DEPARTMENT OF HEALTH AND HUMAN SERVICES

Departmental Appeals Board

Civil Remedies Division

In the Case of:	
The Inspector General,	DATE: February 5, 1990
- v. -	Docket Nos. C-99 and C-100
Anesthesiologists Affiliated, et al. (C-99) and James E. Sykes, D.O. et al. (C-100)	DECISION CR 65
Respondents.	

DECISION OF ADMINISTRATIVE LAW JUDGE

Respondents requested hearings to contest the proposed imposition against them, jointly and severally, of civil monetary penalties and assessments, and also to contest the proposed imposition against them of exclusions from participation in Medicare and State health care programs.[1] Based on the law, regulations, and evidence adduced at the consolidated hearing in these cases, I conclude that Respondents presented or caused to be presented 208 claims for items or services that they knew, had reason to know, or should have known were not provided as claimed.

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[1] "State health care program" is defined by subsection 1128(h) of the Social Security Act to include any State Plan approved under Title XIX of the Act (such as Medicaid). The definition also encompasses programs receiving funds under Title V of the Act (Maternal And Child Health Services Block Grant), and Title XX of the Act (Social Services Block Grant). I use the term "Medicaid," hereafter, to represent all State health care programs encompassed by the exclusions that I impose in these cases.

I impose aggregate penalties of $208,000.00 and aggregate assessments of $50,000.00 against Respondents for a total of $258,000.00, and I apportion each Respondent's maximum liability based on my findings and conclusions in this Decision. I also impose three year exclusions against all Respondents from participating in Medicare and Medicaid, with the exception of: Respondents James A. Barnett, D.O. (Respondent Barnett), James A. Barnett, D.O., P.C. (Respondent Barnett, P.C.) Steven R. Quam, D.O. (Respondent Quam), and Steven R. Quam, D.O., P.C. (Respondent Quam, P.C.), against whom I impose two year exclusions; and James E. Sykes, D.O. (Respondent Sykes), and James E. Sykes, D.O., P.C. (Respondent Sykes, P.C.), against whom I impose no exclusions.

BACKGROUND

On December 13, 1988, the Deputy Assistant Inspector General, Civil Administrative Division, notified Respondents that pursuant to authority delegated to her by the Secretary of Health and Human Services (the Secretary) and the Inspector General (the I.G.), she was proposing civil monetary penalties and assessments against them. She further notified Respondents that she was proposing that they be excluded from participating in the Title V, XVIII, XIX, and XX programs. Specifically, she proposed that Respondents jointly and severally be penalized $211,000.00 and assessed $203,036.00, for a total of $414,036.00. She proposed that each Respondent be excluded for a period of ten years. She cited as legal authority for the proposals the Civil Monetary Penalties Law, section 1128A of the Social Security Act (the Act), as implemented by 42 C.F.R. 1003.100 et seq.

The Deputy Inspector General premised the penalties, assessments, and exclusions on allegations that Respondents presented or caused to be presented to Blue Cross and Blue Shield of Iowa (Blue Cross), the Iowa carrier for the Medicare program, 211 claims requesting $101,518.00 for Medicare reimbursement for anesthesia services which Respondents knew, had reason to know, or should have known were not provided as claimed. She itemized each allegedly false claim as a separate count on a schedule attached to the notice letter.

The Deputy Inspector General alleged that, in 131 of the 211 claims at issue (counts 1-120 and 201-211), Respondents falsely represented or certified the identity and/or employment status of the individual who rendered

anesthesia. She alleged that Respondents improperly specified the time units for which reimbursement was sought in these 131 claims. The Deputy Inspector General concluded that, as a result of these allegedly false representations, $6,875.92 in Medicare reimbursement was improperly paid to Respondents.

The Deputy Inspector General further alleged that, in the remaining 80 claims at issue (counts 121-200), Respondents falsely represented that services described as "pump monitoring" had been rendered. She alleged that, with respect to many of these claims, Respondents falsely stated that a second physician acting as an anesthesiologist was necessary and present to perform the "pump monitoring" services. She asserted that, as a consequence of these allegedly false representations, $16,414.40 in Medicare reimbursement was improperly paid to Respondents.

