Department of Health and Human Services

Departmental Grant Appeals Board

Office of Hearings for Civil Money Penalties

In the Matter of The Inspector General, v. Roy W. Schoettle, D.O., Respondent	DATE: Dec 17, 1985 Docket No. C-6 DECISION CR 5

DECISION AND ORDER

This action was initiated pursuant to §1128a and §1128b of the Social Security Act (42 U.S.C. §1320a - 7a and 7b) as implemented by 45 CFR §101.100 et seq. In a letter dated June 13, 1984, Eileen T. Boyd, Deputy Assistant Inspector General, Civil Fraud Division, U.S. Department of Health and Human Services, notified Respondent Roy W. Schoettle that the Inspector General (I.G.) proposed the imposition of civil monetary penalties and assessments against him in the amount of $112,000 and a suspension from participation in the Title XVIII (Medicare) and Title XIX (Medicaid) programs for a period of seven years.

The position of the I.G. was that Respondent had either submitted or caused to be submitted 50 claims for Medicaid reimbursement containing numerous items or services which he knew or had reason to know were not provided as set forth in the respective claims. The allegation is that such claims falsely and fraudulently misrepresented that Respondent had provided the specified services to Medicaid beneficiaries. The I.G. alleged that in many instances the services for which reimbursement was sought were never provided or were provided by individuals who were not licensed to practice medicine in the State of Texas or in any other state or country.

The Respondent is depicted as an overworked and busy practitioner who treated poverty patients for many years prior to and since the inception of Medicaid. Respondent's

Post-Hearing Brief (R. Br.), p. 36. Counsel for Respondent contended that although "Dr. Schoettle may have been somewhat careless about recordkeeping," the lack of records did not rise to the level of submitting fraudulent claims. Id. at 35. Respondent argued that the government had totally failed to prove any intent to defraud or any actual knowledge of falsity.

Respondent also advanced the proposition that 42 U.S.C. §1320a - 7a, which was enacted August 13, 1981, and thus subsequent to all of the acts and all of the claims that form the basis of the instant litigation, cannot be retroactively applied. He argued that the I.G. had to provide, by clear and convincing evidence, proof that he presented or caused to be presented such claims as are described in §101.102 of 45 CFR §101 et seq., and demonstrate that such claims could have rendered the Respondent liable under the provisions of the False Claims Act, 31 U.S.C. §3729 et seq. 1/ Respondent would have the undersigned strictly construe the applicable statutes to mean that the I.G. must prove that said claims were made with actual knowledge of their falsity and with the intent to deceive.

Respondent further argued that any penalty in this case is limited to the payment that would be authorized under the False Claims Act, 31 U.S.C. §3729, which provides for payment of an amount not less than that proposed. Pursuant to the aforementioned section, the civil penalty is limited to $2,000 for each false claim, plus an amount equal to two times the actual damages the government sustained, plus costs.

Next, Respondent argued that even indulging in the assumption that the government met its burden of proof, the amount of damages demanded was not warranted, pursuant to 42 U.S.C. §1320a - 7a(c). He rightly pointed out that, pursuant to subsection (c) thereof, the amount of, or scope of the penalty or assessment "shall take into account

> (1) the nature of claims and the circumstances under which they were presented,

---

1/ Although both parties cite the False Claims Act as 31 U.S.C. §3729, at the time the Respondent submitted the 50 claims the False Claims Act was codified as 31 U.S.C. §231. In 1983, it was recast (apparently only to improve the structure and wording) and recodified as 31 U.S.C. §3729. Inasmuch as the parties seem to prefer or, at least, accept the 1983 version, that codification will be used in this Decision.

(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."

Respondent contended that he does not have any history of prior offenses nor has he been convicted of any crimes.

Procedural Background

By letter dated July 17, 1984, Respondent requested a hearing before an Administrative Law Judge. The eight day bifurcated hearing was conducted before the undersigned in March and May of 1985 in Houston, Texas. During the course of said hearing, 17 witnesses testified on behalf of the I.G. and three on behalf of Respondent. The I.G. introduced 117 exhibits and Respondent submitted one exhibit. Following the hearing, the parties submitted proposed findings of fact and conclusions of law, accompanied by briefing. After examining the record and these initial briefs and reply briefs, the undersigned requested additional briefing which was concluded on November 18, 1985.

Findings of Fact and Conclusions of Law

Having considered the entire record, the arguments of the parties, and being advised fully herein, the undersigned makes the following findings of fact and conclusions of law: 2/

A. Each of the 50 claims at issue include one or more items or services which the Respondent knew were not provided as claimed and thus are subject to a determination under 45 CFR § 101.102.

2/ In arriving at these findings and conclusions, this ALJ examined each of the proposed findings and conclusions offered by the parties. Some were rejected because they were not supported by the record, others because they were not material, and some the ALJ incorporated elsewhere in the Decision as it was not necessary or desirable to include them here.

1. The Respondent in this case is Roy W. Schoettle, D.O. I.G. Ex. 1. 3/

2. The Respondent has participated in the Texas Medicaid program since its inception in 1966. I.G. Ex. 61 at 8-9.

3. The Respondent submitted or caused to be submitted the 50 claims for Medicaid reimbursement specified in the Inspector General's June 13, 1984 letter. Stipulation 7.

4. The Respondent received payment as specified in the Inspector General's June 13, 1984 letter as reimbursement for the 50 claims which he submitted or caused to be submitted. Stipulation 8.

5. Between May 1979 and April 1980, Respondent owned controlling stock in the corporation which owned Northeast Memorial Hospital. Stipulation 12.

6. The Respondent founded and built Homestead Hospital and Clinic (d/b/a/ Northeast Memorial Hospital) in 1954. Tr. 1452-1453.

7. The Respondent was president of the governing board of Northeast Memorial Hospital. I.G. Ex. 105.

8. The Respondent was a member of the utilization review committee of Northeast Memorial Hospital. Tr. 1480.

9. The Respondent was head of the Department of Education at Northeast Memorial Hospital. Tr. 1502; I.G. Ex. 113.

10. The Respondent was manager of the emergency room at Northeast Memorial Hospital. Tr. 1455.

11. The Respondent exercised control over the billing department at Northeast Memorial Hospital. Tr. 1135, 1472.

3/ The record will be cited as follows:

Transcript - Tr. (followed by the page number)

Exhibit - Ex. preceded by party designation (I.G. or Resp.) and followed by exhibit number and, if appropriate, page number Some exhibits also have month/day identifiers.

12. Between May 1979 and April 1980, the Respondent personally instructed and authorized an employee or employees of Northeast Memorial Hospital to prepare, sign his name, and submit his claims for Medicaid reimbursement. Tr. 1138; I.G. Ex. 57 at 16; I.G. Ex. 61 at 28-29, 34.

13. The Respondent met with the business office supervisor of Northeast Memorial Hospital and established the procedures to be followed in filing his claims for Medicaid reimbursement. Tr. 1135-36; I.G. Ex. 59 at 38.

14. The Respondent instructed the business office at Northeast Memorial Hospital when filing claims on his behalf to bill for a history and physical on the day of a patient's admission to the hospital and daily hospital visits by him for each day up to the day of surgery. Tr. 1135-1136; I.G. Ex. 57 at 9; I.G. Ex. 66, 7/13 at 13; I.G. Ex. 82.

15. Claims were filed on behalf of the Respondent without an examination of the patient's complete hospital record to determine if he actually performed a history and physical and daily visits. Tr. 1136; I.G. Ex. 59 at 31-39.

16. The Respondent routinely reviewed the weekly remittance advice received from the State Medicaid fiscal carrier and agent explaining the amounts paid to him as a result of his claim for Medicaid reimbursement. I.G. Ex. 59 at 42-43; Tr. 1137.

17. The Respondent billed the Texas Medicaid program for medical histories and physical examinations allegedly given by him to Medicaid beneficiaries on dates when he was out of town and/or for which there is a lack of or inadequate documentation in patient medical records for his having rendered the claimed services. I.G. Ex. 2-29, 31-44, 46-51; I.G. Ex. 2A-29A, 31A-44A, 46A-51A; Stipulations 28, 30; I.G. Ex. 93.

18. The Respondent billed the Texas Medicaid program for daily visits on dates when he was out of town and/or for which there is no documentation for the claimed services in patient medical records. I.G. Ex. 2-29, 31-44, 46-51; I.G. Ex. 2A-29A, 31A-44A, 46A-51A; Stipulations 26-28, 30; I.G. Ex. 93.

19. The Respondent left Houston on May 10, 1979 at 11:25 AM to fly to St. Louis and left St. Louis at 3:35 PM on May 14, 1979 to return to Houston. Stipulation 36; I.G. Ex. 93.

20. The Respondent left Houston on May 24, 1979 to fly to the Bahamas and did not return to Houston before June 2, 1979. Tr. 133, 163, 187; I.G. Ex. 93, 109.

21. The Respondent left Houston on June 8, 1979 to fly to Memphis and left Memphis at 11:54 PM on June 11, 1979 to return to Houston. Stipulation 27; I.G. Ex. 93, 109.

22. The Respondent left Houston on September 15, 1979 to fly to Memphis and left Memphis to return to Houston on September 16, 1979. Stipulation 28; I.G. Ex. 93, 109.

23. The Respondent rented a car in Memphis at 9:17 AM on September 15, 1979 and returned it at 10:02 PM on September 16, 1979. I.G. Ex. 109.

24. The Respondent left Houston on September 28, 1979 to fly to Russia and returned from Russia to Houston on October 6, 1979. Stipulation 30.

25. Medicaid beneficiaries stated that they did not receive the services which the Respondent alleged he provided on his claims for reimbursement. I.G. Ex. 67-90c.

26. The Respondent sometimes did not see a patient on the day of discharge. Tr. 1521-1532; I.G. Ex. 66, 10/11 at 169.

27. Representatives of the State Medicaid fiscal carrier (National Heritage Insurance Company) and agent met with the Respondent on February 16, 1978 to review problems with his claims for reimbursement. Tr. 283.

28. On March 14, 1978, the Respondent was re-informed of the Medicaid policy that he should not bill for surgery performed by another physician. I.G. Ex. 98; Tr. 281-283.

29. On July 24, 1979, the Respondent was informed in writing that specific claims had been billed incorrectly and the Medicaid program planned on recouping the funds he improperly received. Tr. 324, 331. The recoupment occurred and was never contested by Respondent. Tr. 325, 330-331.

30. Northeast Memorial Hospital was required to refund $350,000 to the Texas Medicaid program as a result of improper reimbursement to the Hospital. Tr. 1499.

31. Over a substantial period of time, the Respondent submitted numerous false claims for reimbursement. Tr. 136; I.G. Ex. 94.

32. The Texas Attorney General's Office concluded that the Respondent had submitted 90 false Medicaid claims during the period November 1977 through March 1980. I.G. Ex. 94; Tr. 136-138. The State indicted Respondent on 24 of these claims. Tr. 137.

33. The State Medicaid agency concluded, on the basis of 15 claims for Medicaid reimbursement for periods when Respondent was on travel out of Houston, that the Respondent had submitted claims for services which were either not provided, or were provided by others, including unlicensed personnel. Tr. 199.

34. Based on its review of the Respondent's claims for Medicaid reimbursement, the State Medicaid agency terminated Respondent from participation in the State Medicaid program. Tr. 207-208; I.G. Ex. 102.

35. The practice of medicine in Texas is governed by the Medical Practice Act. U.T.C.A. Article 4495 b.; I.G. Ex. 99; Tr. 588.

36. In Texas, hospitals participating in the Medicaid program are required to meet the requirements set forth for participation in the Medicare program. Texas State Medicaid Plan, Article 4.11-A, Section D.2; 42 U.S.C. § 405.1011 et seq.

