by Respondents or these medical doctors' signatures or signature facsimiles on claims forms does not establish a lawful basis for reimbursement of Respondents' clinics services pursuant to Part B of Medicare. Services rendered at Respondents' clinics are not reimbursable under Part B simply because a medical doctor may have at some point in the course of treatment examined the patient on whose account reimbursement for services is claimed. Such services are not reimbursable because they are legitimate under State laws, or because they are not harmful to patients.

4) Prior to approximately July 1982, the Respondents' clinics rendered only chiropractic services, and Respondents were neither affiliated with nor employed medical doctors. Beginning in about July 1982, Respondents became affiliated with a naturopathic physician and an osteopathic physician. Tr. 10/30 at 102B. This relationship lasted a few months. Tr. 10/30 at 113; 11/5 at 24.

5) In October 1982, Respondents hired Dr. Romulo Bernal, a licensed medical doctor, to serve as staff physician. Tr. 10/30 at 154-157. Dr. Bernal began working for Respondents on October 11, 1982. His employment ended on the morning of January 25, 1983. Tr. 10/30 at 178, IG Ex. 194.

6) On January 31, 1983, Respondents hired Dr. Mario Russo, a licensed medical doctor, as Dr. Bernal's successor. Tr. 10/31 at 17, 23-24. Dr. Russo commenced working for Respondents on February 1, 1983, and his employment ended on April 22, 1983. Tr. 10/31 at 24, 52.

7) Respondents then employed Dr. Marta Mendez-Blanco, a licensed medical doctor, beginning August 1, 1983. Tr. 10/31 at 117A-118, 122. Dr. Mendez ceased working at Respondents' clinics on December 5, 1983. Tr. 10/31 at 149.

8) During the period from June 1982, through December 1983, other individuals were employed by Respondents at their clinics in the capacity of staff medical doctors. Dr. Lopez, an unlicensed physician, worked at Respondents' clinics from late April through June 20, 1983. Tr. 10/31 at 231-232; 11/5 at 97; IG Ex. 194. Respondents were unable to obtain a Medicare billing number for Dr. Lopez, and were therefore unable to bill Medicare under

Dr. Lopez' name for services rendered at their clinics. Tr. 11/1 at 49, 73. Respondents also employed an unlicensed physician, a Dr. Franzone, while Dr. Russo was employed by them, and another unlicensed physician, a Dr. Arguello, whose employment in part coincided with Dr. Mendez' employment. Tr. 10/31 at 42; Tr. 11/5 at 87.

9) The purpose of employing medical doctors was to enable Respondents to obtain Medicare reimbursement for services rendered at their clinics. Respondent Dr. Mayers advised his employees that it was necessary for a patient to be seen by a medical doctor in order to obtain Medicare reimbursement for services. Tr. 10/30 at 104. He also stated to clinic employees that he desired to obtain a foreign-born physician who neither spoke nor understood English too well, but who could sign documents. Drs. Bernal, Russo and Mendez are all of foreign extraction. Tr. 10/30 at 115.

10) The conditions of employment of Drs. Bernal, Russo and Mendez were essentially identical. All three medical doctors were ignorant at the time of their employment of the treatment modalities employed by chiropractic physicians. Tr. 10/30 at 156-157; 10/31 at 91, 129. Dr. Bernal was advised that he would be a medical consultant and that he would treat patients' medical problems. Tr. 10/30 at 157-158, 231. Dr. Russo was told that his function would be to examine patients and to advise whether they could be provided chiropractic treatments. Tr. 10/30 at 236; 10/31 at 20. Dr. Russo understood that chiropractic treatments were outside of his area of practice and that he was not to interfere in the rendering of chiropractic services. Tr. 10/31 at 73-74, 107-108. Dr. Mendez was instructed not to interfere in the provision of chiropractic treatments. Tr. 10/31 at 205.

11) As a prerequisite to employment, each medical doctor permitted rubber stamps to be made bearing a likeness of his or her signature. Tr. 10/30 at 170; 10/31 at 24; 10/31 at 122. Custody of these stamps was retained by the clinics' clerical personnel who routinely used them to complete Medicare claims forms. Tr. 11/1 at 35, 46. The medical doctors rarely, if ever, used these stamps. See Tr. 10/30 at 170; 10/31 at 24; 123, 158. Despite efforts by the medical doctors to obtain custody of their stamps from Respondents upon their departure from Respondents' employment, Respondents retained at least one copy of each doctor's stamp. Tr. 10/30 at 130-131, 183, 240; 10/31 at 53; 143; 11/2 at 48.

12) Drs. Bernal, Russo and Mendez had essentially identical duties while employed by Respondents. Each physician performed routine physical examinations of the clinics' new patients and prepared patient history forms. Tr. 10/30 at 158; 10/31 at 25, 128, 202. If patients presented particular medical problems, the medical doctors would order tests, treatment, and followup examinations. See Tr. 10/30 at 166-167; 10/31 at 125. However, such was rarely the case. The doctors normally did not order tests or therapy for the patients they examined. See Tr. 10/30 at 164-166; 10/31 at 40-41, 128.

13) After the initial examinations, the medical doctors generally had little formal contact with patients. Tr. 10/31 at 48-49, 128-129, 279-280. They might occasionally pause to speak to patients while those patients were undergoing tests or therapies at the clinics, but there was no specific pattern or purpose to such contacts. Tr. 11/7 at 108-115, 117-123, 128-129.

14) All of the clinics' Medicare patients received essentially the same tests and therapies unless the medical doctors specifically identified a problem which would contraindicate such treatments. Tr. 10/31 at 248-249; 11/5 at 64-65, 69-70. All Medicare patients received standardized x-rays at uniform predetermined intervals. Tr. 10/31 at 213-216; 11/1 at 165; 11/2 at 36. All Medicare patients received tests, including electrocardiograms (EKGs), plethysmographies, spirometries and vascular analyses at uniform predetermined intervals. Tr. 10/31 at 212-214; 11/1 at 6-7. The treatments generally received by all Medicare patients included chiropractic adjustment, stabilizer (intersegmental traction), diathermy, and extensilizer (inertial extensilizer or longitudinal traction). These treatments are referred to in Respondents' documents by the nomenclature "ADSE". Tr. 10/31 at 248; 11/5 at 9-13, 64-65, 70.

15) The standard tests or treatments rendered to Medicare patients at Respondents' clinics were neither rendered nor supervised by the clinics' medical doctors. Although there were rare exceptions, medical doctors generally did not read x-rays nor did they order other tests or interpret their results. Tr. 10/31 at 40-41; 128-129, 182. Medical doctors did not supervise the day-to-day administration of treatments. Tr. 10/31 at 48-49, 129. The regimen of tests and treatments was established by Dr. Mayers; he also was responsible for modifications in the selection of tests and treatments. Tr. 10/31 at 216, 237, 256; 11/1 at 7-8.

16) Respondents submitted reimbursement claims for Medicare patients to Blue Cross and Blue Shield of Florida, the Medicare Part B Carrier in Florida. See IG Ex. 1, 3, 5. Prior to February 1983, claims for reimbursement were manually generated by Respondents' clerical staff; however, beginning in that month Respondents had installed a computer terminal which enabled them to electronically file reimbursement claims. Tr. 10/30 at 12.