Respondents were advised that the maximum penalty permitted by law for the 211 allegedly false claims was $422,000.00 and that the maximum assessment was $203,036.00, for a total maximum liability of $625,036.00. The Deputy Inspector General advised Respondents that the penalties and assessments she was proposing were based on factors specified by regulations. These included:

> 1. the presence of allegedly aggravating circumstances, including the lengthy period of time during which false claims were allegedly submitted by Respondents, the large number of allegedly false claims, the large amount of reimbursement allegedly falsely claimed (over $100,000.00), and the pattern of allegedly false reimbursement claims;
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> 2. Respondents' culpability, as evidenced by their allegedly false certifications and misrepresentations on claims, and Respondents' alleged reaffirmation of false statements in response to inquiries to them by the Iowa Medicare carrier;
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> 3. the fact that, to the Deputy Inspector General's knowledge, Respondents had not committed prior offenses that would constitute aggravating circumstances;
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> 4. Respondents' financial condition, which, according to the Deputy Inspector General, was not a

mitigating factor because payment of the proposed penalties and assessments by Respondents would not jeopardize their ability to continue as health care providers; and

5. other factors which justice required the Deputy Inspector General to weigh, including Respondents' alleged failure to comply with Medicare and Medicaid reimbursement requirements over an extended period of time, and the allegedly significant unrecouped costs incurred by the Department of Health and Human Services in reviewing and investigating the services Respondents asserted to have rendered in bringing an administrative action against Respondents.

All of the Respondents timely requested a hearing. A joint hearing request was filed on behalf of all Respondents, except Respondents Sykes and Sykes, P.C. Respondents Sykes and Sykes, P.C. filed a separate joint hearing request. As a result, separate administrative hearing dockets were created to hear the request of all Respondents other than Respondents Sykes and Sykes, P.C. (Docket No. C-99), and to hear the request of Respondents Sykes and Sykes, P.C. (Docket No. C-100). However, all of the parties subsequently consented to a consolidated hearing of the cases.

In their hearing requests, Respondents denied the allegations made by the Deputy Inspector General and affirmatively asserted that for each of the 211 claims at issue, all services billed for had been delivered and all payments received were correct. Respondents, other than Respondents Sykes, and Sykes, P.C., also claimed that the I.G. had abused process when conducting his investigation of them. In a prehearing brief, Respondents amplified their defenses by asserting that they had "employed" the individuals who assisted them in rendering anesthesia in the claims listed in counts 1-120 and 200-211, consonant with legal requirements, and were thus entitled to reimbursement as claimed for these individuals' services. Respondents also asserted that, to the extent there were any false or inaccurate statements on their claims, these statements amounted to harmless error which would not justify imposition of any penalties, assessments, or exclusions against them.

I held a consolidated hearing in these cases in Des Moines, Iowa, from July 11 through July 19, 1989. At the completion of the hearing, I issued a schedule for the

parties to file posthearing briefs and reply briefs. All parties complied with this schedule. On December 5, 1989, after I ascertained that Respondent Sykes would not be filing a reply brief, I directed that the record in these cases be closed.

ISSUES

The issues in these cases are whether:

1. the Secretary lawfully delegated to the I.G. the authority to investigate alleged violations of section 1128A of the Act, to propose penalties, assessments, and exclusions pursuant to that section, and to represent the Secretary in hearings brought pursuant to that section;

2. Respondents presented or caused to be presented claims for items or services which they knew, had reason to know, or should have known were not provided as claimed, in violation of section 1128A of the Act;

3. the exclusion remedy is precluded in this case because imposition of exclusions would constitute an unlawful retroactive application of the Act to Respondents; and

4. penalties, assessments, and exclusions should be imposed against Respondents and, if so, in what amount and for what period of time.[2]

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[2] Although all Respondents other than Respondents Sykes and Sykes, P.C. alleged that the I.G. had abused process during the investigation which led to the administrative complaint against them, they offered no evidence as to this defense at the hearing, and made no arguments concerning it in their posthearing briefs. Therefore, I conclude that they abandoned this issue and I make no findings or conclusions concerning it.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Respondents in this case are Anesthesiologists Affiliated (AA), G. Robert Loerke, D.O., G. Robert Loerke, D. O., P.C., James A. Barnett, D.O., James A. Barnett, D.O., P.C., Steven R. Quam, D.O., Steven R. Quam, D.O., P.C., James E. Sykes, D.O., James E. Sykes, D.O., P.C., John P. McDonough, C.R.N.A., John P. McDonough, C.R.N.A., P.C., O. Rex Nelson, C.R.N.A. and O. Rex Nelson, C.R.N.A., P.C. June 26, 1989 Stipulation in Docket No. C-99, number 12 (Stip. C-99 12); Stipulation in Docket No. C-100, number 6 (Stip. C-100 6).

