DEPARTMENT OF HEALTH AND HUMAN SERVICES

In the Matter of: William J. Mayers, D.C., and Patricia M. Mayers, Respondents.	DATE: August 11, 1985 DGAB Doc. No. **DECISION CR 2**

FINAL DECISION

This is a civil monetary penalties and assessments case under section 1128A of the Social Security Act for which review has been requested of the initial decision of the Administrative Law Judge. Section 1128A [1/] authorizes the Secretary of Health and Human Services to impose civil monetary penalties and assessments against any person who makes false or other improper claims under certain Departmental health care reimbursement programs, principally Medicare and Medicaid. The Department's regulations [2/] assign to the

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1/ 42 U.S.C. 1320a-7a.

2/ 45 C.F.R. Part 101, 48 Fed. Reg. 38,827, et seq. (August 26, 1983).

Inspector General the principal implementation responsibility for this authority, provide respondents with a right to a hearing before an Administrative Law Judge (ALJ), and provide for discretionary administrative review of ALJ decisions. This review authority was subsequently delegated to the Under Secretary.

This case involves William J. Mayers, a chiropractor, and his wife, Patricia Mayers, the operators of health care clinics in the vicinity of Fort Myers, Florida. The Inspector General alleged that from June 1982 through January 1984, the respondents submitted claims for Medicare reimbursement for 2,702 medical items or services which they falsely represented as having been provided by licensed physicians. These claims were for an amount of $145,550. The Inspector General proposed the imposition of aggregate penalties and assessments of $2,900,000. The respondents exercised their right to a hearing, which was presided over by Administrative Law Judge Steven T. Kessel. After a lengthy hearing and the accumulation of a substantial record, Judge Kessel issued, on May 14, 1985, an initial decision which imposed an assessment of $291,100 and a penalty of $1,500,000, and suspended the respondents from the Medicare program of a period of 25 years. Thereafter, the respondents filed timely exceptions, which are opposed by the Inspector General. Review is hereby granted.

The conduct of the respondents, as found by the ALJ, can only be characterized as an extremely flagrant abuse of the Medicare program. Medicare Part B health insurance benefits pay for a very broad range of services provided by licensed physicians, including

not only services personally rendered by a physician, but also services provided by other medical professionals that are incident to the physician's services and are ordered and personally supervised by the physician. Medicare also reimburses for a very limited category of medical services provided by chiropractors. The ALJ found that the respondents developed and implemented a method of operation under which they provided to many Medicare patients chiropractic services that the respondents knew were not reimbursable under Medicare, but misrepresented them as being ordered and supervised by a licensed physician incident to the provision of medical services provided by that physician. To accomplish this, the respondents hired a series of three physicians, had rubber stamp likenesses made of the physicians' signatures, and then used the stamps to certify Medicare claim documents to claim reimbursement for physician services in which, in fact, the physicians had no real involvement. So mechanized was this method of operation, according to the ALJ's findings, that these rubber stamps were used during significant periods after the respective physicians left the employ of the respondents.

The method of operation found by the ALJ to have been in existence suggests that generating Medicare claims was the principal function of the respondents' clinics. The physicians employed by the respondents typically performed routine physical examinations of new patients and prepared patient history forms, but for all practical purposes had no further relationship to the medical tests and therapies provided to the patients, which generally consisted

of a standard regime of periodic x-rays and other tests and a standard series of chiropractic adjustments. The standard regimen of tests and treatments was established and supervised not by the physicians whose rubber stamp signatures appeared on the claim forms, but rather by Dr. Mayers. Under this method of operation, up to 170 patients per day were treated at one of the respondents' clinics and up to 250 patients per day at the other. The usual practice was for patients to visit the clinic several times per week to receive this standard series of tests and therapies.

The ALJ also found that the respondents billed Medicare for fees in excess of $1.8 million, attributed as services rendered by or incident to the services of the three physicians. The respondents were reimbursed in excess of $500,000 for these alleged services. The ALJ further found that the vast majority of items or services billed by respondents on the accounts of these physicians were not actually provided, ordered or supervised by these physicians, nor were they provided incident to services provided by them. Among these many claims were the 2,702 items or services for which the Inspector General sought to impose civil monetary penalties and assessments in this action. With respect to these items or services claimed, the ALJ found that the physician employees on whose accounts these items or services were claimed were not present at the clinics or were not employed by the respondents on the dates on which the services were allegedly rendered by those physicians. The ALJ found that these 2,702 items or services represented a small percentage of a much larger pattern of filing false claims for Medicare reimbursement.

In view of these findings, the ALJ found there to be substantial aggravating circumstances 3/ regarding these false claims and imposed an assessment of $291,100, the maximum amount allowable, and a penalty of $1,500,000. He further suspended the respondents from the Medicare program for a period of 25 years. 4/

The respondents have filed a number of exceptions to the initial decision. Most significantly, they argue that various rules and instructions of the Medicare program do not make clear that the degree of involvement of the licensed physicians in patient care at respondents' clinics was insufficient to qualify for reimbursement as physician services. The respondents further assert that they did not receive a fair hearing and that various factors should have been considered in mitigation of the penalty, assessment and suspension.

All of the arguments raised by the respondents were fully addressed and persuasively rejected by the decision of Judge Kessel. Judge Kessel's findings are fully supported by the record. The record reflects that he provided the respondents a fair hearing, and that he fully considered the credibility or lack of credibility of the witnesses and documentary evidence presented. The respondents'

3/ The ALJ's findings detail numerous other circumstances also considered aggravating. These included clear evidence that the respondents knew that their claims were false, that they ignored explicit advice from the Medicare Part B carrier that claims they were submitting were not reimbursable, that they attempted to deceive investigative authorities by preparing false documents to cover up the lack of involvement of licensed physicians in the tests and treatments provided, and that Dr. Mayers intentionally hired foreign-born physicians because he wanted physicians who could not understand English very well, but who could sign claims documents.