37. The Secretary of the U.S. Department of Health and Human Services (DHHS) has promulgated regulations setting forth conditions for participation of hospitals in Medicare. 42 U.S.C. § 1395 x(e); 42 C.F.R. § 405.1011 et seq.

38. As an alternative to complying with the requirements set forth in 42 U.S.C. § 1395 x(e), and the regulations promulgated thereunder for participation in Medicare, a hospital may elect to be accredited by the Joint Commission on Accreditation of Hospitals (JCAH). 42 U.S.C. § 1395bb.

39. If a hospital is accredited by JCAH, it is "deemed" to meet the requirements for participation in Medicare, except for any standard promulgated by the Secretary of DHHS, which is higher than a JCAH requirement. 42 U.S.C. § 1395bb(a)(4).

40. Between May 1979 and April 1980, Northeast Memorial Hospital elected to follow the criteria specified in the JCAH Accreditation Manual for Hospitals, 1979 edition. Stipulation 15.

41. Between May 1979 and April 1980, Northeast Memorial Hospital was accredited by JCAH. Stipulation 13.

42. As a result of its JCAH Accreditation, Northeast Memorial Hospital was deemed to be in compliance with Federal requirements. Stipulation 14.

43. During 1979 and 1980, the Respondent had access to and had, or should have had, knowledge of the JCAH requirements regarding his physician services rendered at the Northeast Memorial Hospital.

44. During certain days, or portions thereof, within calendar years 1979 and 1980, the Respondent repeatedly violated the JCAH requirements upon the Northeast Memorial Hospital when (a) providing or (b) employing persons to provide certain physician services claimed in the 50 claims for Medicaid reimbursement.

45. The Texas Department of Human Resources (TDHR) (and its predecessor, the Texas Department of Welfare) was, during the relevant time period, 1977-1980, the State Medicaid agency and was authorized to administer the Medicaid program in Texas. Tr. 223.

46. TDHR has promulgated specific rules and regulations governing the participation of physicians in the Medicaid program and submission of claims. Tr. 229; I.G. Ex. 97, 97A.

47. The National Heritage Insurance Company (NHIC) (and its predecessor, the National Heritage Health Insurance Company), was during the relevant time period, 1977-1980, the designated fiscal carrier and agent of TDHR for administering the Medicaid program in Texas. Tr. 227.

48. NHIC promulgated and disseminated to all providers participating in Medicaid the Medicaid Provider Procedures Manual, which was approved by TDHR. I.G. Ex. 52; Tr. 228, 247.

49. NHIC promulgated and disseminated to all providers, participating in Medicaid, informational bulletins approved by TDHR, containing specific billing instructions. I.G. Ex. 52A; Tr. 248-250.

50. The Respondent enrolled with NHIC as a physician providing Medicaid services prior to his submission of any of the claims specified in the Inspector General's June 13, 1984 letter, and received an individual provider number. Stipulation 6; Tr. 253-256.

51. The NHIC Medicaid Provider Procedures Manual, and all revisions, were sent to the Respondent. Tr. 273. The Respondent, as well as the employees responsible for filing his Medicaid claims, had a copy of the NHIC Manual and revisions at all times relevant to this proceeding. I.G. Ex. 61 at 9.

52. The Respondent has been submitting claims to NHIC for reimbursement of physician services since 1977. I.G. Ex. 61 at 9.

53. A physician who participates in the Medicaid program and submits claims for reimbursement is required to "be aware of all program limitations." NHIC Manual (I.G. Ex. 52) § 2030.

54. By submitting a Medicaid claim, a provider agrees to abide by the policies and procedures of the Texas Medicaid program. NHIC Manual (I.G. Ex. 52) § 1010.

55. During 1979 and 1980, the Respondent repeatedly violated the requirements of the Texas Medicaid program when providing or authorizing the services to be provided which were billed as physician services in the 50 claims for Medicaid reimbursement.

56. Physician services for purposes of Medicaid coverage and reimbursement are those provided "[w]ithin the scope of practice of medicine or osteopathy as defined by State law; and . . . [b]y or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy." 42 C.F.R. § 440.50

57. The Texas Medicaid program defines authorized physician services as "those reasonable and necessary services provided by or under the personal supervision of a physician and which are within the scope of practice of his profession as defined by State law." TDHR Rule 326.36,06; I.G. Ex. 97.

58. The Texas Medicaid Program further defines physician services by stating that the physician must be physically present in the building when the beneficiary receives services. NHIC Medicaid Provider Procedures Manual, October 6, 1978, par. 2030; I.G. Ex. 52; I.G. Ex. 97A; I.G. Ex. 66, 7/11 at 56-57.

59. On all claims for Medicaid reimbursement, a physician is required to sign a statement certifying that he personally rendered the services for which reimbursement is sought, or they were rendered under his

personal direction. 42 C.F.R. §455.18; TDHR Rule 326.36.01.002; I.G. Ex. 96A and 96B, NHIC Manual §7043(25), 7010.1.

60. On each of the 50 specified claim forms, the Respondent's name is listed in the signature block. On each of the 50 claim forms, the Respondent represented that he had provided the specific services or that they were provided under his personal direction. I.G. Ex. 2-51.

61. In all 50 claims at issue, the Respondent or his authorized representative signed the appropriate block on the claim form certifying that the services were personally rendered by him or under his personal direction. I.G. Ex. 2-51; Tr. 278.

62. The Texas Medicaid program required the listing of procedure codes as a description of services rendered by physicians on all claims between the relevant time period of May 1979 - April 1980. These were promulgated in the Blue Cross/Blue Shield Provider Procedures Manual. Stipulation 9; NHIC Manual, §7043(24c).

63. Prior to the time that the claims at issue were filed, the Respondent received a copy of the Blue Shield Relative Value Study (RVS) Manual for use in determining billing code procedure numbers. Stipulation 68.

64. The Blue Cross/Blue Shield Physician Coding Manual in effect January 1978 through December 1980 specified the following codes and descriptions for physician services:

    9022: Initial hospital visit, complete diagnostic history and physical examination, new patient or major illness, including initiation of diagnostic and treatment programs and preparation of hospital records.

    9019: Daily hospital care.

    I.G. Ex. 107; Tr. 284-291.

65. The Texas Department of Human Resources requires that there be a minimum of one visit per day by a physician in order to properly file a claim for services under the 9019 procedure code. Tr. 286.

66. If a physician does not visit a patient on a particular day and only telephones the hospital, he may not file a claim for his services under the 9019 procedure code. Tr. 287-289.

67. A physician may only file a claim for his services under procedure code 9022 if he personally rendered all the specified services or they were all rendered under his personal direction. Tr. 290.

68. A physician may only file a claim for his services under procedure code 4820 (delivery of baby and after care of mother and child) if he personally delivered the baby and rendered the follow up obstetrical care. Tr. 295.

69. With the exception of claim No. 17 (I.G. Ex. 18), the Respondent represented on every claim for reimbursement that he had rendered the services specified in "procedure code 9022" on the date of a patient's admission to Northeast Memorial Hospital," and, with the exception of claim Nos. 17, 29, 36, and 47 (I.G. Ex. 18, 30, 37, and 48), "procedure code 9019" on each successive day of stay. Stipulation 10; I.G. Ex. 18, 30, 37, 48.

70. The standards governing the content, authentication and maintenance of medical records are designed to insure continuity of care to the patient. Tr. 377.

71. The documentation of the services for which reimbursement is sought is the primary means for verifying the accuracy of claims. Tr. 202.

72. If there is no documentation in a medical record of services being rendered on a particular day, and for which reimbursement is sought, it is presumed that no services were in fact rendered. Tr. 202, 389-390, 1099.

73. A physician participating in the Texas Medicaid program must retain all records necessary to fully disclose the services provided for a period of five years or until all audit questions are resolved, whichever period of time is longer. TDHR Rule, § 5326.36.01.005; I.G. Ex. 66, 7/11 at 60-61.

74. All records and supporting documentation must be submitted upon request to TDHR or NHIC regarding any claim for reimbursement for services allegedly rendered. TDHR Rule 326.36.01.005; 42 U.S.C. § 1396a (a)(27); Tr. 232.

75. The Respondent was president of the governing board of Northeast Memorial Hospital, which board promulgated the hospital's bylaws. I.G. Ex. 105 at 43.

76. Northeast Memorial Hospital bylaws require that a history and physical examination be written within 24 hours after admission of the patient. I.G. Ex. 105 at 3.

77. Northeast Memorial Hospital bylaws require all orders to be written by the attending physician, or, if dictated, by a licensed nurse. I.G. Ex. 105 at 2; Tr. 364, 571-572.

78. Northeast Memorial Hospital bylaws require that physician's orders received verbally by a nurse from a physician and noted in the patient's medical record be countersigned by the ordering physician within 24 hours. I.G. Ex. 105 at 2: I.G. Ex. 63 at 26.

79. Northeast Memorial Hospital bylaws require that orders dictated over the telephone by a physician be authenticated within 24 hours. I.G. Ex. 105 at 2; I.G. Ex. 63 at 26.

80. Northeast Memorial Hospital bylaws require that there be a written discharge order by a physician prior to a patient's discharge from the hospital. I.G. Ex. 105 at 1.

81. Following discharge, Northeast Memorial Hospital bylaws require the attending physician to complete the medical record, including a discharge summary, within 15 days. I.G. Ex. 105 at 3.

82. Since at least January 1, 1978, it has been a violation of Texas laws concerning the practice of medicine for a person: (a) to diagnose, treat, or offer to treat any disease or disorder when that person is not licensed to practice medicine in Texas; (b) for an unlicensed person to impersonate a licensed practitioner; and (c) for a licensed physician to permit another unlicensed person to use his license or certificate to actually practice medicine. I.G. Ex. 66, 7/11 at 141-143; I.G. Ex. 99.

83. Since at least January 1, 1978, it has been a violation of the Texas laws concerning the practice of medicine for an unlicensed person to diagnose a medical condition or disease or to issue a treatment plan for a medical condition or disease without the supervising physician seeing that patient during the time when that medical condition or disease was present. I.G. Ex. 66, 7/11 at 152.

84. The physician is responsible for the primary treatment of the patient and cannot delegate that responsibility to a non-licensed individual. Tr. 1090-1095.

85. In Texas, the physician is required to provide "side-by-side" supervision of any work performed on a patient by unlicensed personnel. I.G. Ex. 66, 7/13 at 62; Tr. 1093.

86. The Texas Board of Medical Examiners requires an institutional permit in the name of a student intern or resident be obtained before the individual may provide services under the supervision of a physician in a hospital. Tr. 611; I.G. Ex. 66, 7/11 at 149; 7/13 at 132.

87. Clerkship is a term used to designate students who are in the process of going through medical school who are working in a hospital or clinic. I.G. Ex. 66, 7/11 at 156; Tr. 630-631, 1088.

88. Clerkships generally are not paid. Tr. 1089

89. All functions performed by a clerk in a hospital require a very high level of supervision. Tr. 635-637, 1089-1094; I.G. Ex. 66, 7/13 at 135.

90. A clerk may take a history and perform a physical examination only if the supervising doctor conducts an independent examination, verifies the clerk's work and countersigns the documenting forms. Tr. 631, 635-637, 1091; I.G. Ex. 66, 7/11 at 157.

91. An internship is the first year of training after graduation from medical school. Tr. 609.

92. If interns are training at a particular hospital, the institution must be affiliated with a medical school. Tr. 610-611; I.G. Ex. 66, 7/13 at 129.