17) Policy concerning the billing of claims was made by both Respondents. Tr. 11/1 at 58, 92, 122; 11/5 at 212. Respondent Patricia Mayers supervised billing personnel. Tr. 10/31 at 232; 11/1 at 27, 41, 65 and 109. Respondents instructed their employees not to discuss billing matters with staff physicians. Tr. 11/1 at 88, 125, 147. The billing personnel did not consult with physicians or other clinic staff in order to determine which services to bill to Medicare. Tr. 11/1 at 62, 98, 103. Nor were physicians' treatment records consulted. Id. The billing staff was instructed to obtain information from clinic records generated by the clinics' clerical staff. See IG Ex. 17A, 20A. These records consisted primarily of a document entitled a "Daily Analysis Sheet" which was prepared at the end of each day's business. Tr. 11/1 at 30, 110-112. Before April 1983, this document was prepared based on appointment records and reflected all of the tests and treatments that the following day's patients were scheduled to receive. The clinics' treatments were so standardized that clerical personnel knew that nearly all patients would be routinely scheduled for the "ADSE" course of treatments, and they neither consulted with staff nor checked clinic treatment records before entering this information on the Daily Analysis Sheet. Tr. 10/31 at 253. Thus, claims information was obtained essentially based on the standardized course of treatments and tests which was the norm for most patients of Respondents' clinics.

18) Beginning in April 1983, information to be placed on the Daily Analysis Sheet was obtained from documents known as "trip tickets". Tr. 10/31 at 222; IG Ex. 195. These were forms supplied to patients when they arrived at the clinics for tests or treatments and were signed by providers of therapies or tests as these services were provided. Tr. 10/31 at 221-222. However, the implementation of trip tickets as records of services rendered did not alter the manner in which services were prescribed or rendered.

19) The clinics' billing personnel billed the "DSE" portion of the treatments recorded on the Daily Analysis Sheets for individual patients on the accounts of the medical doctors who initially examined these patients. Tr. 11/1 at 31, 67-68, 71, 113. Adjustments were billed as chiropractic services. Id. In addition, clinic staff billed every patient for an "office visit" to a physician (Medicare procedure code 90040) every time a patient visited the clinics—whether or not the patient actually was examined by a physician. Tr. 11/1 at 31, 36, 39, 71, 113, 142. If a patient actually was examined by a physician, then the clinic staff would bill Medicare for two office visits by that patient. Tr. 11/1 at 32-33. Dr. Mayers indicated to clinic employees that in his opinion, charging for a 90040 office visit each time a patient visited his clinics reimbursed him for his overhead. Tr. 11/1 at 72; 11/5 at 208. Dr. Mayers stated that a patient should be billed for such service every time that patient breathed his air conditioning and walked on his carpet. Id.

20) In order to attract patients to their clinics, Respondents placed advertisements in local media. Respondents advertised that Medicare beneficiaries would receive essentially free medical care at their clinics, by not being charged the standard Medicare copayment. IG Exs. 227, 228. This policy of Respondents may have attracted patients, but it also violated Medicare guidelines. Tr. 10/30 at 36. Respondents were quite successful in attracting patients to their clinics. Respondents treated from 60 to 170 patients per day at their Cape Coral clinic and between 200 to 250 patients per day at their North Fort Myers clinic. Tr. 10/31 at 219; 11/5 at 268. Each patient, after his initial examination, generally visited Respondents' clinics several times per week, and at each visit the patient received the standardized therapies and tests described supra. As a consequence of the large volume of business they generated, Respondents billed the Medicare Part B Carrier for fees in excess of $1.8 million, attributed as services rendered by or "incident to" the services of Drs. Bernal, Russo and Mendez. Of this amount, $212,817 was attributed to services rendered by Dr. Bernal in 1982, and $174,665 in 1983; $653,324 was attributed to services rendered by Dr. Russo in 1983; and $791,835 was attributed to services rendered by Dr. Mendez in 1983. Respondents were reimbursed in excess of $500,000 by the Part B Carrier for these alleged services. See IG Exs. 221-225.

21) The vast majority of items or services billed by Respondents on the accounts of Drs. Bernal, Russo and Mendez were not rendered by these medical doctors. Nor were these services ordered by or supervised by Drs. Bernal, Russo, or Mendez. Consequently, these services were not rendered "incident to" these physicians' professional services. See Findings 9-20.

22) Each of the 2,702 items or services charged by the Inspector General as constituting a false claim in this case is an item or service subject to determination under 45 C.F.R sec. 101.102. They are as follows:

a) 168 claims for items or services attributed to Dr. Bernal in the amount of $12,240. IG Ex. 6, 9.

b) 1,776 claims for items or services attributed to Dr. Russo in the amount of $99,766. IG Ex. 7, 10.

c) 758 claims for items or services attributed to Dr. Mendez in the amount of $33,544. IG Ex. 8, 11

The total amount claimed by Respondents for these items or services was $145,550 and Respondents received reimbursement from the Medicare Part B Carrier for these items or services in the amount of $24,697.73. IG Ex. 9, 10, 11.

23) The physician employees on whose accounts reimbursement for these 2,702 items or services were claimed were either not present at the clinics or not employed by Respondents on the dates when these items or services were allegedly rendered. Tr. 10/29 at 60-62, 67-69; IG Exs. 6-11. No licensed medical doctors were present or employed by Respondents on these dates. Respondents' attribution of these items or services to Drs. Bernal, Russo or Mendez reflected Respondents' policy to bill their clinics' services to the medical doctor most recently employed by them if no medical doctor was employed at the time the services were rendered. Tr. 11/1 at 74, 118, 147; 11/5 at 187, 195-196, 203-204.

24) Neither Drs. Bernal, Russo, Mendez or any other licensed medical doctor ordered, rendered, or supervised the performance of the 2,702 charged items or services. None of these items or services were actually furnished by a physician or furnished incident to a physician's professional services within the meaning of 42 U.S.C. sec. 1395x(S) and 42 C.F.R. sec. 405.321(a) and (b). See Finding 22.

25) At the time Respondents claimed reimbursement for the 2,702 charged items or services, they either knew that they were not entitled to reimbursement for these items or services, or made these claims in reckless disregard of whether or not they were entitled to reimbursement for the items or services. See Finding 30(d).

26) The 2,702 items or services charged by the Inspector General were not provided as claimed by Respondents within the meaning of Section 1128A of the Social Security Act (43 U.S.C. sec. 1320a-7a). See Findings 23-25.

27) Sec. 1128A(a)(2) of the Social Security Act (42 U.S.C. sec 1320a-7a(A)), provides that an individual who claims reimbursement for items or services not provided as claimed shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for each item or service. It further provides that in addition, such person shall be subject to an assessment of not more than twice the amount claimed for each unlawfully claimed item or service, in lieu of damages

sustained by the United States. Section 1128(b) of the Act (42 U.S.C. sec. 1320a-7(b)) provides that individuals against whom such penalties or assessments are imposed are subject to suspension from participation in the Medicare and Medicaid programs. Thus, Respondents are subject to a maximum penalty of $5,404,000 (2,702 x $2,000) and a maximum assessment of $291,100 (2 x $145,550). See Finding 22.

28) Section 1128A(c) of the Act provides that in determining the amount or scope of any penalty or assessment, the Secretary shall take into account (1) the nature of the claims and the circumstances under which false claims were presented, (2) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims, and (3) such other matters as justice may require.

29) Regulations implementing the aforesaid statutory sections are contained in 45 C.F.R. sec. 101.100 et seq. 45 C.F.R. sec. 101.106(b) establishes guidelines for determining the amount of the penalty or assessment in those cases where an individual has been established to have submitted false reimbursement claims. These generally consist of aggravating and mitigating circumstances. A penalty or assessment should be set at an amount which reflects the presence or absence of aggravating or mitigating circumstances. 45 C.F.R. sec. 101.114(d) provides that Respondents have the burden of establishing, by a preponderance of the evidence, the presence of mitigating circumstances. 45 C.F.R. sec. 101.107 provides that the same guidelines shall be used in determining whether a suspension is appropriate, and the duration of that suspension, as are used in determining the amount of the penalty or assessment. It specifically provides that a person found to have submitted false claims should be suspended where aggravating circumstances are established to exist.