2. Respondent AA is a partnership comprised of the individual Respondents. Stip. C-99 11; Stip. C-100 5

3. Respondents G. Robert Loerke, D.O. (Respondent Loerke), James A. Barnett, D.O. (Respondent Barnett), Steven R. Quam, D.O. (Respondent Quam), and James E. Sykes, D.O. (Respondent Sykes), are licensed doctors of osteopathy and practice medicine as anesthesologists. Stip. C-99 14; Stip. C-100 9.

4. Respondents John P. McDonough, C.R.N.A. (Respondent McDonough), and O. Rex Nelson, C.R.N.A. (Respondent Nelson) are Certified Registered Nurse Anesthetists (CRNAs). Stip. C-99 15; Stip. C-100 10.

5. Respondents G. Robert Loerke, D.O., P.C. (Respondent Loerke, P.C.), James A. Barnett, D.O., P.C. (Respondent Barnett, P.C.), Steven R. Quam, D.O., P.C. (Respondent Quam, P.C.), James E. Sykes, D.O., P.C. (Respondent Sykes, P.C.), John P. McDonough, C.R.N.A., P.C. (Respondent McDonough, P.C.), and O. Rex Nelson, C.R.N.A., P.C. (Respondent Nelson, P.C.) are professional corporations incorporated by the individual Respondents. Inspector General's Exhibit (I.G. Ex.) 221-1 - 221-6.

6. Respondent AA was formed in 1963. Stip. C-99 26.

7. Respondent Loerke was a partner in Respondent AA from the beginning of the partnership in 1977 or 1978 through October 18, 1985. Transcript of July 11-19, 1989 hearing (Tr.) at 976, 977, 1788-1790.

8. Respondent Barnett was a partner in Respondent AA from the beginning of the partnership in 1977 or 1978 until his retirement on or about August 1, 1984. Tr. at 976, 977, 1789, 1790; Respondent's Exhibit (R. Ex.) 44/1.

9. Respondent Quam was a partner in Respondent AA from August 1, 1984 through October 18, 1985. Tr. at 1229, 1789.

10. Respondent Sykes was a partner in Respondent AA from September 1, 1985 through October 18, 1985. Tr. at 1789, 1790; R. Ex. 44/1.

11. Respondent McDonough was a partner in Respondent AA throughout the period in which the claims at issue in this case were presented. Tr. at 1788-1790.

12. Respondent Nelson was a partner in Respondent AA throughout the period in which the claims at issue in this case were presented. Tr. at 1788-1790.

13. During the period at issue in this case, some or all of the Respondents provided anesthesia services at Des Moines General Hospital (DMGH). Stip. C-99 27; Tr. at 1788-1790.

14. On December 13, 1988, the I.G. served notice on Respondents proposing a penalty of $211,000.00, an assessment of $203,000.00, and an exclusion of ten years. Notice.

15. The proposed penalty, assessment, and exclusion were based on allegations that Respondents presented or caused to be presented 211 claims for Medicare reimbursement for items or services which were not provided as claimed. Notice.

16. The Notice alleged that the claims for Medicare reimbursement were submitted by Respondents in violation of the Civil Monetary Penalties Law. See Social Security Act, section 1128(A).

17. The specific claims at issue in this case are itemized as counts 1-211 in a "schedule of false claims" which is attached to the Notice letter. Notice.

18. The 211 claims at issue are reimbursement claims, under Part B of the Medicare Program (Medicare Part B), which Respondents presented or caused to be presented for items or services they alleged to have rendered at DMGH during the period December 10, 1982 through October 18, 1985. Tr. at 10, 13; I.G. Ex 1-1 - 211-1.

19. The Act authorizes the Secretary to impose a civil monetary penalty and an assessment against any person who

presents or causes to be presented, to an officer, employee or agent of any State, a claim for items or services under Title XIX (Medicaid) which that person knew or should have known was not provided as claimed. Social Security Act, section 1128A(a)(i)(2).