93. A physician's assistant must receive special medical training or pass a certification examination. Tr. 629, 1086.

94. A considerable amount of supervision of a physician's assistant by the attending physician is required. Tr. 1087.

95. Between May 1979 and April 1980, Northeast Memorial Hospital had no specific approval from the Texas Board of Medical Examiners to operate a teaching program for interns or residents. Stipulation 20; Tr. 621.

96. Between May 1979 and April 1980, Northeast Memorial Hospital had no specific approval by the JCAH, Texas Osteopathic Association, or American Medical Association to operate as a training hospital. Stipulation 19.

97. It is not an acceptable practice of medicine for an unlicensed person to diagnose, write prescriptions, and/or initiate a plan of treatment for a patient in a hospital emergency room or other hospital setting without the supervising physician being present. I.G. Ex. 66, 7/13 at 65-66, 148-149.

98. In Texas, it is improper to allow a clerk to write patient progress notes, take telephone orders for medication or treatment, or to diagnose a patient's condition without direct physician supervision. Tr. 1094-1095.

99. Any entry in a patient record made by an unlicensed individual must be countersigned within 24 hours by the supervisory physician. Tr. 1095.

100. When writing in a medical record, a clerk or medical student must identify himself when writing the notation. Tr. 1097.

101. Anyone identifying himself as an M.D. in a medical record must be licensed to practice medicine in Texas. Tr. 1099.

102. Sharon Schoettle has never been licensed to practice medicine in Texas. Tr. 149, 1158; Stipulation 22.

103. Michael Petrone has never been licensed to practice medicine in Texas. Tr. 149; Stipulation 23.

104. From 1977 through 1979, Sharon Schoettle worked at Northeast Memorial Hospital. Tr. 1150, 1159; I.G. Ex. 66, 10/11 at 187.

105. The Respondent paid Sharon Schoettle for services she performed for him at Northeast Memorial Hospital. I.G. Ex. 95.

106. During 1978 and 1979, the Respondent assumed sole responsibility for the actions of unlicensed medical students (including Sharon Schoettle) attending to patients, including Texas Medicaid patients, at the Northeast Memorial Hospital. I.G. Ex. 66, 10/11 at 158-159, 207-209, 212-213.

107. The Respondent was not approved by the Texas Board of Medical Examiners to supervise Sharon Schoettle or Michael Petrone as a physician's assistant and such approval was required before they could perform the duties of a physician's assistant. I.G. Ex. 66, 7/11 at 148; Tr. 620-621.

108. Sharon Schoettle and Michael Petrone did not have the institutional permits necessary to provide services under physician supervision. I.G. Ex. 66, 7/11 at 148; Tr. 621.

109. In 1977, the Respondent asked the Texas Board of Medical Examiners what types of services could be performed by Sharon Schoettle. I.G. Ex. 101.

110. The Texas Board of Medical Examiners told the Respondent in 1978 that Sharon Schoettle could not refer to herself as doctor, nor diagnose or treat patients. I.G. Ex. 101.

111. If an unlicensed person saw a patient in a clinic or a hospital, before a licensed physician saw that patient, and on some occasions indicated that she was taking the place of a licensed physician, such action could be considered as a representation to the patient that the unlicensed person was a licensed physician. During 1979 and 1980, Sharon Schoettle engaged in the practices described above in the presence of Medicaid recipients where in instances physician services were billed to the Texas Medicaid program. I.G. Ex. 66, 7/13 at 140-141, 224, 249.

112. Sharon Schoettle and Michael Petrone were referred to as "doctor" by the medical staff and patients. Tr. 805; 850; I.G. Ex. 59, 68.

113. Sharon Schoettle saw the patients and ordered plans of treatment for Texas Medicaid patients in the Northeast Memorial Hospital for days (1) in which no licensed physician supervised her determination for the plans of treatment and (2) for which the Texas Medicaid program was billed by the Respondent for a daily physician's visit. I.G. Ex. 66, 7/13, 223-236; 10/11 at 205.

114. Sharon Schoettle and other unlicensed employees established medical diagnoses for patients, including Texas Medicaid patients, of the Northeast Memorial Hospital without the supervision of a licensed physician. I.G. Ex. 66, 7/12 at 214-215, 229, 271, 273-275; 10/11 at 193, 197, 204, 213-214.

115. The Respondent's standard practice was to have Sharon Schoettle or Michael Petrone visit and treat his patients without his direct personal supervision. Tr. 1487-1489.

116. Since at least January 1, 1978, it has been a violation of the Texas laws concerning the practice of medicine for a licensed physician to attempt to personally supervise an unlicensed person providing services to a patient when that licensed physician is more than 100 miles distant from where the unlicensed person is providing the services. I.G. Ex. 66, 7/11 at 151-152.

117. During 1978 and 1979, Sharon Schoettle and other unlicensed employees, violated the Northeast Memorial Hospital bylaws by indicating on the hospital patient charts of Medicaid patients that she had received a verbal or telephone physician's order from the Respondent when he was on an out-of-town trip and did not give such an order. I.G. Ex. 3A; I.G. Ex. 66, 10/11 at 164-165, 194-195, 202-203, 214-215.

118. Neither Sharon Schoettle nor any other person who was not a licensed physician was authorized to make entries in medical records without direct physician supervision. Tr. 381-382, 402; I.G. Ex. 105.

119. In Texas only a licensed physician can perform the primary history and physical examination. Tr. 1090-1091.

120. Michael Petrone performed histories and physical examinations on the Respondent's patients without supervision. I.G. Ex. 79, 80; I.G. Ex. 61 at 56; Tr. 1487.

121. The Respondent paid both Sharon Schoettle and Michael Petrone to take a patient's history and perform a physical examination. Tr. 1493.

122. Since at least January 1, 1978, it has been a violation of the Texas laws concerning the practice of medicine for a licensed physician to presign prescription pads and to allow an unlicensed person to thereafter place on those pads a patient's name, name of medication ordered, and prescription date. I.G. Ex. 66, 7/11 at 152; 7/13 at 61.

123. Sharon Schoettle and Michael Petrone wrote medication orders on prescription pads which had been presigned by the Respondent. I.G. Ex. 80.

124. Sharon Schoettle worked in the hospital's emergency room and treated patients by herself without supervision by a physician. Tr. 1167-68; I.G. Ex. 63 and 33, 39-40, 73-74; I.G. Ex. 59 at 21-22.

125. The Respondent was at times sleeping in the doctor's lounge or was in his clinic across the street when Sharon Schoettle treated patients in the emergency room. Tr. 1165, 1167-1168, 1553.

126. Dr. Gary Carpenter never supervised Sharon Schoettle in the emergency or non-emergency room areas of Northeast Memorial Hospital. I.G. Ex. 56 at 26.

127. It is not an acceptable practice of medicine for a licensed physician to authorize unlicensed persons to place the physician's rubber stamp signature on portions of a patient's medical record. I.G. Ex. 66, 7/13 at 75, 7/13 at 84-85.

128. Under JCAH standards, the only way a physician can properly use a signature stamp is if he had exclusive use of the stamp and files a statement to that effect with the hospital administrator, and the administrator approves. Tr. 954; I.G. Ex. 53 at 76.

129. The use of a rubber signature stamp to authenticate medical records is discouraged because of its potential for abuse. Tr. 372, 954-960; I.G. Ex. 66, 7/13 at 85.

130. The use of a rubber signature stamp to authenticate medical records is extremely infrequent in Texas. Tr. 1098.

131. The Respondent knew that medical records had to be properly documented and authenticated. Tr. 1515-1516.

132. During 1978 and 1979, the Respondent violated the Joint Commission on Accreditation requirements for the Northeast Memorial Hospital by allowing use of the rubber stamp of his signature by other persons to authenticate entries on the patient medical records. I.G. Ex. 66, 10/11 at 179-180.

133. Between the relevant dates May 1979 through April 1980, the Respondent authorized Lorene Blackwell, the Director of the Medical Records Department, to use a rubber stamp of his signature on Medicaid patient records maintained by the Hospital. Stipulation 25.

134. Lorene Blackwell knew that it was improper for either herself or medical records department staff to use the

Respondent's rubber signature stamp to authenticate medical records of his patients. Tr. 1407-1408; I.G. Ex. 81.

135. Lorene Blackwell returned the Respondent's rubber signature stamp to him in December 1979 when she became aware of a pending survey of the hospital by the Department of Health. Tr. 1407-1410.

136. The Respondent's rubber signature stamp was kept in an unlocked desk drawer and anyone in the medical records department could use the stamp to complete records. Tr. 1293.

137. Medical records personnel routinely used the Respondent's rubber signature stamp to authenticate and update his medical records. Tr. 1397-1399; I.G. Ex. 60 at 36; I.G. Ex. 81.

138. The medical records department staff used the Respondent's rubber signature stamp to authenticate both the Respondent's entries as well as those of his clerks. Tr. 1397-1402.

139. On all claims for Medicaid reimbursement, a physician is required to list the appropriate identification number of each physician providing a specified service, the type of service or procedure rendered, the dates the services were provided, and the appropriate identification number of the ordering physician if the service was provided by another doctor. TDHR 326.36.06.001.

140. By listing an individual identification number on a claim, a physician represents that he either personally rendered the specified services or they were rendered under his personal supervision. I.G. Ex. 66, 7/11 at 49-51; Tr. 241, 258.

141. A physician must apply to NHIC for a provider identification number to be listed on all claims for reimbursement. Tr. 237.

142. Provider identification numbers provide an "audit trail" for NHIC in determining whether services were rendered as claimed, and to ensure proper payment. Tr. 237, 245-246, 249, 260.

143. The Texas Medicaid program has promulgated specific procedures governing the submission of claims by a group of physicians. NHIC Manual (I.G. Ex. 52) §§ 7043 (24F), 7046; Tr. 234-250.

144. NHIC notified all physicians participating in the Medicaid program of the specific requirements governing the submission of claims by groups of physicians. I.G. Ex. 52A; Tr. 247.

145. Dr. Schoettle's clinic (Homestead Clinic) had two group billing numbers for purposes of filing claims for Medicaid reimbursement for services provided by physicians within the group. Tr. 254.

146. Dr. Roy W. Schoettle was registered in the Homestead Clinic application for a group number as one of the four physicians within the group who were rendering services. Tr. 255.

147. Dr. Morton Rubin was registered in the Homestead Clinic application for a group number as one of the four physicians within the group who were rendering services. Tr. 256.

148. If several physicians within a group rendered services to a Medicaid beneficiary, a claim would be filed under the group billing number and the physicians who rendered services would be specified along with their individual identification numbers. Tr. 241-242, 257.

149. Prior to 1980, Homestead Clinic filed claims for Medicaid reimbursement under its group numbers. Tr. 260.

150. None of the 50 claims at issue here were filed under the group numbers. Tr. 253; I.G. Ex. 2-51.

151. Since at least January 1, 1977, the Texas Medicaid program did not permit a physician to certify on a physician services claim that the services were provided by him or under his personal supervision when, in fact, some or all of the physician services claimed were actually provided by another physician or under that other physician's personal supervision. I.G. Ex. 66, 7/11 at 112-115, 10/12 at 57-58, 10/12 at 60-62.

152. The Respondent submitted, or caused to be submitted, claims for Medicaid reimbursement specifying services which he claimed he performed and which were in fact either not rendered, or provided by other individuals.

153. Dr. Morton Rubin had a working relationship with the Respondent from August 1977 through September 1981. Tr. 463; I.G. Ex. 92.

154. Dr. Rubin had both an individual provider number and a number to be used when submitting claims on behalf of the group practice of which both he and the Respondent were members. Tr. 256.

155. Dr. Rubin would "cover" for the Respondent when requested if Respondent was going to be out of town and no other doctor was seeing the patient. Tr. 467-468, 484; I.G. Ex. 58 at 67.