30) Substantial aggravating circumstances exist which conform to examples specifically enumerated as aggravating factors in 45 C.F.R. sec. 101.106.

a) The items or services not provided as claimed were of several types, occurred over a lengthy period of time, and there were many such items or services (45 C.F.R. sec. 101.106(b)(1)). The items or services established not to have been provided as claimed in this case included claims for a wide variety of tests and treatments. These included x-rays, plethysmographies, spirometries, vascular analyses, diathermy and stabilizer and extensilizer treatments, as well as office visits to medical doctors. The claimed items or services were assertedly provided over a period of about twenty months, beginning June 1982 and extending through early January 1984, and many items or services (2,702) were claimed. IG Exs. 6-11.

b) The nature and circumstances of the claims for reimbursement indicate a pattern of claims for such items or services which reflects Respondents' standard practices (45 C.F.R. sec. 101.106(b)(1)) The 2,702 items or services established to have not been provided as claimed were routinely attributed to medical doctors who were either not present at Respondents' clinics or not employed by Respondents on the dates when such items or services were supposed to have been provided. See Finding 23. Respondents routinely submitted numerous claims for reimbursement for office visits to medical doctors in circumstances where patients were not treated by medical doctors. See Finding 19. Moreover, the 2,702 items or services

established not to have been provided as claimed are but a small percentage of a much larger pattern of claims for items or services which were made by Respondents and which were not furnished by a physician or furnished incident to a physician's professional service. This larger pattern reflects an intent by Respondents to obtain reimbursement for items or services in circumstances where they were not entitled to such reimbursement. See Findings 4-21.

c) The amount claimed for the 2,702 items or services established to have not been provided as claimed was substantial (45 C.F.R. sec. 101.106(b)(1)). In this case the total amount claimed was $145,550. See Finding 22.

d) Respondents knew that the 2,702 items or services were not provided as claimed (45 C.F.R. sec. 101.106(b)(2)). Respondents made each of the claims in question with knowledge that it was false, or with reckless disregard for the truthfulness or falseness of the claim, which is tantamount to having knowledge that the claim was false. Respondents had in their possession and routinely used Medicare documents which expressly stated that items or services could not be attributed to medical doctors unless those items were either rendered by or ordered and personally supervised by those medical doctors. These documents included Medicare claims forms. See Finding 2. The claims forms contained certifications that the items or services claimed were rendered by or ordered and personally supervised by physicians, and Respondents executed these certifications, or ordered that they be executed. Id. Respondents also knew that the medical doctors to whom the 2,702 items or services are attributed neither rendered nor ordered and supervised the rendering of these items or services. This knowledge resulted from Respondents' familiarity with the terms and conditions of the medical doctors' employment and their understanding of these doctors' actual duties and activities. See Findings 9, 12, 13. Respondents knew, moreover, that the medical doctors to whom these items or services are attributed were either not present at their clinics or not employed by them on the dates when the items or services were ostensibly rendered. They also knew that these items or services included many claims for fictitious office visits with physicians--claims which were deliberately made by Respondents to compensate them for their "overhead", rather than for items or services actually rendered. See Finding 19.

31) There exist other aggravating factors which must be taken into consideration pursuant to 45 C.F.R. sec. 101.106(b)(5). These are as follows:

a) Respondents have submitted claims for reimbursement for items or services which were not provided as claimed despite explicit advice from the Part B Carrier that their claims were not reimbursable. In August 1983, the Medicare Part B Carrier conducted a routine audit of Respondents' reimbursement claims. Tr. 10/30 at 24. This audit uncovered improprieties in Respondents' claims documentation. Tr. 10/30 at 42. These included Respondents': use of physicians' stamped signatures to execute claims; use of financial data, rather than treatment records, to document claims; and failure to provide documentation of claims for reimbursement of office visits (billed under procedure code 90040). Tr. 10/30 at 27-28, 31-32, 77. The Carrier's representative specifically advised Respondents during the course of this

audit that rubber stamps could not be used to endorse claims or treatment records, that financial records did not constitute acceptable claims documentation, and that claims for office visits were not reimbursable unless medical doctors actually rendered and correctly documented the services claimed. Id.

However, Respondents continued to use physicians' signature stamps to document claims. Moreover, Respondents continued to submit claims for reimbursement for office visits in instances where medical doctors had not examined or treated patients. Tr. 10/30 at 88-89.

b) Respondents have attempted to deceive investigating authorities. In late February or early March 1984, aware that agents of the Inspector General were investigating their activities for evidence of unlawful conduct, Respondents directed several of their clerical employees to prepare or alter documents so as to show that physician employees had ordered or supervised the rendering of items or services. Tr. 10/31 at 226-30; 11/1 at 11-15, 19, 21-22. Documents so prepared or altered included trip tickets, test reports, and daily analysis sheets. Id. They also included "doctor's orders" which contained checklists of Respondents' clinics' standard tests and treatments. Clerical employees were instructed to complete such forms and insert them in patients' files. Id. These forms were in many cases backdated to make it appear as if they had been prepared contemporaneously with patients' initial examinations by examining physicians. Id. They were stamped with medical doctors' signatures, weeks or months after the doctors in question had left Respondents' employment. Id. These forms made it appear as if medical doctors had, at the time of their initial examination of patients, ordered tests and treatments which they in fact did not order. Respondents' attempts to mislead investigators establishes both a design to interfere with investigation of their activities and knowledge that their efforts to obtain reimbursement for the 2,702 charged items or services were unlawful.

32) Respondents have made assertions which they contend must be considered as mitigating factors pursuant to 45 C.F.R. sec 101.106. The evidence fails to establish the existence of such factors.

a) Respondents assert that they acted on a good faith, albeit mistaken, understanding that their claims for reimbursement were properly made. There is no credible evidence to show that Respondents relied on misleading or vague Medicare reimbursement guidelines. Rather, as noted supra, Medicare guidelines are explicit and comport with relevant statutory language. These guidelines are contained in documents which Respondents utilized in their daily business activities. IG. Ex. 196, 243.

b) Respondents assert that they relied on misleading statements by representatives of the Part B Carrier, and that any false claims they may have made resulted from good faith reliance on these allegedly misleading statements. However, there is no evidence that the Carrier's representatives made misleading statements.

c) Respondents contend that any false claims they made were but an insignificant part of a large number of legitimate claims. Respondents' unlawful claims were not insignificant. As noted supra, there were many falsely claimed items or services which constituted a small part of a much larger pattern of unlawful activities.

33) The evidence of record justifies imposition of an assessment of $291,100 and a penalty of $1,500,000, as well as a suspension of each Respondent from participating in the Medicare and Medicaid programs for 25 years beginning May 3, 1984.

DISCUSSION

1) Respondents knew that the 2,702 charged items or services were not provided as claimed, in violation of Section 1128A of the Social Security Act.

Section 1128A of the Social Security Act effectively provides that it shall be a violation for any person to submit a claim for reimbursement for an item or service that that person knew or should have known was not provided as claimed. The evidence in this case clearly establishes that Respondents knew that the 2,702 charged items or services were not provided as claimed.

a) The 2,702 charged items or services were not provided by or incident to the professional services of licensed medical doctors, and were therefore not provided as claimed.

Each of the items or services at issue in this case consists of an item or service submitted by Respondents on the account of one of three medical doctors who were employed by Respondents between October 1982 and December 5, 1983. Respondents submitted either written or electronic claims or documentation, which made it appear that the items or services in question were reimbursable physicians' services pursuant to the Medicare laws. In fact, these items or services were not physicians' services and therefore, the charged items or services were not provided as claimed.