20. Prior to December 1987, the Act provided for imposition of a penalty, asessment, and exclusion against a person who filed a claim for an item or service where that person "knows or has reason to know" that the item or service was not filed as claimed. Social Security Act, section 1128A(a)(i)(2).

21. Effective December 22, 1987, the phrase "should know" was substituted for the phrase "has reason to know." Pub. L. 100-203, section 4118(e) (1987).

22. Section 4118(e)(3) of this law provided that the language substition was intended to apply retroactively.

23. Medicare Part B is a voluntary insurance program to provide medical insurance benefits for aged and disabled individuals who elect to enroll in the program, to be financed from premium payments by enrollees together with contributions from funds appropriated by the federal government. Social Security Act, Sections 1831 et seq.

24. Medicare Part B covers services rendered by physicians which are reasonable and necessary for the diagnosis or treatment of illness or injury. Social Security Act, sections 1832(a)(1); 1862(a)(1)(A).

25. Medicare Part B covers services which are furnished as an incident to physicians' professional services, of kinds which are commonly furnished in physicians' offices, and are commonly either rendered without charge or included in the physicians' bills. Social Security Act, section 1861(s).

26. The Secretary of the Department of Health and Human Services (the Secretary) is authorized to enter into contracts with health care carriers, in order to efficiently provide for the administration of health care benefits under the Medicare program. Social Security Act, section 1842.

27. Carriers which contract to administer Medicare benefits are authorized to make determinations of the rates of reimbursement and amounts of payments required

to be made to providers of services. Social Security Act, section 1842(a)(1)(A).

28. Carriers which contract to administer Medicare benefits are also authorized to serve as a channel of communication of information to providers relating to the administration of the Medicare program. Social Security Act, section 1842(a)(1)(B)(3).

29. Blue Cross and Blue Shield of Iowa (Blue Cross) has been the contracted Medicare carrier for the State of Iowa since at least 1972. I.G. Ex. 214-1 - 214-7; Tr. at 40.

30. Physicians in Iowa who render services to Medicare beneficiaries under Medicare Part B and who seek reimbursement from Medicare file their reimbursement claims with Blue Cross. I.G. Ex. 214-2; Tr. at 40, 1116-1120.

31. Anesthesia services rendered to Medicare beneficiaries under Medicare Part B are covered and reimbursed by Medicare as are all other physicians' professional services. Stip. C-99 9; Tr. at 41.

32. Prior to October 1, 1983, Blue Cross reimbursed under Medicare Part B for services rendered by physicians' auxillary personnel, as services "incident to" services rendered by physicians, only where the personnel who rendered the services were employed by and working under the supervision of the physicians claiming reimbursement. I.G. Ex. 214-2/1.

33. This reimbursement policy applied to reimbursement claims made by anesthesiologists for services rendered by Certified Registered Nurse Anesthetists (CRNAs). I.G. Ex. 214-4; Tr. at 63.

34. Prior to October 1, 1983, in order for an anesthesiologist in Iowa to be entitled to reimbursement under Medicare Part B for services rendered by a CRNA, the CRNA had to be the salaried employee of the anesthesiologist, and the anesthesiologist had to supervise the rendering of the service for which reimbursement was claimed. I.G. Ex. 214-1.

35. Prior to October 1, 1983, Blue Cross defined "supervision" to mean direct, personal, and continuous supervision. I.G. Ex. 214-1.

36. Prior to October 1, 1983, Blue Cross also defined "supervision" to mean that the physician claiming reimbursement would be present while services were rendered by his or her auxillary staff. I.G. Ex. 214-6.

37. Blue Cross communicated these Medicare reimbursement policies to Iowa health care providers, including Respondents. I.G. Ex. 214-1 - 214-6; Tr. at 45.

38. Respondents were aware of these Medicare reimbursement policies. Tr. at 1817.

39. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) directed the Secretary to establish regulatory criteria to distinguish reimbursement for professional medical services personally rendered in hospitals by physicians (which may be reimbursed under Medicare Part B) from other professional services rendered in hospitals (which may be reimbursed under other Medicare provisions). Social Security Act, section 1887(a)(1).