156. If another doctor was "covering" for the Respondent and treating his patients, they would not be seen by Dr. Rubin. Tr. 468.

157. If Sharon Schoettle was available to see the Respondent's patients, Dr. Rubin would not provide care to those individuals. Tr. 472; I.G. Ex. 58 at 77-78, 83.

158. If Michael Petrone was available to see the Respondent's patients, Dr. Rubin would not provide care to those individuals. I.G. Ex. 58 at 78, 83.

159. Whenever Dr. Rubin provided care or treatment to one of Dr. Schoettle's patients, Dr. Rubin's policy was to enter and authenticate an order or progress note in the patient's medical record. Tr. 470; I.G. Ex. 58 at 14-15.

160. Whenever Dr. Rubin gave a verbal or telephone order to a nurse, Dr. Rubin would subsequently countersign the order. Tr. 471, 480; I.G. Ex. 58 at 17, 19, 47, 82.

161. Whenever Dr. Rubin did issue an order through either Sharon Schoettle or Michael Petrone, Dr. Rubin always countersigned that order. Tr. 478; I.G. Ex. 58 at 84.

162. Any record order or entry of medical diagnosis or treatment by Sharon Schoettle or Michael Petrone which is not countersigned by Dr. Rubin was not issued or supervised by him. Tr. 478.

163. Dr. Rubin did not supervise either Sharon Schoettle or Michael Petrone when the Respondent was out of town. I.G. Ex. 58 at 69-70.

164. The Respondent's clinic (Homestead Clinic) had an agreement with Northeast Memorial Hospital for providing physician services in the Hospital's emergency room. Stipulation 67.

165. The emergency room doctors were paid from an account the Respondent maintained at Northeast Memorial Hospital. Tr. 1457, 1459; I.G. Ex. 63 at 13.

166. The history and physical examination performed as a part of the emergency room intake is distinct and separate from the complete history and comprehensive physical examination performed upon a patient's admission to the hospital. Tr. 1028-1029, 1073.

167. The emergency room history and examination is inadequate to provide the necessary documentation in the medical record for the comprehensive history and physical examination. Tr. 1029, 1073.

168. After the patient was treated in the emergency room and admitted to Northeast Memorial Hospital, the emergency room physician was no longer responsible for the care of the patient. Tr. 1320.

169. The services and care provided to a Medicaid beneficiary in the emergency room were billed for by Northeast Memorial Hospital. Tr. 1579, 1581; I.G. Ex. 114.

170. The physicians in the emergency room had a standard procedure of referring to Respondent's service any patient who did not have a doctor. Tr. 1135, 1457; I.G. Ex. 56 at 14; I.G. Ex. 59 at 31.

171. The Respondent paid the emergency room doctors' salaries. Tr. 1455.

172. The Respondent paid the emergency room doctors a bonus for referring a patient to him. Tr. 1525; I.G. Ex. 95.

173. Respondent's wife drew a check for $150 from Respondent's personal hospital account to "Dr. Sharon Schoettle" for six hospital admissions. Tr. 1525; I.G. Ex. 95.

174. Forty-seven of the 50 claims submitted or caused to be submitted by the Respondent are false in that one or more of the specified services were not provided as claimed.

    a. Claim I.G. Ex. 2. I.G. Ex. 2A; I.G. Ex. 84; I.G. Ex. 93; Tr. 390-394, 490-499, 916, 919.

    b. Claim I.G. Ex. 3. Stipulation 26; I.G. Ex. 3A; I.G. Ex. 76; Tr. 402-403, 515-521, 702-706, 916-917, 948-950.

c. Claim I.G. Ex. 4. Stipulation 26; I.G. Ex. 4A; I.G. Ex. 68; Tr. 522-529, 917, 1400-1402.

d. Claim I.G. Ex. 5. I.G. Ex. 5A; I.G. Ex. 69; Tr. 529-533, 708-713; 918.

e. Claim I.G. Ex. 6. I.G. Ex. 6A; I.G. Ex. 69; Tr. 533-535, 708-713; 920.

f. Claim I.G. Ex. 7. I.G. Ex. 7A; I.G. Ex. 77; Tr. 536-544, 920-921, 1007.

g. Claim I.G. Ex. 8. I.G. Ex. 8A; I.G. Ex. 72; I.G. Ex. 93; Tr. 163, 167, 544-550, 675, 869, 919, 921, 1527.

h. Claim I.G. Ex. 9. Stipulation 27; I.G. Ex. 9A; I.G. Ex. 67; Tr. 550-574, 921-922.

i. Claim I.G. Ex. 10. Stipulation 30; I.G. Ex. 10A; I.G. Ex. 78; Tr. 575, 679-684, 922.

j. Claim I.G. Ex. 11. I.G. Ex. 11a; I.G. Ex. 93; I.G. Ex. 73; Tr. 163, 167, 408-411, 576-579, 919, 923.

k. Claim I.G. Ex. 12. I.G. Ex. 12A; I.G. Ex. 71; Tr. 579-583, 685-688, 923.

l. Claim I.G. Ex. 13. Stipulation 30; I.G. Ex. 13A; I.G. Ex. 74; Tr. 638-643, 923-924.

m. Claim I.G. Ex. 14. Stipulation 28; I.G. Ex. 14A; I.G. Ex. 109; Tr. 643-652, 924-925.

n. Claim I.G. Ex. 15. Stipulation 27; I.G. Ex. 15A; I.G. Ex. 75; Tr. 655-658, 665-667, 925-926.

o. Claim I.G. Ex. 16. Stipulation 26; I.G. Ex. 16A; I.G. Ex. 64; Tr. 658-664, 926, 1188, 1510 - 1512.

p. Claim I.G. Ex. 17. Stipulation 27; I.G. Ex. 17A; I.G. Ex. 90B; Tr. 753-756, 927.

q. Claim I.G. Ex. 18. I.G. Ex. 18A; I.G. Ex. 90C; Tr. 756-757, 928.

r. Claim I.G. Ex. 19. I.G. Ex. 19A; Tr. 758-760, 928, 1535.

s. Claim I.G. Ex. 20. I.G. Ex. 20A; Tr. 760-763, 928-929.

t. Claim I.G. Ex. 21. I.G. Ex. 21A; Tr. 764-776, 929-930.

u. Claim I.G. Ex. 22. Stipulation 28; I.G. Ex. 22A; I.G. Ex. 109; Tr. 776-794, 930-931.

v. Claim I.G. Ex. 23. I.G. Ex. 23A; Tr. 794-798, 933-934.

w. Claim I.G. Ex. 24. I.G. Ex. 24A; Tr. 799-801, 934.

x. Claim I.G. Ex. 25. I.G. Ex. 25A; I.G. Ex. 90; Tr. 801-805, 934-935.

y. Claim I.G. Ex. 26. I.G. Ex. 26A; Tr. 806-808, 935.

z. Claim I.G. Ex. 27. Stipulation 26; I.G. Ex. 27A; I.G. Ex. 70; Tr. 695-701, 808-811, 935-936, 1512.

aa. Claim I.G. Ex. 28. I.G. Ex. 28A; Tr. 811-817, 936.

bb. Claim I.G. Ex. 29. I.G. Ex. 29A; Tr. 818-820, 936-937.

cc. Claim I.G. Ex. 31. Stipulation 26; I.G. Ex. 31A; Tr. 827-829, 937, 951-952, 1531.

dd. Claim I.G. Ex. 32. I.G. Ex. 32A; Tr. 829-838, 937-939.

ee. Claim I.G. Ex. 33. I.G. Ex. 33A; Tr. 839-841, 939.

ff. Claim I.G. Ex. 34. I.G. Ex. 34A; Tr. 841-847, 939-940.

gg. Claim I.G. Ex. 35. I.G. Ex. 35A; I.G. Ex. 93; Tr. 865-869, 940.

hh. Claim I.G. Ex. 36. Stipulation 28; I.G. Ex. 36a; I.G. Ex. 93; I.G. Ex. 109; Tr. 869-875, 940, 1532.

ii. Claim I.G. Ex. 37. I.G. Ex. 37A; Tr. 875-876, 941.

jj. Claim I.G. Ex. 38. I.G. Ex. 38A; Tr. 876-880, 941.

kk. Claim I.G. Ex. 39. I.G. Ex. 39A; Tr. 880-882, 941-942.

ll. Claim I.G. Ex. 40. I.G. Ex. 40A; Tr. 882-888, 942.

mm. Claim I.G. Ex. 41. I.G. Ex. 41A; Tr. 889-890, 942.

nn. Claim I.G. Ex. 42. I.G. Ex. 42A; Tr. 890-985, 942-943.

oo. Claim I.G. Ex. 43. I.G. Ex. 43A; Tr. 896-897, 943.

pp. Claim I.G. Ex. 44. I.G. Ex. 44A; Tr. 898-901, 943, 1191.

qq. Claim I.G. Ex. 46. I.G. Ex. 46A; Tr. 903-905, 944.

rr. Claim I.G. Ex. 47. I.G. Ex. 47A; Tr. 905-907, 944-945.

ss. Claim I.G. Ex. 49. I.G. Ex. 49A; Tr. 907-908, 946.

tt. Claim I.G. Ex. 50. Stipulation 27; I.G. Ex. 50A; I.G. Ex. 109; Tr. 908-912; 946-947.

uu. Claim I.G. Ex. 51. I.G. Ex. 51A; I.G. Ex. 86; Tr. 912-914, 947-948.

175. The Inspector General has met his burden of proving by clear and convincing evidence that Respondent is liable under the CMPL for the filing of 47 false claims.

176. The I.G. did not prove by clear and convincing evidence that the following services were falsely claimed:

a. In the claim for services to Stacy German, a daily visit on September 3, 1979. The history and physical and daily visits on September 4-6 were falsely claimed. See I.G. Ex. 7, 7a.

b. In the claim for services to Joseph Johnson, the history and physical on June 2, 1979. The daily visits on June 3-9 were falsely claimed. See I.G. Ex. 9, 9a, 67.

c. In the claim for services to Beverly Manley Page, daily visits on September 5 and 6, 1979. The history and physical and daily visits on September 7-9 were falsely claimed. See I.G. Ex. 15, 15a.

d. In the claim for services to Elizabeth Papillion, a daily visit on June 7, 1979. The history and physical and other daily visits on June 6 and 8-11 were falsely claimed. See I.G. Ex. 17, 17a.

e. In the claim for services to Anna Gibson, the history and physical and a daily visit on January 10, 1980. A daily visit on January 11 was falsely claimed. I.G. Ex. 20, 20a.

f. In the claim for services to Thomas Hair, the history and physical and daily visits on February 5-7, 10-19, 21 and 23, 1980. A daily visit on February 27 was falsely claimed. See I.G. Ex. 21, 21a.

g. In the claim for services to Dorothy Harris, daily visits on January 2-4, 6-8, and 10, 1980. The history and physical and daily visit on January 11 was falsely claimed. See I.G. Ex. 23, 23a.

h. In the claim for services to Ruby Hill, the history and physical. A daily visit on February 7, 1980 was falsely claimed. See I.G. Ex. 24, 24a.

i. In the claim for services to Rowena Lawrence, the history and physical and daily visits on February 11-13, 1980. A daily visit on February 14, 1980 was falsely claimed. See I.G. Ex. 26, 26a.

j. In the claim for services to Lanell Wiseman, the history and physical. See I.G. Ex. 30, 30a.

k. In the claim for services to Linda Lane, a daily visit on July 16, 1979. The history and physical and other daily visits on July 15 and 18-27 were falsely claimed. See I.G. Ex. 34, 34a.

l. In the claim for services to Mary Riggins, the history and physical and daily visits on August 31, 1979 and September 1-14, 1979. The daily visit on September 15, 1979 was falsely claimed. See I.G. Ex. 36, 36a.

m. In the claim for services to Debbie Mayes, the history and physical and daily visits on August 5-9, 1979. The daily visits on August 4 and 10, 1979 were falsely claimed. See I.G. Ex. 40, 40a.

n. In the claim for services to Bobby Devers, the history and physical and daily visits on February 4 and 5, 1980. See I.G. Ex. 45, 45a.

o. In the claim for services to Dollie Ervin, daily visits on January 3-9, 1980. The history and physical and daily visits on December 29 and 30, 1979 were falsely claimed. See I.G. Ex. 47, 47a.

p. In the claim for services to Alberta Jack, the history and physical. See I.G. Ex. 48, 48a.