In order for items or services to constitute reimbursable "physicians services" under the Medicare law, the items or services must be rendered by or "incident to" the professional services of "physicians". 42 U.S.C. sec. 1395x(S); (1); 42 C.F.R. sec. 405.321(a) and (b). The Medicare law generally defines a "physician" as a licensed doctor of medicine or osteopathy. 42 U.S.C. sec. 1395x(r). The law clearly distinguishes between chiropractors and medical doctors. A chiropractor is not a "physician" for purposes of Medicare reimbursement except in the very limited circumstance where he renders treatment consisting of "manual manipulation of the spine (to correct a subluxation demonstrated by x-ray to exist)." Id. Plainly, Congress intended to deny reimbursement to chiropractors (and also to unlicensed medical doctors) for many items or services which would be reimbursable when rendered by licensed medical doctors. This statutory distinction does not turn on the issues of whether the services were actually rendered or whether they are beneficial. The distinction is premised on the type of provider who renders the services.

Neither the Act nor the regulations specifically define the term "incident to," but the plain meaning of the term is that in order for services to be rendered "incident to" a physician's professional services, they must at the least have been ordered and supervised by that physician. The Secretary of Health and Human Services has promulgated interpretive statements in the Medicare Part B Carriers Manual which comport with statutory language. The Carriers Manual provides at section 2050.1 that the term "incident to a physician's professional service" means that services of non-physician employees "must be rendered under the physician's direct supervision by employees of the physician." Section 2050.2 of the same Manual provides that "direct supervision" means that the physician "must be present in the office with and immediately available to provide assistance and direction throughout the time the aide is providing services." Therefore, in order to be reimbursable, an item or service must be provided by a licensed medical doctor or doctor of osteopathy, or pursuant to his close personal supervision. Services provided by or supervised by unlicensed doctors or chiropractors are not generally reimbursable.

The evidence establishes that none of the medical doctors to whom the items or services are attributed rendered or ordered and supervised the provision of such items or services. The evidence shows, and Respondents concede, that the medical doctors were either not employed by Respondents or not present at the clinics when the items or services were ostensibly rendered. It would have been impossible for these medical doctors to have provided or ordered and supervised the rendering of items or services on the dates when such items or services were ostensibly provided. The charged items or services, to the extent they were provided, were rendered by chiropractors or by unlicensed medical doctors or others.

For example, the evidence establishes that Dr. Mendez was employed by Respondents beginning August 1, 1983 and ending December 5, 1983. Yet the items or services claimed by Respondents as having been rendered by Dr. Mendez or incident to her professional services consist of 758 separate items or services, all allegedly rendered by her after December 5, 1983. IG Ex. 8. These items or services were billed to the Carrier by Respondents, who used standard Blue Cross and Blue Shield procedure codes to describe the particular item or service claimed. These codes were obtained from manuals which Respondents had in their possession and which they used in the regular course of their business. Tr. 10/30 at 120; 11/1 at 37, 42, 83; 11/6 at 285, 290, 306; 11/7 at 8. These manuals included the Blue Cross and Blue Shield Manual for Physicians. IG. Ex. 218a, 218 b. The 758 items or services claimed by Respondents include over 350 "brief office medical services" claimed pursuant to Procedure Code 90040, defined as brief services "performed by a physician in his own office...." IG Ex. 218a at M2 (emphasis added). They also include 95 "intermediate office medical services" claimed pursuant to Procedure Code 90015, defined as "a level of service such as a complete history and examination of one or more organ systems...." Id. at 48. Thus, Respondents attributed hundreds of items or services to Dr. Mendez, including examinations allegedly performed by her, which Dr. Mendez could not possibly have rendered or supervised.

Indeed, many of the charged items or services consist of items or services which were not provided by any clinician. As noted above, many of the charged items or services consist of "office visits" to physicians. The evidence establishes that Respondents made a practice of billing for an "office visit" to a physician pursuant to Medicare procedure code 90040 (which essentially defines such service to include a brief examination of a patient by a physician) every time a patient visited one of their clinics. Such charges were made routinely even though patients neither were examined by nor consulted with physicians. The alleged purpose of claiming such charges was to compensate Respondents for their "overhead". In those rare instances when a patient actually consulted with a medical doctor, Respondents would submit claims to the Part B Carrier for two office visits. See Finding 19. Not only were the office visits attributed by Respondents to Dr. Mendez not provided by her, they were not provided by anyone. The record also establishes that, although Respondents routinely x-rayed all their patients, many of these x-rays were never read, either by medical doctors or by chiropractors. See Finding 15. Also see Tr. 10/31 at 39-40, 137; 11/1 at 168-169; 11/2 at 43-44. And, although Respondents' clinics routinely administered tests and therapies to patients, most of these were not actually ordered by licensed medical doctors. See Findings 14-15.

Therefore, although the claims rendered by Respondents make it appear as though the charged items or services were submitted by or "incident to" the professional services of "physicians," they were not provided as claimed.

According to Respondents, even though they represented to the Part B Carrier that the items or services had been provided by or incident to the professional services of licensed medical doctors, and, in fact, they were not, the items or services were nonetheless "provided as claimed" because they were arguably supervised by chiropractors. Respondents argue that because the term "physician" is not defined in the Carriers Manual sections 2050.1 and 2050.2, which discuss services provided "incident to" a physician's professional services and "supervision," a "supervising physician" can be a chiropractor. Respondents, therefore, assert that based on a literal reading of these sections of the Carriers Manual, without any reference to relevant statutes or regulations, or to other sections of the Carriers Manual, the services in question were provided as claimed.

This argument is without merit. In the first place, Respondents represented that the items or services in question had been provided by licensed medical doctors when in fact they had not been so provided. Many of these items or services were not provided at all. Many of the items or services may have been provided by chiropractors or by the clinics' lay employees, but were never ordered by licensed medical doctors. Furthermore, the statutory distinction between medical doctors and chiropractors is clear and is in fact restated at sections 2020.1 and 2020.2 of the Carriers Manual. Sections 2050.1 and 2050.2 incorporate this statutory distinction. Therefore, the Carriers Manual is not in any sense ambiguous and it cannot be read to permit Respondents to obtain reimbursement for items or services which Congress clearly did not intend to reimburse. Finally, Respondents' argument avoids the fact that the Carriers Manual is merely an interpretive document which is not intended to alter statutory meaning. See Snider v. Blue Cross and Blue Shield of Michigan, [1979-2 Transfer Binder] MEDICARE REP (CCH) Paragraph 29.905.

b) Respondents knew that the 2,702 charged items or services were not provided as claimed.

The evidence establishes efforts by the Respondents to obtain reimbursement from Medicare for items or services which they knew were not provided as claimed. Respondents knew that the items or services at issue were not reimbursable unless they could be represented as having been provided by or supervised by a licensed medical doctor. They knew that none of the charged items or services was provided by or supervised by a licensed medical doctor. They deliberately presented claims to Medicare for the charged items or services in a manner designed to deceive the Carrier into believing that the claims were reimbursable.

Respondents had operated chiropractic clinics for several years. In mid-1982, Respondents became aware that Medicare would reimburse them for services rendered at their clinics if Respondents could represent that these services had been rendered by or incident to the professional services of licensed medical doctors. This knowledge is established not only by Respondents' association with and subsequent employment of medical doctors beginning in 1982 and consequent billing of clinic services to the accounts of those doctors, but by statements made by respondent Dr. Mayers to his employees. See Finding 9.

In order to obtain reimbursement for services rendered at their clinics, Respondents not only had to employ licensed medical doctors, but had to certify that these medical doctors had either provided or supervised the rendering of items or services. Respondents made such certifications either by stamping physicians' signatures on Medicare claims forms or by transmitting physicians' Medicare provider numbers as part of computer generated claims. Every time Respondents made such claims, they expressly represented to the Carrier that the items or services had been provided by or supervised by their medical doctor employees.

Respondents routinely used standard Medicare claim forms. IG Ex. 196 and 243; see Finding 2. These forms contain the following certification:

> I (the physician signing the form) certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision...

Many of the items or services were billed electronically by Respondents through the use of a computer terminal located in Respondents' clinics. When claims were filed on the computer system, the following statement appeared on the terminal screen:

> I (the physician providing the services) certify that the services submitted and referenced by this transmission were rendered by me...