40. On March 2, 1983, the Secretary published new regulations pursuant to TEFRA. 48 Fed. Reg. 8902 et seq., codified at 42 C.F.R. 405.550 et seq.

41. The new regulations became effective October 1, 1983. Stip. C-99 10.

42. The regulations contained specific provisions governing reimbursement for anesthesia services. 42 C.F.R. 405.552, 405.553.

43. Effective October 1, 1983, anesthesia services rendered to a covered beneficiary are reimbursable under Medicare Part B, provided that the physician either performs the procedure directly, without the assistance of a CRNA, or directs no more than four anesthesia procedures concurrently and does not perform any other services while he or she is directing the concurrent procedures. Additionally, for each anesthesia service for which reimbursement is claimed, the physician must:

a. perform a pre-anesthetic examination and evaluation;

b. prescribe the anesthesia plan;

c. personally participate in the most demanding procedures in the anesthesia plan, including induction and emergence;

d. ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;

e. monitor the course of anesthesia administration at frequent intervals; and

f. provide indicated postanesthesia care.

42 C.F.R. 405.552(a).

44. Anesthesiologists frequently claim reimbursement from Medicare for services rendered to Medicare beneficiaries by utilizing formulas, generally derived from documents prepared by professional associations ("relative value guides"), which combine procedure-specific base value units with time units. R. Ex. 2, 3; Tr. at 532-533, 657-658, 1436, 1607-1608; 48 Fed. Reg. 8929 (1983).

45. To determine a fee for a specific procedure by utilizing such a formula, anesthesiologists identify the appropriate base value for the procedure and add that to time units derived from the actual time spent performing the procedure. The sum is then multiplied by a conversion factor to establish the fee. R. Ex. 2, 3; Tr. at 532-533, 657-658, 1436, 1607-1608; 48 Fed. Reg. 8929 (1983).

46. Where anesthesiologists base their charges on such formulas, Medicare carriers use the same method to determine reasonable charges for anesthesiology services. 48 Fed. Reg. 8929 (1983).

47. Effective October 1, 1983, Medicare allowed anesthesiologists to calculate reimbursement claims for their services and for the services of CRNAs employed and directed by them by charging one time unit for each 15 minute interval, or fraction thereof, of anesthesia time. 42 C.F.R. 405.553(b)(2).

48. Effective October 1, 1983, Medicare allowed anesthesiologists to calculate reimbursement claims for the services of CRNAs who were not employed by them, but which the anesthesiologists directed, by charging one time unit for each 30 minute interval, or fraction thereof, of anesthesia time. 42 C.F.R. 405.553(c).

49. Effective October 1, 1983, the time for which anesthesiologists were permitted to claim time units for anesthesia services was defined to begin when the physician or CRNA began to prepare the patient for induction of anesthesia, and to end when the patient was safely placed under post-operative supervision and the physician or CRNA was no longer in attendance. 42 C.F.R. 553(b)(2), (c).

50. Respondents became aware of the Medicare anesthesia reimbursement criteria adopted pursuant to TEFRA in May, 1984. Tr. 1124, 1223.

51. Respondents informed Blue Cross that the mailing address for Respondent AA was that of their billing clerk, Donna Elliot Henderson (then Donna Elliot). Tr. at 1116, 1123; R. Ex. 40; I.G. Ex. 1-1 - 211-1, 215.

52. Ms. Henderson received and maintained in her office a copy of the BC/BS Medicare Manual; she also received all Blue Cross communications for Respondents. Tr. at 1118, 1184-1185; I.G. Ex 215.

53. When Ms. Henderson received a Medicare communication relating to reimbursement for anesthesia, she would make copies and make sure that each member of AA got a copy of the communication. Tr. at 1119.

54. It was Ms. Henderson's responsibility to complete Medicare claim forms on behalf of Respondents and to submit them to Blue Cross. Tr. at 1118, 1120, 1184, 1683-1684.

55. All 211 Medicare claims at issue were presented by Ms. Henderson on Respondents' behalf on "HCFA 1500" claim forms. Stip. C-99 16; I.G. Ex. 277.

56. By signing the "HCFA 1500" claim form, the provider attests that the services were medically indicated and necessary and were personally rendered by the provider or by the provider's employee under his personal supervision. I.G. Ex. 277.