177. The following services are credited to Respondent in mitigation:

1. Claim I.G. Ex. 4. Daily visits on May 11 and 12, 1979. I.G. Ex. 4a.

2. Claim I.G. Ex. 9. Daily visits on June 7 and 8, 1979. I.G. Ex. 9a.

3. Claim I.G. Ex. 11. Daily visits on May 26, 28, 30, 1979. I.G. Ex. 11a.

4. Claim I.G. Ex. 16. Daily visit on May 11, 1979. I.G. Ex. 16a.

5. Claim I.G. Ex. 33. Daily visit on December 24, 1979. I.G. Ex. 33a.

6. Claim I.G. Ex. 34. Daily visit on July 19, 1979. I.G. Ex. 34a.

7. Claim I.G. Ex. 39. Daily visit on December 24, 1979. I.G. Ex. 39a.

8. Claim I.G. Ex. 40. Daily visit on August 4, 1979. I.G. Ex. 40a.

9. Claim I.G. Ex. 41. Daily visit on December 20, 1979. I.G. Ex. 41a.

10. Claim I.G. Ex. 46. Daily visits on November 26 and 27, 1979. I.G. Ex. 46a.

11. Claim I.G. Ex. 47. Daily visit on December 29, 1979. I.G. Ex. 47a.

12. Claim I.G. Ex. 50. Daily visits on June 7 and 12, 1979. I.G. Ex. 50a.

178. The I.G. is entitled to assessments totalling $12,000. The amounts falsely paid totalled $4,217. Subtracting $267.40 for the daily visits of Dr. Rubin which the undersigned has allowed in mitigation, this total is reduced to $3,949.60. This total multiplied by a federal share factor of .5835 equals $2,304.59. Doubled, this total is $4,609.18. The cost of the hearing transcript, witness fees, and salaries and transportation for the investigators and the expert witness employed by the U.S. Department of Health and

Human Services totals $7,878.15. The total of $4,609.18 and $7,878.15 is $12,487.33. The federal share of the State's investigative effort related to this proceeding is $621.95. Other State costs related to the CMP hearing totalled $2,367.00.

179. The final decision of the Contract Appeals Committee of the Texas Department of Human Resources in Roy W. Schoettle, D.O., Appellant, v. Texas Department of Human Resources, Appellee, No. 82-97 and 82-110, is material and relevant to this proceeding and is received into evidence.

B. With respect to mitigating and aggravating circumstances:

1. The factors to be considered in setting the amount of penalties and assessments and length of suspension are: a) the nature and circumstances under which the claims were presented; b) the degree of culpability, history of prior offenses, and the financial condition of the person presenting the claims; and c) such other matters as justice may require. 42 U.S.C. § 1320a7a(c); 45 C.F.R. §§ 101.106(b), 101.107.

2. The Respondent had the burden of producing and proving by a preponderance of the evidence the existence of circumstances that would justify reducing the amount of the penalty or assessment, or the period of suspension. 45 C.F.R. § 101.114(d).

3. With these regulations in mind, the ALJ finds and concludes that the Respondent has shown only those mitigating circumstances described in Finding No. 177, supra.

4. The Inspector General has shown by a preponderance of the evidence that there are a number of aggravating circumstances, as listed hereafter:

   a. The nature of the claims that were charged in this case and the circumstances under which they were presented are aggravating circumstances. The claims were filed over a lengthy period, and encompassed a large number of items and services.

   b. The pattern of filing false claims was a conscious one, created and implemented by the Respondent.

c. The amounts falsely claimed by the Respondent for the charged items and services are substantial.

d. The Respondent was aware that he was filing claims for items and services not provided as claimed.

e. Respondent ordered the creation of false documentation to make it appear that the services for which reimbursement was sought had in fact been rendered by him.

f. The Respondent consciously sought to mislead the Government in order to cover up the nature of his activities.

g. The cover-up activities of Respondent evidence the knowing and willful nature of his activities with respect to filing claims.

h. Knowledge and intent to file false claims can be presumed from Respondent's actions in filing claims when he was out of town or when he knew that he had not rendered the services.

i. At a minimum, the Respondent's attitude toward the claims he filed for Medicaid reimbursement reflects a reckless disregard for their truth or falsity.

DISCUSSION

Essentially, this case turns on the extent of knowledge of the Respondent as to the submission of the 50 claims at issue. Although there was testimony from various I.G. witnesses as to 90 allegedly tainted claims having been submitted by Respondent, only 50 have been made the subject of this litigation, said 50 claims having been submitted for payment to the Texas Medicaid program between June 1979 and April 1980.

The undersigned finds that in 47 of the 50 claims at least one of the listed services was not provided as claimed. Each of these 47 claims was in one way or another inaccurate, inconsistent, deficient, or not reflective of what really happened. In all 50 claims there were violations of recognized and approved state medical practice as well as violations of standards promulgated by the JCAH (Joint Commission on Accreditation of Hospitals), AMH (Accreditation Manual for Hospitals), and NHIC (National Heritage Insurance Company) for the proper submission of Medicaid claims.

1. General background -- billing codes and practices

The testimony of Sharon E. Thompson, Administrator, Fraud and Abuse Division, Quality Assurance Bureau, Texas Department of Human Services, provided examples of these violations. See Tr. 191-345. Her office became aware of Respondent on referral from the Texas Attorney General's Office. This witness testified that she has personal knowledge of many of the claims at issue in the instant matter. Among the deficiencies she alluded to were the following:

1. Billing in a "coverage" situation whereby another physician provided a particular service to a patient and the billing was submitted under Respondent's provider number.

2. Permitting unlicensed individuals to perform unsupervised services and Respondent billing for same.

3. Submitting claims for services when in fact no service had been provided.

This witness indicated that the Department of Human Resources of the State of Texas has a contractual arrangement with the NHIC to process claims, publish manuals, and maintain a review program to check for fraud and abuse. She testified that the Medicaid Provider Procedures Manual prepared by NHIC and approved by the Department of Human Resources mandates that a provider may bill Medicaid either individually or as part of a group. For example, an individual might have an alpha-numero designation such as P100 as an individual provider number. This is different from the individual designation which a doctor might have as a member of a group using a group designation such as Z100. When a group submits a bill for services to the Texas Medicaid program, the code number designation on the claim form corresponds to the doctor in the group who actually performs the service, he or she being the designee on the claim form by number. The group, however, is the recipient in this instance of reimbursement for the claim submitted. Essentially, this is a tracking system for the Department of Human Resources.

From time to time, NHIC will issue bulletins containing instructions for billing that augment the Medicaid Provider Procedures Manual. I.G. Ex. 96a, identified by this witness as a letter from National Heritage Insurance Company with attachments, is a sample of the NHIC claim form that was furnished to Medicaid providers from January 1977 through July 1978. Attachment 2 thereof is the American Medical Association approved form that NHIC adopted and began

sending to its providers in July 1978. Furthermore, Medicaid instructions for the health insurance claim form of July 1978 were disseminated by NHIC to all its providers. (See Exhibit 96a) Both Attachments 1 and 2 of Exhibit 96a provide for certification and state that "the physician or supplier signature in block 25 on the reverse side of this form is certification that the services were personally rendered by the practitioner or under his personal direction, and that in the case of physician services, the services, supplies, or other items billed for were medically necessary for the diagnosis or treatment of the condition of the patient."

Ms. Thompson indicated that Respondent had met with NHIC personnel on February 16, 1978 in his office for purposes of discussing the appropriate use of codes for the various types of office, hospital, and emergency room visits. This meeting was summarized in a March 14, 1978 letter to Respondent by Dr. Jack M. Perlman, Associate Medical Director, National Heritage Insurance Company. I.G. Ex. 98. In said letter Respondent was once again put on notice about proper billing practices, both individually and in group situations, and their proper coding. Ms. Thompson testified that the Blue Cross/Blue Shield Physician Coding Manual, Medicaid Provider/Procedures Manual, the Texas Register section, the NHIC Manual, and the Medicaid Bulletins promulgated by NHIC, mandate that it is an impropriety for one physician to bill for another physician's services to a Medicaid beneficiary in a so called "coverage" situation. See I.G. Ex. 52, 52a, 97, 107. It was Respondent's position that such billing did not violate the Civil Money Penalties Act and the record contains many instances where Respondent billed for services provided by another physician.

Respondent testified that he did not remember giving any specific instructions to the insurance clerks at the hospital regarding Medicaid billings. He indicated that he was aware that the National Heritage Insurance Company would not pay for a hospital visit on the last day of a hospital stay, therefore if Northeast Memorial Hospital billed for this they did so improperly but he was unaware of whether or not this practice was actually followed. Tr. 1496-1498.

2. Services performed by physician or other person covering for Respondent

The filing of a claim for reimbursement under the Medicare or Medicaid program for physician services not personally rendered by the doctor who bills for such services has been the basis for an action under the False Claims Act in 31 U.S.C. §231, and its criminal counterpart, 18 U.S.C. §237. The Inspector General maintains that physician services, as

defined in 42 CFR §440.50, must be personally rendered by, or personally supervised by, the doctor who bills for the services. The gravamen of the government's case under the False Claims Act is the falsity of the claim, regardless of the existence or nonexistence of a statutory or regulatory duty to provide a true and accurate basis for the claim. See Petersen v. Weinberger 508 F. 2d 45 (5th Cir. 1975). 4/

In United States v. Adler 623 F. 2d 1287 (8th Cir. 1980), it was held in a criminal prosecution for false claims submitted under the Medicare and Medicaid programs that evidence that the defendant did not keep office hours on Fridays and yet submitted claims for Friday office visits permitted an inference of an intent to make a false claim, although the defendant had introduced evidence that the services may have been performed by another physician. There, the government was not required to prove that no services were provided; it was only required to prove that no services were provided by that particular defendant on the days for which he billed Medicare and Medicaid for the alleged services.

Called as a witness was one John H. Sortore, Director of the Hearing Division, Texas State Board of Medical Examiners, Austin, Texas. See Tr. 585-637. In December, 1978, this witness was employed by the Texas State Board of Medical Examiners in the capacity of Director of Investigations. On December 15, 1978, Mr. Sortore wrote the following memorandum to Dr. A. Bryan Spyers, Secretary of the Texas State Board of Medical Examiners, concerning Respondent:

> December 7, 1978, Dr. Schoettle called about his daughter, Sharon Schoettle, working for him as an intern or doing a clerkship. He related that she graduated from Guadalajara but was required to do a year of clinical clerkship before she could complete her studies and receive a degree. He wished to know what she could do.
>
> I had previously had a call for verification of license on Sharon Schoettle and had been given a little information on this.

4/ Although the facts of Petersen v. Weinberger do not parallel the case at hand, the legal principle expounded by the Court there is still applicable. There, the doctor had no actual knowledge that a false claim had been filed by his brother using the doctor's rubber stamp signature, but he nevertheless had reason to know that reimbursement checks issued in his name were not due. See Petersen v. Weinberger, supra.