See IG Ex. 230. Inasmuch as Respondents knew that their medical doctor employees had neither provided nor supervised the rendering of the items or services, they knew that the representations made on the claims forms and on the computer were false. Respondents were, after all, Drs. Bernal, Russo, and Mendez' employers. They had to know that these physicians were not employed by them or not present at their clinics on the dates when the charged items or services were ostensibly rendered, and they therefore could not possibly have rendered or supervised the rendering of the charged items or services. In fact, Respondents were aware that there were no licensed medical doctors present at their clinics on the relevant dates. Yet, despite this knowledge, Respondents submitted claims in a manner designed to make it appear as if these physicians had rendered or supervised the rendering of the charged items or services. I conclude that this false characterization is exactly what Respondents intended.

My conclusion that Respondents knew that the 2,702 charged items or services were not provided as claimed is in part based on Respondents' conduct once it became apparent to them that they were being investigated by agents of the Inspector General. Nothing in the record of this proceeding could more clearly establish Respondents' culpability than their attempts to cover up their unlawful activities. The record establishes that months after the dates of patients' initial visits to the clinics, and after Drs. Bernal, Russo, and Mendez had ceased their employment with Respondents, Respondents instructed several of their employees to generate or alter documents to make it appear as if these medical doctors had actually ordered or rendered the items or services at issue. The inference which I draw from such actions is that Respondents intended to deceive the Inspector General's investigators. Patients' files were systematically culled by Respondents' employees. "Doctors Orders" were created for patients, listing the clinics' standard treatments. These fictitious "orders" were backdated to the dates of the patients' initial examinations and were stamped with the appropriate medical doctor's signature. See Finding 31(b). To the casual or uninformed observer, these altered or fabricated documents made it appear as if, on the dates of patients' initial examinations by a medical doctor, that doctor had ordered and signed for treatments.

Nor does the record support Respondents' contention that they believed that their claims for reimbursement were proper, or that the Medicare Carrier or its representatives misled them into believing that their billing practices were proper. There is nothing in this record to suggest that Respondents were confused about or misunderstood their responsibilities. And, although Respondents' counsel now asserts that allegedly ambiguous statements in the Carriers Manual would lead a person reading that Manual to believe that the items or services in question were reimbursable, the record is devoid of evidence to show that Respondents premised their claims on this "interpretation." Indeed, there is no evidence to suggest that Respondents actually consulted the Carriers Manual or reviewed the law in order to determine the propriety of their actions. The record is also devoid of evidence of any serious attempts by Respondents to obtain clarification from the Part B Carrier as to what kinds of services were reimbursable. However, there is credible evidence that Respondents were told in August 1983 by Ms. Morgan-Lucidi, the Carrier's representative, that their actions were improper, and Respondents nonetheless continued for several months thereafter to unlawfully claim reimbursement, notwithstanding this explicit warning.

Respondents have suggested that the "unique" circumstance of a chiropractor employing medical doctors is not addressed in applicable law, regulations, and interpretive statements. From this they seem to argue that Medicare's failure to address this allegedly novel relationship creates uncertainty as to the applicability of reimbursement criteria to Respondents and their clinics' operations. To the contrary, the Act and regulations explicitly describe the circumstances under which medical doctors' and chiropractors' items or services will be reimbursed. There is nothing about the work relationships in Respondents' clinics which would call into question the applicability of relevant law and regulations. Nor does the record suggest that Respondents' employment of medical doctors ever raised questions in Respondents' minds as to what items or services would be reimbursed.

Respondents were aware of the criteria for reimbursement and knowingly submitted false claims. But had the record established that Respondents were ignorant of Medicare reimbursement criteria, such ignorance would not have excused their conduct. Respondents could not possibly have been ignorant of Medicare reimbursement criteria unless they failed to read the claims forms they utilized on a regular basis, or disregarded the language which appeared on the terminal screen every time they electronically transmitted a reimbursement claim to the Part B Carrier. Such failure to read prominently displayed criteria would amount to reckless disregard of Medicare reimbursement criteria, and recklessness is tantamount to an intentional violation of the law.[3] United States v. Sarantos, 455 F.2d 877, 880 (2d Cir. 1972). Even if Respondents simply negligently disregarded reimbursement criteria, their negligence would not constitute a defense to the charges in this case. Respondents were under a duty to learn and understand Medicare reimbursement criteria before they submitted reimbursement claims. As is pointed out in the Comments to 45 C.F.R. Part 101, contained in 48 Fed. Reg. 38831 (August 26, 1983): "The statute sweeps within its ambit not only the knowing, but the negligent...."

2) There exist substantial aggravating factors.

Having established that Respondents violated section 1128A of the Social Security Act, the question then becomes what penalty, assessment, and/or suspension should be ordered. The statutory provisions governing assessments, penalties and suspensions are contained in 42 U.S.C. secs. 1320a-7a(A) and 7(c). The law provides that a person found to have submitted a false claim shall be subject, in addition to any other shall be subject,

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3/ Dr. Mayers testified that he first learned of Medicare's reimbursement requirements in February 1984. Tr. 11/5 at 192. He admitted, however, that he had personally signed "many, many, many" Medicare claims forms between 1980 and February 1984. Id. He testified that he had "never bothered to read" the certification language contained on the back of the form. Id. He explained this lapse by stating: "I didn't scrutinize every part of the claim form. The claim form was put in front of me and I signed it. I didn't turn it over and read all of the ramifications of it." Tr. 11/5 at 1984.

in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for each falsely claimed item or service, and an assessment of not more than twice the amount claimed for each such item or service. Inasmuch as I have found that Respondents falsely claimed 2,702 items or services totalling $145,550, Respondents are subject to a maximum assessment of $291,100 and a maximum penalty of $5,404,000. The law further provides that persons against whom penalties and assessments are imposed are subject to suspension from participation in the Medicare and Medicaid programs.

The statute provides that in determining the amount or scope of any penalty or assessment, the Secretary shall take into account: (1) the nature of the claims and the circumstances under which false claims were presented; (2) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims; and (3) such other matters as justice may require. 45 C.F.R. sec. 101.106 establishes guidelines for determining appropriate assessments and penalties. The regulation requires the administrative law judge to balance aggravating against mitigating factors. It provides that in cases in which there are substantial or several aggravating circumstances the aggregate amount of the assessment and penalty should be set at an amount sufficiently close to or at the maximum permitted penalty, to reflect that fact. It further provides that the regulatory guidelines are not binding. 45 C.F.R. sec. 101.107 provides that in determining a suspension, the administrative law judge should consider the same guidelines outlined in 45 C.F.R. sec. 101.106. It also provides that these guidelines are not binding. Finally, 45 C.F.R. sec. 101.106(b)(4) provides that in all cases, the resources available to respondent will be considered when determining the amount of the penalty and assessment.

I have concluded that there exist many aggravating factors in this case. These are discussed at Findings 29 and 30. As noted therein, the charged items or services were of many different types, were made over an extended period of time, and involved substantial sums. Furthermore, the record establishes a high degree of culpability. It also establishes that the charged items or services constitute merely an aspect of a broad pattern of unlawful conduct by Respondents.

As noted supra, Respondents' claims concerning the charged items or services were made despite their knowledge that these items or services were not provided as claimed. There is no evidence that these claims were the consequence of an innocent mistake. Therefore, any determination of penalty, assessment, and suspension must be premised on my conclusion that the unlawful conduct in this case was deliberate. It must also be premised on my conclusion that Respondents attempted to deceive government investigators. By falsifying treatment records, the Respondents engaged in a double deception concerning the charged items or services: first, in representing that the claims were for physicians' services or services rendered incident to physicians' services; and, second, in attempting to convince investigators with false documentation that these services had been provided as claimed.

examinations of new patients. Generally, the medical doctors did not order treatments and tests, nor did they review test results and therapy progress reports. They did not involve themselves in the day-to-day supervision of therapies and treatments. Their post-examination contacts with patients usually consisted of chance encounters. See Findings 12, 13, and 15.[5]

But, notwithstanding the minimal contact these medical doctors had with the clinics' patients, Respondents submitted claims for reimbursement on the false premise that these doctors were intimately involved in the ordering, rendering, and supervision of treatments. All of the clinics' services except for chiropractic adjustments were attributed by Respondents to their medical doctor employees. Respondents billed the Medicare Part B Carrier for fees in excess of $1.8 million, attributed as items or services rendered by or "incident to" the professional services of Drs. Bernal, Russo, and Mendez. A substantial portion of these claims was paid by the Carrier. See Finding 20.