57. Ms. Henderson prepared Medicare claims based on instructions she received from Respondents. Tr. at 1125-1126, 1128-1129, 1132-1133, 1134, 1135-1138, 1139-1140, 1141-1142, 1149, 1153-1154, 1157, 1220, 1698-1700, 1706.

58. Respondents' practice in preparing Medicare billing instructions for Ms. Henderson was to have the

anesthesiologist or CRNA primarily responsible for providing anesthesia in a given case list the pertinent billing information, including the specific procedures for which reimbursement was claimed, the base units, and the time units on a hospital "charge slip" (a copy of the face sheet of the patient's medical record). Tr. at 1698.

59. The billing instructions would then be brought to an office used by AA at the hospital and, if the services were not rendered by an AA partner, the sheet would be reviewed by a partner who would calculate the dollar amount of the claim and write that amount on the "charge slip." Tr. at 1699-1700, 1796-1797.

60. Ms. Henderson would pick up the completed billing instructions and prepare patient ledger cards and Medicare claim forms based on the information contained in the billing instructions. Tr. at 1225, 1698.

61. In preparing claims, if Ms. Henderson knew a particular code that Blue Cross used to describe a particular procedure, she would write that code in the "code box" on the claim form for the procedure for which reimbursement was claimed. Tr. at 1120.

62. If Ms. Henderson did not know the code, she would not write anything in the "code box" on the claim form. Tr. at 1120.

63. If Blue Cross later assigned a code to the procedure, Ms. Henderson would thereafter use that code for all subsequent claims for that procedure. Tr. at 1120.

64. If Blue Cross had questions about information in a claim, Ms. Henderson would answer the questions based on information contained in the patient ledger cards or, when the cards did not contain the information she needed, based on Respondents' answers to inquiries which she would direct to them. I.G. Ex. 217-1 through 217-9; Tr. 1138-1142.

65. The claims contained in counts 1, 11, 14-16, 21, 25-47, 49-54, 56-120, 201-204, 206, 207, 210, and 211 state that the anesthesia items or services for which reimbursement was claimed were provided by an anesthesiologist. I.G. Ex. 1-1 - 11-1, 14-1 - 16-1, 21-1, 25-1 - 47-1, 49-1 - 54-1, 56-1 - 120-1, 201-1 - 204-1, 206-1, 207-1, 210-1, 211-1.

66. The claims contained in counts 48 and 55 imply that the anesthesia items or services for which reimbursement was claimed were provided by an anesthesiologist. I.G. Ex. 48-1, 55-1.

67. The anesthesia items or services for which reimbursement was claimed in the claims contained in counts 1, 11, 14-16, 21, 25-105, 107-120, 201-204, 206, and 210 were principally provided by CRNAs and not by anesthesiologists. Findings 68-80.

68. At DMGH, the operating room record is the document that would most reliably identify the anesthesia person who was principally responsible for administering anesthesia in a given case. Tr. 613-616, 635, 748-749, 751-753, 765-768, 770-771, 1084-1085. I.G. Ex. 229, 234-2.

69. Operating room personnel at DMGH were instructed to record on the operating room record the names of all persons in attendance at any operation. Tr. at 610-613, 748-753.

70. Records prepared by operating room personnel were prepared contemporaneously with surgery. Tr. at 610-615, 635-638.

71. The names of the individuals principally responsible for providing services during surgery were recorded on the operating room record. Tr. at 1057, 1071.

72. The name of the person who had primary responsibility for performing anesthesia services during surgery would be recorded first on the "Anesthetist" line of the operating room record. Tr. at 1085.

73. Operating room records for procedures occurring prior to May 4, 1984, in claims for anesthesia at issue in these cases, with few exceptions, show only CRNAs as having provided the anesthesia. I.G. Ex. 1-2 - 41-2.

74. Beginning May 4, 1984, most operating room records list the name of an CRNA first on the "Anesthetist" line, followed by the name of an anesthesiologist. I.G. Ex. 42-2 - 209-2.

75. Operating room personnel were instructed to add the name of the anesthesiologist to the operating room record after the name of the CRNA who performed the anesthesia

in order to demonstrate that supervision was being provided. Tr. at 617-620, 1060, 1076-1077.