> I questioned Dr. Schoettle about what she was doing and he said (sic) as a Physician's Assistant. It was explained that she couldn't be called a P.A. He said she was referred to as doctor. It was explained that she couldn't do this as she was not a licensed doctor in Texas and this led the public to believe she was and could practice medicine. I explained that she should be referred to as Ms. and should not diagnose or treat but could work as a technician. If we received a complaint and it was proven that she had violated the Medical Practice Act, it could prohibit her from ever securing a license in Texas or any other state.
>
> Dr. Schoettle said he did not know the situation but now that he did, the necessary corrections would be made.
>
> This report is for information.

I.G. Ex. 101.

This witness testified that the Texas State Board of Medical Examiners promulgated rules which were in effect in 1976 which covered the issue of necessary board approval for proper supervision of physician's assistants. The witness indicated that the Respondent had authorization in 1977 and 1978 to supervise a Mr. Parker, but never received board authorization to supervise either Sharon Schoettle or Michael Petrone. He further indicated that no institutional permit was granted to either Sharon Schoettle or Michael Petrone and Northeast Memorial Hospital was specifically not granted a training program permit. (See I.G. Ex. 100.)

This record is replete with instance after instance of Sharon Schoettle being referred to as doctor. By her own admission, she indicated that she had personal checks made up referring to herself as doctor. (See Tr. 1194 and I.G. Ex. 112) I.G. Ex. 95 shows checks were made payable to Sharon Schoettle as Dr. Sharon Schoettle and endorsed as Sharon Schoettle M.D. She denies any status at Northeast Memorial Hospital other than that of a clerk. She indicates that she never held herself out as a licensed physician, but could have made a mistake and signed her name as doctor. She felt her status at Northeast Memorial Hospital was one of a clerk. She denies having used prescription pads pre-signed by Respondent to fill out prescriptions. She testified that her formal relationship with Northeast Memorial Hospital ended in September 1979. Tr. 1213.

The former Director of Medical Records of Northeast Memorial Hospital, Lorraine Blackwell, was called as a witness by

Respondent. She testified that in the time period 1979 - 1980, she had a grandson who was hospitalized at Northeast Memorial. Sharon Schoettle took his temperature and listened to his pulse. The witness said that some people referred to Sharon Schoettle as "Doctor." Tr. 1290.

Several of the Medicaid beneficiaries, to wit, Diane Jackson, Carol Marves, Beverly Manley Page, Brenda Shaw, Jacqueline Busby, and Thelma Giddens, all testified that they never saw Respondent while hospitalized. Thelma Giddens testified that her two children were admitted to the hospital from Homestead Clinic by "Dr. Sharon Schoettle." While hospitalized, the two children were visited only by "Dr. Sharon Schoettle" and a "foot doctor." See Tr. 709 and I.G. Ex. 5a and 6a. According to this witness, "Dr. Sharon Schoettle" performed "most of . . . a history and physical" at the clinic and wrote out a prescription which the witness had filled. Id. Delphine Collins, another Medicaid beneficiary, testified that on May 7, 1979 she went to the Homestead Clinic to inquire about an insect bite. Ms. Collins was examined by "Dr. Sharon Schoettle" in Respondent's absence. See Tr. 850 and IG Ex. 5la. The witness was admitted to Northeast Memorial Hospital where she was questioned by "a doctor named Dr. Petrone." On May 11, 1979 Sharon Schoettle told this witness that she was going to discharge her from the hospital and Sharon Schoettle wrote out several prescriptions which the witness had filled. Tr. 851.

Testifying in his own behalf, Respondent Roy W. Schoettle indicated that his instructions to his daughter Sharon Schoettle were to take histories and physicals, prepare hospital summaries, make rounds with physicians, and write out progress records. Tr. 1486-1488. He acknowledged that he would sign blank prescription pads and "student externs would fill out the prescriptions." Tr. 1489-1490. He acknowledged not having an institutional permit for handling externs and clerks. Tr. 1501.

Patricia Brooks read into the record in pertinent part the April 10, 1984 deposition of Cynthia Caldwell. See I.G. Ex. 59. This witness was employed by Northeast Memorial Hospital in various capacities, one of which was as a PBX operator. She was questioned extensively about billing practices, Sharon Schoettle, and Respondent.

In response to questions about Sharon Schoettle, she indicated that Ms. Schoettle worked as an emergency room physician:

> Q. While you were an emergency room clerk, did you ever have an opportunity to enter the actual

emergency room where a patient was being seen by Sharon Schoettle?

A. Yes. It's hard to explain how they do things there. But if the doctor, which, I'm referring to if Sharon was in the treatment room and the nurse wasn't readily available or something, they would ask you to bring them something. Or if the chart wasn't there, they would say, 'Hey bring us the chart real quick.' And you pick it up and take it in and give it to them. I can't really say that I remembered exactly when I did this, but it was a real common practice to do that around there. If you were the ER clerk you were always in and out of the treatment rooms all the time.

* * *

Q. Would there be another physician other than Sharon in that room during most of the times when you would enter?

A. Not normally. If it were a particular -- I don't know how to say this -- a case maybe with extenuating circumstances and there were another doctor who had passed by and saw all this business going on, he may stop in for a minute and take a look. Or if her father were around, sometimes he would go in with her. Dr. Schoettle was always in and out. But other than that, the doctor in the emergency room was, per se, the person in charge of the Department. He pulls head rank on everybody down there.

* * *

Q. "While you were employed at the Northeast Memorial Hospital, did Sharon Schoettle ever chat with you about prescriptions for any patients?

A. When Sharon worked in the emergency room -- I'll have to figure out how to say this so I don't say it wrong -- when she worked in the emergency room -- let me put it this way -- when you work in the emergency room and you're down there day after day after day, you're familiar with what goes on and how things are done. And a lot of things are routine. You do that, and you do that for this and this for that.

And sometimes, when Sharon would have a patient -- and she did personally ask me this -- she'd be

> filling out an emergency room record is what it's called, the ER sheet and get down to the part to where it says what you're going to do. And it is as if I'm sitting there and she's sitting here; she would look up and go 'oh, how much penicillin do you give little kids?'
>
> * * *
>
> And I'd say, 'Sharon, I'm not a doctor. You need to figure that out.'
>
> And she'd say, 'oh, come on, man, you know.'
>
> But that would be general things; but they would ask you or Sharon would ask you, 'Do they usually prescribe this or this?' the usual run-of-the-mill thing that they did around there. She has personally asked me that. * * *

I.G. Ex. 59, pp. 21-23, 47-48.

3. Use of rubber stamp to authenticate records

A common practice running throughout almost every one of the 50 claims at issue in the instant matter is the usage of a so called rubber stamp to authenticate records. Much evidence was submitted showing this to be a common practice in the claims submitted. It seems well settled that this practice is not per se evidence of liability under the False Claims Act. The requirement that medical records be signed by a licensed physician does not appear to be related to preventing false claims so much as insuring the integrity of a particular record. Moreover, the use of such a stamp does not render a document invalid under Texas law. See Stout v. Oliveira 153 S.W. 2d 590 (Texas Civ. App. 1941).

Beverly A. Ripple, Director of Medical Records, Hermann Hospital, was called as a witness by the Inspector General. Tr. 348-443. In the capacity of the Director of Medical Records, she is familiar with the Joint Commission on Accreditation of Hospitals and the Accreditation Manual for Hospitals. This expert testified that she is unaware of any hospital allowing its staff to use a physician's signature stamp for authenticating records. Record completion is a physician responsibility; therefore, limiting the use of a rubber stamp insures accuracy in records. She testified that unsigned progress notes are not proper authentication.

Ms. Ripple indicated that the Accreditation Manual for Hospitals, 1979 edition, at p. 76 under standard 3 sets

forth the proper procedure whereby the usage of rubber stamp signatures may be accomplished as well as who may properly make entries in medical records:

> When rubber stamp signatures are authorized, the individual whose signature the stamp represents shall place in the administrative offices of the hospital a signed statement to the effect that he is the only one who has the stamp and is the only one who will use it. There shall be no delegation of the use of such stamps to another individual.

I.G. Ex. 53, pp. 76-77.

There is no evidence that Respondent complied with this requirement during the period in question. 5/

Ms. Ripple called attention to a provision in the Accreditation Manual for Hospitals which parallels the Northeast Memorial Hospital bylaws:

> Authenticate - to prove authorship, for example, by written signature, identifiable initials, or computer

---

5/ Ms. Ripple also pointed to a letter from Respondent to the hospital administrator of Northeast Memorial, dated June 14, 1980, stating:

> This is to notify you that due to the volume of my medical records and for the advantages of saving time, I have had a rubber stamp made of my signature, to be used on my records. No one but myself will be allowed to use this stamp, and this stamp signature is to be considered as valid as a written one.

This letter to the hospital administrator was necessitated by the medical records section of the rules and regulations of Northeast Memorial Hospital, which provide as follows:

> If any physician wishes to use a rubber stamp for authentication of medical records documentation, he must attest, documented in a letter, that the rubber stamp represents his signature and that he is the only one who will possess and use the stamp. This situation must be approved by the Hospital Administrator and documentation of this approval must be on file in the Administrator's office.

I.G. Ex. 104, p. 51

key. The use of rubber stamp signatures is acceptable only under the following conditions:

1. the physician whose signature the rubber stamp represents is the only one who has possession of the stamp and is the only one who uses it; and

2. the physician places in the administrative offices of the hospital a signed statement to the effect that he is the only one who has the stamp and is the only one who will use it.

I.G. Ex. 53, Glossary.

The testimony of Lorraine Blackwell highlights the issue of the rubber stamp. In 1978 and 1979 Ms. Blackwell was the Director of Medical Records at Northeast Memorial Hospital. As part of her duties she kept the records of various patients at the Northeast Memorial Hospital.

She testified that she kept a rubber stamp with the name "Schoettle" on it in an unlocked desk drawer and sometimes used it to supply a "missing" signature of Respondent's on a patient's record, Tr. 1293. She did this with Respondent's approval and was "not the only one" permitted to use the stamp for this purpose. Id. Respondent acknowledged that he gave Ms. Blackwell permission to use his stamp if he "happened to miss a progress note, or miss a signature, somewhere," but insisted that "she didn't do it routinely." Tr. 1492-1493.

The Accreditation Manual is clear that authentication by use of a rubber stamp may be done only by individuals given this right as specified in hospital and medical staff policies. In that regard, Beverly Ripple testified that I.G. Ex. 105 speaks to the issue of who may make entries in medical records; in the case of Northeast Memorial Hospital, only the physician. However, those individuals whose names appear on a privileged list of the hospital can enter progress notes. Ms. Ripple testified that where the bylaws are silent with respect to who may make entries, it was her experience that only the physician or hospital personnel are the proper people allowed to accomplish same. Ms. Ripple indicated that the rules, regulations and bylaws of Northeast Memorial Hospital provide that discharge of a patient from this institution can only be accomplished upon written authorization from the physician.

In the instance of physician's orders, namely verbal orders, Ms. Ripple indicated that it is a violation of the bylaws of Northeast Memorial Hospital to have allowed Sharon Schoettle to countersign a verbal order from Respondent. Furthermore,

if a rubber stamp appeared on this order, that too would be improper. Specifically the bylaws provide that "all orders for treatment shall be in writing. An order shall be considered to be in writing if dictated by the attending physician to a licensed nurse or nurse attending the nurse's station and signed by the attending physician. Orders dictated over the telephone shall be signed by the person to whom dictated, the name of the physician dictating the orders, and by her own name and initialed by the attending physician no later than twenty-four (24) hours." (Emphasis added.) I.G. Ex. 105, p. 2. The bylaws also state that "all records shall be completed in detail within fifteen days following the discharge of the patient from the hospital. * * * Accompanying history and physician examination shall in all cases be written within twenty-four (24) hours after admission of the patient." Id. at p. 3

In light of the above, the ALJ finds that most of the entries where a rubber stamp was used to authenticate a history and physical or a progress note were not services provided by Respondent, even though he billed for them. His filing of a false claim under such circumstances is evidence of intent to defraud the government. However, in a few instances the I.G. did not prove by clear and convincing evidence that some histories and physicals and some daily visits billed for by Respondent on seven claims were false. See Finding No. 176a.-d., k.-m.