The nature of Respondents' scheme is established as much by Respondents' billing methods as it is by the evidence establishing the roles and activities of the medical doctor employees. The record establishes that Respondents jointly developed billing procedures, and that Respondent Patricia Mayers supervised the activities of the clinics' billing department. Analysis of Respondents' billing procedures reinforces the conclusion that the prime purpose for employing medical doctors was to obtain names and provider numbers to which items or services could be attributed. Testimony and documentary evidence proves that clinic employees were instructed to routinely attribute the clinics' services to medical doctors without determining whether these doctors actually ordered, rendered, or supervised the performance of items or services. These employees were instructed not to discuss billing matters with staff physicians. See Finding 17. Billing information was obtained from records generated by the clinics' clerical employees. The items or services rendered by the clinics were so standardized that these clerical records were for a time generated in advance of patients' actual visits. Clinic employees neither consulted with medical doctors nor examined their treatment records in constructing billing documents. Claims forms were "signed" by clerical employees, using physicians' signature stamps. And, as noted supra, if no licensed medical doctor was present at Respondents' clinics on dates when items or services were rendered, Respondents' policy was simply to attribute those items or services to the licensed medical doctor most recently employed by them. See Findings 11, 17, and 23.

5/ Dr. Mayers conceded that the employment of medical doctors had very little impact on the day-to-day operations of his clinics. He testified that: "When we brought medical physicians on the staff very little changed in the way we would take care of the patients other than the additions that the medical doctors wanted." Tr. 11/5 at 65. Dr. Mayers acknowledged that such additional services were very rare. Id.

Therefore, the evidence in this case establishes that Respondents' medical doctor employees were hired in order to provide Respondents with names and Medicare provider numbers to affix to reimbursement claims. These medical doctors had minimal actual involvement in Respondents' clinics' activities. The services attributed to these doctors by Respondents were by and large never provided by the doctors, and Respondents' reimbursement claims for these services were mostly false.

Much of Respondents' case was devoted to either attacking the credibility of the Inspector General's witnesses who testified as to the purpose for hiring medical doctors and the medical doctors' actual activities, or to presenting evidence for the purpose of showing that medical doctors were actually intimately involved with the rendering of items or services at Respondents' clinics. I conclude that these efforts notwithstanding, the testimony of the Inspector General's witnesses was generally truthful and consistent. By contrast, evidence offered by Respondents was generally not credible.

The Inspector General's witnesses included Drs. Bernal, Russo, and Mendez, and several of the clinics' former clerical employees. Respondents have suggested that these witnesses were "coached" to give testimony damaging to the Respondents' case. I find nothing in the record of this proceeding which would support this allegation. Respondents have also suggested that several of these witnesses, particularly Dr. Mendez, colored their testimony in a manner favorable to the Inspector General as a consequence of threatening statements made to them by the Inspector General's agents. Again, there is no evidence of record that supports this allegation. The Inspector General's witnesses, including Dr. Mendez, forcefully denied that their testimony was made under threat or duress. I was especially impressed with Dr. Mendez' credibility. She delivered her testimony with great clarity, and I note that the evidence she gave included revelations about the activities at the Respondents' clinics which might be professionally embarrassing to her. Such admissions make her testimony more credible.

Respondents have also asserted that several of the Inspector General's witnesses, especially the three medical doctors, were biased against them. I recognize that these doctors may bear some personal animosity towards Respondents. But this animosity is understandable in light of the manner in which Respondents misused these doctors' names and licensure for personal gain. Given the events that occurred at Respondents' clinics it would be incongruous for these doctors not to feel some ill-will toward Respondents. I conclude that these doctors' reactions to their employment by Respondents does not detract from their credibility.

The evidence offered by the Inspector General as to the medical doctors' activities was to a large extent buttressed by the testimony given by two of Respondents' own witnesses, Herman Colby and Ralph James. Each of these witnesses had been patients at Respondents' clinics. They both asserted that their treatments had been rendered by chiropractors or by the clinics' lay employees. Neither of these witnesses' treatments was rendered or supervised by a medical doctor. They only saw or spoke with medical doctors if these physicians happened to be passing through the treatment rooms. See Tr. 11/7, at 105-129.

Other evidence offered by Respondents concerning medical doctors' activities was simply not credible. They introduced the testimony of several witnesses including Dr. Mayers and several employees concerning the extent of the medical doctors' involvement in the treatment of patients. The gist of this testimony was that the medical doctors made "rounds" of the therapy areas several times daily during which they observed and supervised clinic activities.[6] According to Dr. Mayers it was his policy that a medical doctor at least "see" each patient each time that patient visited the clinics.[7] The implausibility of this testimony is obvious. Each of Respondents' clinics treated as many as 200 patients per day. Given the level of activity at these clinics, the medical doctors could not have given more than cursory attention to any of the patients even if they did make "rounds". Moreover, the testimony is squarely contradicted by the testimony of Respondents' patient-witnesses.

Dr. Mayers made other assertions which I conclude are not credible. For example, Dr. Mayers testified that all of the tests performed at his clinics were ordered by medical doctors. Tr. 11/5 at 177, 181. This statement is contrary to the great weight of the evidence, including the testimony of Drs. Bernal, Russo and Mendez, that such tests were not ordered by medical doctors, but were routinely made of every patient as part of the standardized tests and therapies developed by Dr. Mayers.[8] It is, furthermore, contradicted by Dr. Mayers' admission that the medical doctors' employment had minimal effect on the daily operations of the clinics. Tr. 11/5 at 65. Dr. Mayers also asserted that the medical doctors ordered x-rays using standard nomenclature for these tests ("Series I, Series II and Series III"). Tr. 11/5 at 34-35. According to Dr. Mayers, one of the medical doctors, Dr. Bernal, actually assisted him in determining what x-ray views would comprise

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6/ This testimony included that of Elizabeth Meyerrose, who was an employee of Respondents on the dates the hearing was held in October-November 1984. Ms. Meyerrose' subsequently offered to recant her testimony, and did so at a supplemental hearing held on January 29, 1985. Due to the obviously conflicting evidence given by this witness, I have elected not to base any of my findings or conclusions on Ms. Meyerrose' testimony. However, I would note that Ms. Meyerrose' original testimony on Respondents' behalf was not credible and even had she not subsequently recanted this testimony I would have concluded that it did not support Respondents' assertions concerning the medical doctors' roles at the clinics.

7/ Dr. Mayers' explanation of what was meant by medical doctors "seeing" patients was "that the medical doctor would come by and say a few words to them and observe them, ask them whatever questions they wanted to ask or let the patients ask the doctor whatever questions they wanted to ask." Tr. 11/5 at 247. The record does not establish that doctor-patient communications regularly occurred even on this level, but had such meetings taken place, they would not have constituted either rendering or supervising of performance of items or services.