76. Operating room personnel were instructed to add the name of an anesthesiologist, regardless of whether an anesthesiologist actually was present during surgery. Finding 75. Tr. at 617-620, 1060.

77. Operating room records establish that the primary provider of anesthesia items or services for which reimbursement was claimed in the claims contained in counts 1, 11, 14-16, 21, 25-105, 107-120, 201-204, and 206 was a CRNA. I.G. Ex. 1-2, 11-2, 14-2 - 16-2, 21-2, 25-2 - 105-2, 107-2 - 120-2, 201-2 - 204-2, 206-2.

78. The claim contained in count 210 is for emergency anesthesia services. I.G. Ex. 210-1.

79. The anesthesia items or services for which reimbursement was claimed in the claim contained in count 210 were provided by a CRNA and not by an anesthesiologist. I.G. Ex. 210-2; Tr. at 1635-1645.

80. Respondents' anesthesia records are not a reliable indicator of the personnel who were primarily responsible for providing anesthesia. Findings 81-83.

81. Names of anesthesia personnel were frequently added to anesthesia records in the DMGH records department days or longer after surgery took place. Tr. at 1800.

82. Anesthesia records were often signed or stamped in large groups. I.G. Ex. 277/3.

83. The anesthesiologist signing a particular anesthesia record may not have participated in the case documented by that record. I.G. 277/3.

84. The claims contained in counts 1, 11, 14-16, 21, 25-105, 107-120, 201-204, 206 and 210 are reimbursement claims for items or services which were not provided as claimed. Findings 65-83.

85. The I.G. failed to prove that the claims for items or services contained in counts 106, 207, and 211 were not provided as claimed. Findings 86-89.

86. The operating room record which documents the anesthesia items or services claimed in count 106 does

not establish that a CRNA was the primary provider of anesthesia. I.G. Ex. 106-2.

87. The operating room record which documents the anesthesia items or services claimed in count 207 is illegible and does not establish that a CRNA was the primary provider of anesthesia. I.G. Ex. 207-2.

88. The claim contained in count 211 is not for anesthesia performed during surgery. I.G. Ex. 211-1.

89. Although treatment records, generated in the case for which count 211 claims reimbursement for anesthesia items or services do not specifically describe anesthesia services, Respondent Quam credibly testified that such items or services had been provided. Tr. at 1391-1395.

90. Claims in counts 2-10, 12, 13, 17-20, 22-24, 205, 208, and 209 represent that anesthesia services were provided by CRNAs employed by Respondent AA. I.G. Ex. 2-1 - 10-1, 12-1, 13-1, 17-1 - 20-1, 22-1 - 24-1, 205-1, 208-1, and 209-1, 217-4, 217-6.

91. The claims contained in counts 2-10, 12, 13, 17-20, 22-24, 205, 208, and 209 are for items or services which were not provided as claimed. Findings 92-116.

92. The items or services for which reimbursement was claimed for the claims contained in counts 2-10, 12-13, 17-20, 22-24, 205, 208, and 209 were provided by CRNAs retained by Respondent AA. I.G. 2-1 and 2 - 10-1 and 2, 12-1 and 2, 13-1 and 2, 17-1 and 2 - 20-1 and 2, 22-1 and 2 - 24-1 and 2, 205-1 and 2, 208-1 and 2, 209-1 and 2.

93. Under applicable Medicare regulations, a CRNA is "employed" by an anesthesiologist for the purpose of determining appropriate reimbursement for the CRNA's services, where the anesthesiologist retains substantial control over the details of the performance of the CRNA's work. 42 C.F.R. 405.553(b)(3).

94. Respondents retained minimal control over the performance of work by CRNAs who were retained by Respondent AA. Findings 95-99.

95. In at least some cases involving anesthesia provided by Respondents, CRNAs provided anesthesia without the presence of, or supervision by, an anesthesiologist. I.G. Ex. 221/1, 227/2.

96. Physicians who were partners in AA or retained by AA did not closely supervise the rendering of anesthesia services by CRNAs that AA retained. I.G. Ex. 223-1, 224, 225, 226, 227; Tr. at 1239-1244, 1250-1251.

97. Physicians who were partners in AA or retained by AA did not schedule the work to be performed by CRNAs. Tr. at 1242, 1704.