Four of the claims covered by Finding No. 176 are based on patient records which contain progress notes on which the stamp "Schoettle" was used to authenticate the record. This ALJ holds that generally the appearance of that stamp was not a proper authentication because the record does not show that at the time in question Respondent was authorized to use the stamp and also because Respondent did not restrict the stamp to his own use. Thus it is a false claim for which Respondent could have been liable under the False Claims Act. This ALJ finds, however, the stamped authentication of a daily visit on some of the days in question was corroborated by entries in the nurses' notes that Respondent visited the patient. Thus, billing for a daily visit under such circumstances was not clear and convincing evidence that Respondent knew or should have known that he had not provided the services as claimed. See I.G. Ex. 7, 15, 17 and 34.

In two other claims, the histories and physicals and progress notes are authenticated by a written signature which the I.G. did not prove was not that of Respondent. Patricia Brooks, a medical records expert, did testify to what to her were "unusual circumstances" of these signed entries: i.e., that they were all signed, and that they

were sometimes squeezed in as though they were added later. See I.G. Ex. 36, 40; Tr. 869-875, 882-888. The I.G. has failed to persuade the undersigned that he has carried the day on this issue as the "unusual circumstances" testified to by witness Brooks in re these entries do not satisfy the clear and convincing test.

In another patient's record, the history and physical was authenticated with a "Schoettle" stamp. I.G. Ex. 9. Moreover, the I.G. provided documentation that a purchase in the Bahamas was charged to Respondent's credit card account on June 2, 1979, the date of the history and physical. I.G. Ex. 93. However, the I.G. also introduced the statement of the patient's mother that Dr. Roy Schoettle had seen her son at Homestead Clinic on June 2, 1979, and while there Respondent looked at her son's eyes and ears and checked his reflexes and admitted him to the hospital. I.G. Ex. 67. She opined that "no one at the hospital ever gave Joseph a complete physical examination." Id. Despite her denial that her son received a physical, the stamped authentication that a history and physical was performed is sufficiently corroborated by her statement of the services Respondent provided to lead this ALJ to conclude the I.G. has not shown by clear and convincing proof that the history and physical was falsely claimed.

4. Effect of State's seizure of hospital records

David Clore, Supervising Investigator with the Texas Attorney General's Medicaid Fraud Control Unit, was called as a witness. Tr. 96-190. Mr. Clore was in charge of the State's investigation of allegations that Respondent had filed fraudulent claims. Respondent contended that Mr. Clore's seizure of patient records at Northeast Memorial Hospital on January 17, 1980, and subsequent control of access to those records over the ensuing eight months prevented Respondent and other hospital personnel from making entries necessary to complete those records. Respondent argued in effect that incomplete records on Medicaid recipients who entered the hospital after December 1, 1979, were due to the inability of hospital personnel to complete and get Respondent's signature on histories and physicals, physician's orders, and progress notes. Resp. Post Hearing Brief, pp. 8-18.

Mr. Clore testified as follows:

> Q. What access was permitted to hospital personnel of those records, during your eight months of investigation at the hospital?

A. They had access to those records, at any time that we were in the hospital, in that room, working.

Q. Okay.

When I say access to the hospital, did that permit them to go in and add something to the record, to finish a medical record, or anything like that?

A. We considered it reasonably prudent to not allow them to make any additional changes in the record, after we had obtained them from the hospital.

Tr. 175-176.

In this matter, there are nine claims at issue where non-access is involved, to wit: I.G. Ex. 20, 23, 30, 47 and 48, in which the services were allegedly provided in January 1980; I.G. Ex. 21, 24 and 45 in which the services were allegedly provided in February 1980; and I.G. Ex. 26 in which the services were allegedly provided in March 1980.

Arguably, the seizure of certain of the hospital records by investigator Clore and his team and the subsequent prevention of "additions or deletions" to these records by him could make a strong showing for Respondent's failure to complete some of these charts. Furthermore it should be remembered that the hospital bylaws of Northeast Memorial mandate that orders dictated over the telephone shall be signed by the person to whom dictated, the name of the physician dictating the orders, and initialed by him no later than 24 hours. I.G. Ex. 105 at 2. The bylaws also provide that "all records shall be complete in detail within 15 days following the discharge of the patient from the hospital; accompanying history and physician examination shall in all cases be written within 24 hours after admission of the patient." Thus, at most the seizure of the records might excuse the failure to complete only those records of patients discharged on or after January 2, 1980.

Consequently, this ALJ is persuaded that in the instance of the aforementioned nine claims, the I.G. has failed to demonstrate by clear and convincing evidence that Respondent could have completed these records within, at the outer limits, 15 days of discharge of a patient. See Finding No. 176. e.-j and m.-p. As the records in these nine cases had been seized by a State investigator who did not consider it "reasonably prudent" to allow Respondent and others to make any additional changes in the records, the undersigned assumes Mr. Clore would not have allowed Respondent to add even his signature to the histories and physicals and progress notes, much less fill in missing entries. This ALJ

is not unmindful of the fact that Respondent's practice was to bill for a history and physical and daily visits each time a patient was admitted, even though the patient's record was incomplete and not properly authenticated, but feels that the totality of the circumstances is such that he is left with a reasonable doubt as to whether or not these records could have been completed.

5. The Standard of Liability

Essentially, this case turns on an interpretation of the False Claims Act (31 U.S.C. §3729) and the Civil Money Penalties Act (42 U.S.C §1320a - 7(b)). The Civil Money Penalties regulations provide that to the extent a proposed penalty and assessment is based on claims filed prior to August 13, 1981, the I.G. must prove by clear and convincing evidence that the Respondent presented or caused to be presented a claim for an item or service which that person either knew or had reason to know was not rendered and that such claim could have rendered the Respondent liable under the provisions of the False Claims Act, 31 U.S.C. §3729, for payment of an amount at least equal to that proposed by the I.G. 45 CFR §101.114(b).

Although some jurisdictions regard the False Claims Act as quasi-criminal in nature, the weight of authority holds that its sanctions are civil rather than criminal in nature. A false claim against the government, but not a fraudulent claim, is actionable under the Act when a person makes a negligent misrepresentation that is tantamount to actual knowledge of the falsity of the claim and intent to defraud the government. United States v. Cooperative Grain & Supply Co. 476 F.2d 47 (8th Cir. 1973). In Cooperative Grain, the Court ruled that even though the defendants did not have actual knowledge of the falsity of their claim for price support payments and did not have a specific intent to defraud the government, they nevertheless had a duty to read the regulations or otherwise be informed of basic eligibility requirements for payment and to advise the government of the true and accurate basis for their claim. The Court upheld the government's argument that the statutory language reading "knowing such claim to be false, fictitious, or fraudulent" created alternative grounds for liability, so that a person may be liable for a false claim without the specific intent to defraud the government. Specific intent, therefore, is not a necessary element under the provisions of the Act. Moreover, the court pointed out that the statute was part of the federal civil code, rather than the criminal code, which contains its counterpart (18 U.S.C. §237). Accordingly, the word "knowing" must be construed as applying to civil actions for misrepresentation and includes

those acts of negligence which would be tantamount to "knowledge" of falsity. 6/

In an action brought by the government to recover farm subsidy payments made on the basis of false claims, the Court stated: "to establish a violation of the False Claims Act, the United States must demonstrate, by a preponderance of the evidence, that the defendant possessed guilty knowledge or guilty intent to 'cheat the Government'". By referring to a quantum of proof necessary to prevail in a civil action for misrepresentation, the Court implicitly construed the word "knowing" as not being limited to actual knowledge that a claim is false and implicitly endorsed the view that negligent misrepresentation could be the basis for recovery by the government under the False Claims Act. United States v. Thomas 709 F. 2d 968, 971-972 (5th Cir. 1983). 7/ Accord: McCarthy v. United States 670 F. 2d 996 (Ct. Cl. 1982); United States ex rel. Fahner v. Alaska 591 F. Supp. 794 (N.D. Ill. 1984).

It seems clear from a fair reading of Cooperative Grain that gross negligence is not the standard vis-a-vis the False Claims Act. The Court implied that the degree of negligence required to permit the government to prevail under the Act is the same as that which a plaintiff must prove in a common law action for negligent misrepresentation. 8/ There, the Court held that "knowing Within the False Claims Act is "knowing" in the civil Sense and not the guilty Knowledge of the criminal mens rea.

6/ Actual knowledge of falsity of a statement or a claim is not required to sustain a conviction under 18 U.S.C. §1001 (false statements) or 18 U.S.C. §237 (false claims). The conviction will be sustained on showing that the defendant had a "reckless disregard" for truthfulness and a "conscious purpose" to avoid learning the truth. United States v. Evans, 559 F. 2d 244 (5th Cir. 1977); United States v. Restrepo-Granda, 575 F. 2d 524 (5th Cir. 1978) (willful ignorance of importing control substance); United States v. Cook, 586 F. 2d 572 (5th Cir. 1978).

7/ The quantum of proof necessary to prevail on the basis of a fraudulent claim is "clear and convincing evidence." Hageny v. United States 570 F. 2d 924, 933-934 (Ct. Cl. 1978).

8/ Texas case law allows recovery for fraud without evidence of actual knowledge of the falsity of the representation. See 26 Texas Digest 2d, "Fraud", Section 13 (2).

Since the False Claims Act is civil in nature, the definition of "knowing" should be the definition as applied in the civil action of misrepresentation. Since we have decided that a false claim, not only a fraudulent claim, is actionable under the Act, a negligent misrepresentation can constitute the necessary knowledge.

Prosser says that:

> "A representation made with an honest belief in its truth may still be negligent, because of lack of reasonable care in accepting the facts . . ." Prosser at 713-714.

6. Suspension under the Civil Money Penalties Law

Part 101 of 45 CFR -- Civil Money Penalties and Assessments -- provides in section 101.105 that a person subject to a penalty or assessment under section 101.102 may, in addition, be suspended from participation in the Medicaid program for a period to be specified by the Secretary. Section 101.106 discusses the factors and guidelines for determining the amount of the penalty or assessment. The undersigned has carefully studied this section and concludes that as aforementioned there are many aggravating circumstances surrounding Respondent's submission of the 50 claims at issue in the timeframe indicated, to wit a ten month span from June 1979 through April 1980. The record should reflect that the undersigned ALJ specifically finds that the Respondent knew that the itemization of 47 of the 50 claims at issue was defective in that the actual service was not provided as claimed. To the extent any penalties and assessments are imposed hereunder, the ALJ has considered and carefully studied section 101.106 of 45 CFR § 101 and concludes that there are no prior offenses that would constitute an aggravating circumstance, the financial condition of the Respondent does not appear to be such as to place him in jeopardy should imposition of civil money penalties be imposed hereunder so that same cannot be considered a mitigating circumstance.