The most significant aggravating circumstance in this case is the fact that the 2,702 charged items or services represent only a small portion of a pattern of claims for items or services by Respondents that Respondents knew were not provided as claimed. Respondents hired medical doctors so that they could falsely represent to the Medicare Carrier that their clinics' services were being rendered by or incident to the professional services of these doctors. Their scheme enabled them to mulct Medicare of hundreds of thousands of dollars.4

Beginning in mid-1982, Respondents determined that they could obtain Medicare reimbursement for their clinics' services to eligible beneficiaries if they could satisfy the Part B Carrier that these items or services were rendered by or incident to the professional services of licensed medical doctors. In order to accomplish this objective, they hired medical doctors and began submitting claims for items or services over these doctors' signature facsimiles and Medicare provider numbers. From the outset Respondents' intent in employing these medical doctors was to obtain their names and provider numbers for claims purposes. Respondents never intended that these medical doctors play an active role in rendering or supervising the providing of items or services at their clinics. Their mere presence at the clinics was all that was ever required. The evidence establishes that none of the medical doctors employed by Respondents prior to January 1984, ever had more than tangential involvement in the day-to-day provision of items or services at Respondents' clinics.

The medical doctors employed by Respondents had in common the fact that they were foreign-born physicians with little or no knowledge of the "chiropractic medicine" provided by Respondents. There is more than coincidence in this fact, for Dr. Mayers stated to his employees that it would be advantageous to obtain foreign-born physicians who did not speak English well, but who could sign documents. Drs. Bernal, Russo, and Mendez all understood that the purpose of their employment was to perform physical examinations of new patients. None of these doctors understood their roles to include providing or supervising the therapies and tests rendered by the Mayers' clinics. Indeed, Drs. Russo and Mendez were told by Dr. Mayers not to involve themselves with or interfere with the clinics' rendering of chiropractic services. See Findings 9 and 10.

The record establishes that rather than receiving individualized treatment pursuant to medical doctors' orders, all of the clinics' patients received a standardized regimen of tests and therapies devised by Dr. Mayers. The medical doctors played no role in either the development or administration of these tests and therapies. See Finding 14. The medical doctors' activities were essentially limited to performing brief, routine physical

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4/ This pattern of unlawful conduct has not been charged by the Inspector General as violations of sec. 1128A, although clearly it could have been. It is relevant as an aggravating factor, and my decision to impose an assessment, penalty and suspension is in part based on this and other aggravating factors which I have identified.

"Series I" x-rays. Id. These statements are contradicted by the testimony of the medical doctors, including Dr. Bernal, who stated unequivocally that they had never used the "Series" terminology to order x-rays and did not know what the "Series" terminology meant. Tr. 10/30 at 165; 10/31 at 40, 139. Dr. Mayers' testimony is also contradicted by evidence showing that the "Series" terminology and in particular, the term "Series I" was invented after Dr. Bernal had left Respondents' employment. Tr. 11/2 at 26.

3) There exist no mitigating factors.

Respondents have argued that I should conclude that there exist mitigating factors in this case. They assert that the charged items or services constitute only a tiny portion of Respondents' otherwise legitimate business activities. They assert that no harm resulted from the false claims inasmuch as the items or services were actually "provided," were provided in conformity with State laws concerning the provision of chiropractic services, and were not harmful to the patients. They assert that to the extent they made false claims it was in large measure due to their reliance on misleading information provided by Medicare or the Part B Carrier.

The requirement that mitigating factors be considered in determining an appropriate penalty, assessment and suspension is enumerated in 45 C.F.R. sec. 101.106. Respondents bear the burden of establishing by a preponderance of the evidence that substantial mitigating factors exist. 45 C.F.R. sec. 101.114(d). The mitigating factors argued by Respondents essentially fall into the categories of potentially mitigating factors listed in 45 C.F.R. secs. 101.106(b)(1), (2), (4) and (5). I have considered each of them carefully, and I conclude that Respondents have failed to establish by a preponderance of the evidence that any substantial mitigating factors exist in this case.

Respondents' argument that the charged items or services constitute but a small portion of their overall business would not be a mitigating factor, even if correct. As noted supra, there were a great many false claims filed by Respondents requesting a substantial sum, over an extended period of time. Moreover, I am satisfied that a high percentage of claims Respondents filed with the Part B Carrier between mid-1982 and early 1984 were not legitimate. Indeed, it is the overall pattern of false Medicare claims filed by Respondents which comprises a major aggravating factor in this case.

Respondents' "absence of harm" assertion is irrelevant, and also largely untrue. The test for violation of Section 1128A of the Act is whether items or services were falsely claimed. An item or service can be "provided" in conformity with State laws and be beneficial to patients, and can still be

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8/ Dr. Mayers admitted that he knew that Medicare would not reimburse for a test read by an unlicensed medical doctor or a chiropractor. He admitted billing for such tests under the names of licensed medical doctors. Tr. 11/5 at 187.

falsely claimed because it is nevertheless not properly reimbursable by Medicare. Of course, if an item or service is not "provided" and a claim is made for reimbursement, that claim is also a false claim. The Act does not distinguish between the former type of false claim and the latter. Therefore, Respondents' argument fails. It should also be noted that I have found that many of the items or services at issue were in fact never provided by Respondents.

Respondents' assertion that they were misled into believing that their billing practices were proper has been previously dealt with in this decision. I have found this assertion to be without merit. The record establishes that Respondents had in their possession materials which explicitly stated Medicare reimbursement requirements. There exists no evidence that Respondents were misled into believing that their claims were proper. To the contrary, Respondents chose to disregard an explicit warning from the Part B Carrier to cease engaging in improper billing practices. See Finding 30(a).

4) The assessment, penalty and suspension are supported by the record of this proceeding.

The Inspector General has requested that I order a combined assessment and penalty against Respondents in the amount of $2,900,000. The Inspector General has also requested that I order that Respondents be suspended from the Medicare and Medicaid programs for 25 years. I conclude that, based on applicable law and the evidence of record, Respondents shall be assessed $291,100, the maximum assessment permitted by law. Respondents shall be penalized $1,500,000. They are each ordered suspended from participation in the Medicare and Medicaid programs for 25 years.

The purpose of the statutory assessment provision contained in 42 U.S.C. 1320a-7a is established both by the language of the statute and regulations and by Comments to the regulations. Essentially, the assessment provisions are intended to enable the United States to recover the damages resulting from false claims, including the reimbursement actually paid and the costs of investigating and prosecuting the unlawful conduct. The statute provides at 42 U.S.C. sec. 1320a-7a(a), that the assessment is "in lieu of damages sustained by the United States...because of such (false) claims." The Comments reiterate that the assessment provision enables the United States to recoup damages without having to assume the difficult burden of establishing actual damages. 48 Fed. Reg. 38831 (Aug. 26, 1983).

The penalty provision is intended to serve as a deterrent to future unlawful conduct by a particular respondent or by other participants in the Medicare or Medicaid programs. In its report on the bill which was eventually passed and codified as 42 U.S.C. sec. 1320a-7a, the House Ways and Means Committee noted that criminal penalties had not effectively deterred fraudulent practices under the Medicare and Medicaid programs. It found that "civil money penalty proceedings are necessary for the effective prevention of abuses in the medicare and medicaid programs...." H.R. Rep. No. 97-158, 97th Cong., 1st Sess. Vol. III, 327, 329.

45 C.F.R sec. 101.107 requires the same criteria used in determining the assessment and penalty be considered in determining the length of any suspension imposed. The Comments to the regulations provide that the factors used in establishing the assessment and penalty, including the presence of aggravating and mitigating factors, apply to the question of suspension. As with the penalty, the purpose of the suspension is to deter would-be violators. 48 Fed. Reg. 38832 (Aug. 26, 1983).

This is a case in which there exist many aggravating factors. The charged items or services are the product of a scheme by Respondents to unlawfully obtain Medicare reimbursement. They represented only the tip of the iceberg; many of the claims for items or services filed by Respondents between mid-1982 and early 1984, were false. Moreover, Respondents, by their efforts to deceive the Inspector General's investigators have demonstrated not only a high degree of culpability, but contempt for the law and those who would enforce it.