4/ At one point in the initial decision the ALJ stated that the period of suspension would begin May 3, 1984, the date the Inspector General initiated this action. Under the regulation, 45 C.F.R. §§101.105(b) and 101.125(f), the suspension period will begin when this decision comes final, as specified in §101.125(f).

exceptions raise no credible basis to revise the findings in the initial decision or to reduce the amount of penalties and assessments or the period of suspension. Therefore, the respondents' exceptions are denied, and the initial decision is affirmed.

One issue in this case merits additional discussion. This is the matter of the amount of penalties and assessments imposed by the ALJ. The initial decision reflects that both the Inspector General and the ALJ believed the egregious circumstances in this case might have justified imposition of the maximum penalty and assessment. Under the statutory formula, the maximum penalty could have been $5,404,000, and the maximum assessment, an additional $291,100. However, both the Inspector General and the ALJ believed a lesser amount should be imposed to ensure consistency with the civil nature of the statutory authority and the concept that restitution and deterrence, but not retribution, are the objectives. The Inspector General noted this theme by referring to an internal guideline that generally limits aggregate penalties and assessments to $20 for each dollar falsely claimed, in this case $2,900,000. 5/ Judge Kessell, although disinclined to adopt the Inspector General's internal guideline, decided to limit the penalty to $1,500,000 because this, in his view, represented a sufficient deterrent.

5/ This internal guideline, as explained by counsel for the Inspector General at the oral argument provided by the ALJ, was imprecisely summarized in the ALJ's initial decision at page 28, note 10. The ALJ's summary does not make clear that counsel described this guideline as generally limiting the aggregate penalties and assessments to 20 times the amount of the false claims in cases in which the maximum under the statutory formula is greater and there are substantial aggravating circumstances. This is quite different than the implication that this guideline is generally used to set the proposed civil liability.

This is a subtle, but important issue. Both the Inspector General and the ALJ acted prudently and properly to factor in the restraining concept of civil liability. This factor, however, should be considered in the totality of the circumstances of the case. Under the scope of the civil monetary penalty authority, these circumstances can vary widely, and can include situations where the Inspector General's purported internal guideline simply does not fit. 6/ Tailoring the aggregate penalties and assessments amount to the totality of the circumstances eschews general reliance on a numerical multiple of any single factor, including the amount of the false claims. 7/ Thus, Judge Kessel's disinclination to follow the Inspector General's internal guideline was quite understandable.

6/ One of the only two other civil monetary penalties and assessments cases that have thus far been the subject of initial decisions by ALJs is an example of a situation in which this internal guideline does not fit. In In the Matter of George Griffon, DGAB Doc. C-8 (May 15, 1985), a pharmacist falsely claimed Medicaid reimbursement at the rate allowed for brand-name drugs for 22 prescriptions actually filled with lower priced generic drugs. The ALJ in this case imposed liability of $44,000, the maximum penalty allowed, which was many times the amount falsely claimed in connection with the 22 prescriptions. Much more significant than the amount of the claims directly involved in the case was the fact that those 22 claims, all filed in a two-month period, represented just a tiny fraction of a much larger scheme that was found to have been in practice at least six years.

7/ In In the Matter of Harold Chapman and Autumn Manor, Inc., DGAB Doc. No. C-5 (March 8, 1985), factors other than the amount of the false claims were also quite significant. One such factor was that because the amount of damages to the State agency was much less than the amount of the claims, liability under the False Claims Act would have been less than that permitted under the civil monetary penalties statute. Although in many cases, this would be a weighty factor, in that case it was not compelling because the offenders' fraudulent scheme was designed to obtain a much greater illegal windfall. This again underscores that it is the totality of the circumstances that must be the basis for the judgment.

But further explanation of Judge Kessel's decision that a penalty of $1,500,000 was an adequate deterrence would have been helpful. Consideration of this question should include substantial attention to the magnitude of the offenders' wrongful conduct. In the present case, the ALJ found that the respondents had billed the Medicare program for more than $1,800,000. Other findings strongly indicate that not more than a tiny fraction of this amount was properly reimbursable and that virtually all of it was a function of the respondents' fraudulent scheme. In view of this factor, the ALJ's imposition of aggregate penalties and assessments of $1,791,100 approximates the magnitude of the fraudulent scheme and is entirely justifiable based on the totality of the circumstances established in the record. 8/

For these reasons, the initial decision is hereby affirmed.

8/21/85 /s/

Date

Charles D. Baker
Under Secretary

8/ Additional points that might be pertinent to the application of the concept of civil liability limitations could include recognition of the apparent abuse of many Medicare patients who likely receive unnecessary tests and treatments, or possibly worse, in cases such as this. Also to be noted in considering notions of adequate deterrence is that in the past the presumed unlikelihood of getting caught at Medicare and Medicaid fraud has diminished the deterrent effect of available legal authorities, including criminal liability. Such matters were not developed in the record of this case. Refinement and application of these concepts are not easily accomplished, particularly in the context of this, only the third civil monetary penalties and assessments case to be heard by an ALJ. Although egregious circumstances such as those present in this case might well support aggregate liability higher than that imposed by Judge Kessel, it appears preferable at this point of experience under this statutory authority to aim toward further reflection and refinement by the Inspector General and Administrative Law Judges in future cases of this kind.