With respect to the imposition of civil money penalties pursuant to section 101.102 and section 101.103 of 45 CFR 101, the undersigned is of the opinion that there is no retroactive application being applied hereunder wherein the imposition of money penalties must lie. The bench mark case in this area is United States ex rel. Fahner v. Alaska, supra, wherein the Court, in sustaining the imposition of money penalties, assessed a forfeiture of $2,000 for each of the Medicaid claims submitted by the defendant, as well as an award of double the government's damages. Ibid. pp. 798-799. In that case the Court upheld the federal government's position that actual damages equalled one half

of the amount improperly paid to the defendant as a result of his false claims for Medicaid reimbursement (the federal government and the State of Illinois each contributed one half of the total payment). 42 U.S.C §1320a-7a, effective August 13, 1981, being section 1128a of the Social Security Act, indicates in the preamble that "since 1863 Congress has provided for the United States to recover in a civil suit double damages in $2,000 forfeitures from those making or causing to be make (sic) false claims against the Federal Government." 31 U.S.C. §3729 is closely modeled on that statute. Although there are some differences between them, the undersigned has restricted the retrospective application of section 1128a to circumstances in which the Respondent would have been liable under the False Claims Act. 45 CFR §101.114 (b). With respect to claims presented before August 13, 1981, the undersigned has also limited the substantive liability to that which would have been imposed under that statute.

Here the undersigned is of the opinion that section 1128a, at least for purposes of the imposition of civil money penalties, does nothing more by way of retrospective application than to refer back to the False Claims Act, 31 U.S.C. §3729, which provides, in part, that any person who shall make or cause to be made, or present or cause to be presented, for payment or approval, any claim upon or against the government of the United States, or any department or officer thereof, knowing such claim to be false, fictitious, or fraudulent shall forfeit and pay to the United States the sum of $2,000, and, in addition, double the amount of damages which the United States may have sustained by reason of the doing or committing such act, together with the costs of the civil action. It does not appear to the undersigned that an imposition of civil money penalties pursuant to 45 CFR §101 et seq. would be a retrospective application of the law such that same would be constitutionally prohibited. It is well to point out at this juncture that the undersigned does not have the authority to pass on constitutional questions. It appears to this ALJ that Respondent's argument that 42 U.S.C. §1320a - 7a is being retroactively applied is unfounded as the proscriptive remedy existed under the False Claims Act.

To the extent that the Respondent obliquely refers to termination (suspension) pursuant to 42 U.S.C. §1320a-7 as being retroactively applied, it is incumbent upon the undersigned to comment briefly on same. The rationale Respondent would have the undersigned adopt is that any suspension is controlled by 31 U.S.C. §3729, the False Claims Act, and because same is silent with respect to suspension, the Administrative Law Judge is bound by such determination and consequently cannot impose such a sanction. The fallacy in this line of reasoning is that it seems clear from a fair reading of the statutory and regulatory intent as promulgated by the Secretary that where penalties and assessments

would lie then naturally flowing from such imposition was the suspension remedy. The legislative history suggests that there is no prohibitive stigma attached to the so called retroactive application of 42 U.S.C. §1320a-7a(c) with respect to suspensions. This Administrative Law Judge reads the regulations propounded by the Secretary as inferentially providing for suspensions wherein it first could be determined that penalties and assessments were an appropriate remedy regardless of whether the claims were presented prior to or after August 13, 1981. The authority to impose suspensions derives from the determination that liability exists for penalties and assessments, to wit,

> A person subject to a penalty and assessment determined under Section 101.102 may, in addition, be suspended from participation in Medicare and Medicaid.

See 42 CFR §101.105(a). There is express provision in the Regulations for the imposition of penalties and assessments for acts occurring prior to August 13, 1981, to the extent of liability under the False Claims Act. 45 CFR §101.114(b). The Civil Money Penalties Act is basically composed of two provisions, Section 1128a, which addresses penalties and assessments, and Section 1128b, which addresses suspensions. Though the Preamble to the Regulations discusses the applicability of 1128 to claims presented prior to August 13, 1981 and states the liability which flows therefrom, it is silent with respect to suspensions. However, the undersigned is of the opinion that the suspension remedy has been contemplated by the Secretary since at least 1972. The suspension authority under the Civil Money Penalties Act does not reflect an expansion of preexisting liabilities since such authority existed under Section 1862(d)(1)(A) of the Social Security Act since 1972.

7. The assessments

The standard of liability for the calculation of assessments in a Civil Money Penalties case is that the assessments, with the penalties, shall not be greater than the amount for which the Respondent might have been liable under the False Claims Act. Thus, we look to the False Claims Act.

Under the False Claims Act, the government must prove actual damages with reasonable specificity to recover. The measure of such damages for failure to provide goods or services for which the government was charged is the amount paid by the government for goods or services not received or rendered. See United States v. Woodbury, 359 F. 2d 370 (9th Cir. 1966). See also United States ex rel. Fahner v. Alaska, supra.

The False Claims Act provides for a penalty of $2,000 for each false claim, plus an amount equal to double the actual

damages, plus costs. The penalty portion of the government's recovery, therefore, may be denied unless an aggravated form of negligence can be proved. In Prosser, Law of Torts, pp. 9-12, 180-187, it is stated that aggravated forms of negligence such as "gross", "wanton", or "reckless" may serve as a basis for the award of punitive damages.

Respondent asserts in his Supplemental Brief that no authority exists under 45 C.F.R. §101.100 et seq. for the imposition of costs. He argues that because the Inspector General has proceeded on the basis of recovery on a retroactive application of 42 U.S.C. §1320a-7a, Respondent should not be taxed costs as all or part of this proceeding might not have been necessitated but for that position.

The Inspector General asserts that the False Claims Act (31 U.S.C. §3729) provides that the amount awarded may include the government's "costs of the civil action . . ." In Nissho-Jwai Co. v. Occidental Crude Sales, 729 F.2d 1530 (5th Cir. 1984) the Court upheld travel costs of witnesses, witness fees, subsistence allowance, the costs of copying, and the expense of depositions. The Federal Rules of Civil Procedure, Rule 54(d), provides that "Except when express provision therefor is made either in a statute of the United States or in these rules, costs shall be allowed as of course to the prevailing party unless the court otherwise directs . . ."

The ALJ is of the opinion that common sense dictates an extension of this principle to include the instant action. Accordingly, assessments totalling $12,000 as requested by the Inspector General are authorized. See Finding No. 178, infra. 9/

8. The Texas State decision

The ALJ had taken under advisement the motion of the I.G. offering into evidence the transcript of the Final Decision of the TDHR Contract Appeals Committee in the action involving Respondent, Cause Nos. 82-97 and 82-110. After having considered same, the undersigned is of the opinion that pursuant to the authority granted the ALJ under 45 CFR 101, specifically §101.118, the receipt into evidence of the above referenced transcript is proper. Accordingly, the

---

9/ The undersigned does not decide whether costs incurred by the State of Texas, but not shown to have been reimbursed by the United States, may be used to support the assessments, as it is not necessary to do so here. The $12,000 is justified without it.

undersigned finds the same to be relevant and material and receives it into evidence.

9. Mitigating and aggravating circumstances

The undersigned has fully scrutinized the instant matter in an attempt to recoup some measure of mitigation, but can find little. While it may be, by way of example only, that the usage of a rubber stamp, or permitting the use of a rubber stamp by another, cannot serve as evidence of negligence to establish liability under the False Claims Act, it does, along with countless other commissions and omissions, establish a pattern of reckless disregard for truth and veracity such as to elevate and highlight individual out-of-context instances of negligence to a plateau bordering on gross negligence sufficient to fall within the ambit of the False Claims Act.

Throughout this record, we have seen instances of claims for reimbursement offered by the Respondent when he full well knew that it was impossible for him to have personally supervised the rendition of services by himself or another when, for example, he was out of town. Were it an isolated instance, same might be inconclusive on Respondent's scienter, however, we have seen this pattern occur on at least five different occasions from May 10 through October 6, 1979, wherein claimant traveled twice to Memphis and once each to St. Louis, the USSR, and the Bahamas. We have seen instances of unlicensed individuals (Sharon Schoettle and Michael Petrone) being turned loose to "practice" their brand of medicine in a clinic and hospital whose overseer was Roy W. Schoettle. Perhaps one of the most reprehensible and egregious examples of this was on a particular weekend when the Respondent could not provide coverage through another physician and resorted to his daughter to cover the emergency room at Northeast Memorial, and this individual, a person unlicensed in any state or country, asking a PBX operator for advice on what dosage medication a child should receive. That this individual, and others, should be in possession of signed but blank prescription pads and given carte blanche, particularly piques the conscience of the undersigned. Respondent had personally met with representatives of the National Heritage Insurance Company (fiscal intermediary for the Texas Medicaid program) on February 16, 1978, in an attempt to review problems with claims he had submitted for payment. Thereafter, he received a March 14, 1978 letter summarizing this meeting in which he was instructed not to bill for services rendered by another physician. He then turned around over the course of the next two years or so and did the opposite.

This brings home to this author that there is culpability here pursuant to the standard suggested by the Cooperative Grain, case wherein knowledge and intent to the degree required in the False Claims Act must be construed and is against Respondent, the undersigned finding that he knew or had reason to know that the claims as submitted were false, fictitious, or fraudulent.

The undersigned does not include here the few documented instances where Dr. Rubin did provide services -- daily visits as shown by progress notes -- which Respondent billed in his own name. 10/ These were falsely claimed and meet the guilty avoidance of knowledge/bona fide belief resulting from negligence test suggested in Cooperative Grain, if not the negligent misrepresentation test of the Thomas case. However, since the services were provided by a qualified physician who contracted to substitute for Respondent in his absence, the following daily visits will be credited to the Respondent in mitigation. Cf. Finding no. 177.

Let us not forget that there was testimony that Respondent instructed billing clerks in the hospital insurance office how to submit claims to Medicaid, specifically instructing them to bill for a history and physical and daily hospital visits for each of Respondent's patients once it was determined that he was the attending physician. In perusing the evidence, the undersigned has found many references in hospital records of billings submitted by Respondent for daily visits when he would not even see the patient that day, such as on a date of discharge where there would be reference to the Respondent having seen the patient the date before discharge, arranging for the actual discharge to occur in the a.m. of the following day.

Additionally, there were many instances where the patient would be discharged with a mere phone call and yet there would be a claim submitted for a daily hospital visit on the date of discharge. Let us also not forget that there was testimony received from many of the Medicaid beneficiaries that they never saw Respondent during their entire hospitalization and yet progress notes would be rubber stamped with Respondent's signature as having seen the patient so as to document the claims. Let us also remember that although we are hearing concerns of 50 claims, the State of Texas

---

10/ Dr. Schoettle testified that he had a written "partnership" agreement with Dr. Morton Rubin -- and only Dr. Rubin --whereby when Dr. Schoettle was out of town Dr. Rubin was to see Dr. Schoettle's patients. Tr. 1475 - 1476. Respondent billed Medicaid under his own name for these visits and services. Tr. 1476 - 1477.

looked at circumstances involving 90 such alleged false claims over a period of some two and a half years.

There is no doubt in the view of the undersigned that the totality of the circumstances is such that the burden of proof has been met by the I.G. in that he has shown by clear and convincing evidence that 47 of the 50 claims were tainted in some respect or another as contemplated by the revisions of the False Claims Act and the civil monetary penalties and assessments provision authorized by §1128a of the Social Security Act (42 U.S.C. §1320a-7a) as implemented by 45 CFR §101.100 et seq. That this Administrative Law Judge should turn his cheek to the conduct and practice found to permeate this record would be a grave injustice and travesty to visit upon unwary and unsuspecting past, present, and future Medicaid beneficiaries, not to mention the taxpayers.

ORDER

Penalties of $2,000 for each of 47 false claims ($94,000), plus assessments of $12,000, for a total dollar amount of $106,000; plus suspension from participation as a provider in the Medicaid and Medicare programs for a total of seven (7) years, are hereby imposed and the Respondent is Ordered to pay the total amount of the penalties and assessments.

/s/

Sherwin F. Biesman
Administrative Law Judge