The evidence in this case establishes that there exists a need to assure that others who might be encouraged by Respondents' success in extracting monies from the Part B Carrier be forcefully warned against such activities. The record demonstrates just how vulnerable the Carrier is to unscrupulous or larcenous providers. As was attested to by Ms. Morgan-Lucidi, the Carrier's representative, the Carrier is responsible for processing and paying a huge volume of claims. It is not practicable to audit every claim as it is filed; rather, the Carrier must depend on spot checks and random audits to police its claims. Above all, it depends on the good faith and honesty of providers of services who submit claims.9 The Carrier, and hence, the Medicare program, is easy prey for persons who use fraud and chicanery to unlawfully extort funds from the Medicare program. Consequently, a strong deterrent is required.

A maximum assessment is easily justified, both by the presence of substantial aggravating factors and by the obvious substantial expense to the Government of investigating and prosecuting this case. Hearing alone required approximately ten days in two locations (Tampa and Fort Myers, Florida) sited far from the Inspector General's offices in Washington, D.C. Hearing costs included the costs of transporting and lodging government personnel and witnesses, and the costs of providing a transcript exceeding 2,000 pages. Costs also included the salaries of the many Federal employees who were involved with the case for the time required for its completion.

9/ The need for provider honesty is made even more acute by the Carrier's use of electronic data processing equipment and computers to transmit and process reimbursement claims. Under these circumstances the Carrier functions almost like an electronic bank teller, and it is utterly dependent on providers to honestly represent their services. When a provider of services files a reimbursement claim with the Carrier via a computer terminal, the claim is not normally reviewed by any individual. Rather, it is automatically processed and the provider is reimbursed based on the representations he has made. Tr. 10/30 at 8-9.

Given the presence of the many aggravating factors, the absence of mitigating factors, and the guidelines set forth in 45 C.F.R. sec. 101.106, a penalty approaching the maximum allowed by law ($5,404,000) is arguably in order. However, I have determined that a penalty of $1,500,000 is appropriate, because a penalty in that amount, when coupled with the assessment, is sufficient to strongly deter both Respondents and other would-be wrongdoers from committing the kinds of unlawful practices that the Respondents engaged in. The aggregate penalty and assessment, $1,791,100, is a very large sum. Adding additional penalties to this amount would not necessarily cause these Respondents or other persons to think any harder about the consequences of their actions than would the amounts imposed.[10] The penalty, assessment and suspension imposed in this case should send a message to all persons who participate in the Medicare and Medicaid programs not to engage in the conduct engaged in by Respondents.

I have considered evidence concerning Respondents' financial condition in determining the amount of the assessment and penalty. As noted supra, the statute, as well as 45 C.F.R. sec. 101.106(b)(4), require that I consider Respondents' financial condition as an aspect of determining the assessment and penalty. 45 C.F.R. sec. 101.106(b)(4) further provides that it should be a mitigating circumstance if "imposition of the penalty or assessment without reduction will jeopardize the ability of the respondent to continue as a health care provider." The burden of proof of financial hardship, as with other mitigating factors, is on Respondents. See 45 C.F.R. sec. 101.114(d).

Respondents did introduce evidence, in the form of financial statements and the testimony of respondent Patricia Mayers, which was intended to show that Respondents were unable to pay a substantial assessment and penalty. Having reviewed this evidence carefully, I conclude that it is of little probative value. The evidence consists largely of financial statements which were neither certified as being accurate nor complete. Moreover, the record shows that on the eve of the commencement of this proceeding, in an apparent effort to shield their assets from attack by creditors, Respondents attempted to transfer many of their possessions to third parties or place them into a trust. Respondents have simply failed to draw an accurate picture of their present financial status. Certainly, they have not established that their financial condition constitutes a basis for reducing the penalty and assessment beyond that which I have determined to be appropriate.

10/ At oral argument, the Inspector General stated that the proposed penalty and assessment was calculated based on internal guidelines which directed an aggregate penalty and assessment of $20 for each dollar falsely claimed. Thus, the Inspector General's proposed penalty and assessment of $2,900,000 is approximately the product of $145,550 x 20. These guidelines are not regulatory guidelines and are not binding on me. By imposing a penalty of $1,500,000 in this case I am not suggesting that penalties based on the Inspector General's formula are inappropriate in every case; rather I am concluding that the penalty I have elected to impose is an effective deterrent.

The regulatory language concerning the effect of the penalty and assessment on the ability of a respondent to continue as a health care provider must be construed in the context of the suspension that is imposed. In cases such as this one, where a lengthy suspension is ordered, Respondents' financial capacity to continue as a provider of services is of little or no consequence.

In this case, a 25 year suspension is appropriate. I have found that Respondents have engaged in blatantly unlawful conduct. Their activities constitute systematic looting of the Medicare trust fund. It must be made clear to these Respondents as well as to other health care providers that persons who engage in such activities will forfeit the privilege of participating in the Medicare and Medicaid programs.

Respondents have made three arguments against imposition of a lengthy suspension. First, they assert the same allegedly mitigating factors which have been considered and rejected elsewhere in this decision. Second, they argue that the regulations sections which establish suspension criteria give the Secretary "unbridled discretion" to impose suspensions in contrast to other regulations which ennumerate specific suspension criteria for persons found to violate provisions of the Medicare law other than section 1128A. From this assumption, they seem to argue that the criteria contained in 45 C.F.R. secs. 101.106 and 101.107 are either too vague, or should in any case not permit lengthier suspensions than those provided pursuant to other statutes and regulations. This argument is without merit. The regulatory criteria promulgated in 45 C.F.R. secs. 101.106 and 101.107 do not provide specific suspensions for specific acts, but they do set forth adequate guidelines. The regulatory language comports with statutory language which does not establish specific suspensions. Congress clearly intended that the length of any suspension be governed by the presence of mitigating and aggravating factors. It also conferred on the Secretary the authority to impose suspensions commensurate with the need to deter future unlawful conduct.

Finally, Respondents note that in the one other case decided to date pursuant to section 1128A, In the Matter of Harold Chapman and Autumn Manor, Inc., GAB Docket C-5, March 8, 1985, no suspension was imposed. While this may be true, the Chapman decision does not derogate from my duty to decide this case based on the evidence and the appropriate statutory and regulatory criteria. In this case, the evidence demands that a lengthy suspension be imposed.[11]

5) Respondents received a fair hearing.

Respondents have charged that they were not afforded due process in the conduct of the hearing of this case. Their assertions are that: (1) I improperly excluded evidence from the record, or unfairly restricted

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11/ One fact which distinguishes Chapman from this case is that Respondent in Chapman voluntarily divested himself of ownership or operation of the nursing homes from which false claims emanated. Divestiture was a condition of sentencing in a criminal case which was based on essentially the same facts as the false claims administrative proceeding.

Respondents from attacking evidence offered by the Inspector General; and (2) that I exceeded the ambit of my authority as trier of fact by extensively questioning certain witnesses. These allegations are baseless. Both sides were afforded substantial leeway, both with respect to offering evidence and attacking the probative value of evidence offered by their opponents. I frequently allowed the parties to introduce testimony and documents despite my stated reservations concerning the relevance of these items. Respondents were afforded greater freedom to present their case than they would have had had the proceeding been conducted pursuant to the Federal Rules of Evidence. Any questioning of witnesses by me was intended to clarify the record and was conducted pursuant to the authority granted the administrative law judge by 45 C.F.R. sec 115(b)(8).

ORDER

Based on the evidence of record and the appropriate law and regulations, I order that an assessment of $291,100 and a penalty of $1,500,000 be imposed. The Respondents are hereby ordered to pay this amount. Each of the Respondents is liable for the entire amount or such part of it as is directed by the Inspector General; except that the Inspector General may not collect more than $1,791,100.

It is further ordered that each of the Respondents be suspended from participating in the Medicare and Medicaid programs for a period of 25 years.

/s/

Steven T. Kessel
Administrative Law Judge