98. Respondent AA did not promulgate written work or performance standards for the CRNAs it retained. Tr. at 1791-1792.

99. CRNAs retained by AA were retained to perform the same anesthesia services as were provided by physicians. I.G. Ex. 22.

100. CRNAs retained by AA were extensively trained and highly skilled professionals. R. Ex. 8; Tr. at 1662-1663; 1669-1671; 1675-1680.

101. Respondent AA retained the services of CRNAs to provide anesthesia at DMGH. Finding 102.

102. During the period December 10, 1982 through October 18, 1985, the following CRNAs worked for Respondent AA: Berg, Caputo, Franzen, Hunt, McDonough, Nelson, Nichols, and Topp. I.G. Ex. 1-1 and 2 through 211-1 and 2.

103. Respondent AA entered into independent contractor agreements with some of the CRNAs it retained. I.G. Ex. 223-1, 223-3, 225, 280, 290; Tr. at 1689.

104. Respondent AA's independent contractor agreements with CRNAs expressly provided that CRNAs were not employees. I.G. Ex. 223-3, 280, 290.

105. CRNAs retained by Respondent AA considered themselves to be independent contractors, not employees. I.G. Ex. 223-1, 224, 225, 226.

106. Respondent AA had the same contractual and working relationship with all of the CRNAs it retained as with those who executed the independent contractor agreement. Tr. at 1692.

107. Under Iowa law, a CRNA may provide anesthesia services without supervision by a physician. Tr. at 1680-1681.

108. Respondent AA did not issue federal W-2 forms for the CRNAs it retained. Tr. at 1791.

109. Respondent AA did not pay the professional dues or malpractice insurance for the CRNAs it retained. I.G. Ex. 223-3, 280, 290.

110. Respondent AA did not withhold federal income taxes for its CRNAs, and did not make contributions to Social Security on behalf of these CRNAs. Tr. at 915, 1790-1791.

111. Some of the CRNAs retained by Respondent AA were made partners in Respondent AA. Tr. at 1682, 1686, 1789.

112. Respondent AA compensated its partner CRNAs based on a share of the profits. IG. Ex. 222; Tr. at 1690, 1790.

113. The partner CRNAs shared in the expenses of the partnership. I.G. Ex. 222; Tr. at 1696.

114. Respondent AA did not prohibit its CRNAs from performing anesthesia services for other providers when not performing those services for Respondent AA. Tr. at 1616.

115. CRNAs retained by Respondent AA were not "employed" within the meaning of relevant Medicare reimbursement regulations. Findings 93-114.

116. Respondents' assertions caused Blue Cross to reimburse Respondents in false claims contained in counts 1-105, 107-206, and 208-210 as if services had been provided by anesthesiologists or by CRNAs employed by anesthesiologists. I.G. Ex. 237-1.

117. Respondents' false assertions in claims contained in counts 1-105, 107-206, and 208-210 resulted in substantial overpayments by Blue Cross to Respondents. Findings 90-116.

118. Claims contained in counts 121 through 200 are for items or services which Respondents presented or caused to be presented for anesthesia services in coronary artery bypass or other cardiac surgery. Stip. C-99 16, I.G. Ex. 121-1 - 200-2.

119. Items or services listed in counts 121-200 were not provided as claimed. Findings 120 - 147.

120. Respondents claimed reimbursement in the claims listed in counts 121-165, 167, and 174-200 for a specific procedure, in addition to the base anesthesia charge, which they described as "pump monitoring." I.G. Ex. 121-1 - 165-1, 167-1, 174-1 - 200-1.

121. The inclusion of the term "pump monitoring" in claims would lead a reasonable person to believe that Respondents were claiming reimbursement, in addition to their base anesthesia charge, for the monitoring of a pump used during surgery, such as a heart-lung machine. Tr. at 430, 432-436.

122. Respondents did not monitor a heart lung machine or other similar pump in surgeries for which they presented or caused to be presented claims for "pump monitoring." Tr. at 436-441, 1260-1261, 1300.

123. The term "pump monitoring" did not accurately describe any items or services which Respondents rendered. Tr. at 907, 1260-1261; See Tr. at 900-901.

124. In claims listed in counts 146-165 and 196-199, Respondents further described the "pump monitoring" service, for which they were claiming reimbursement, with the code designation "K3798." I.G. Ex. 146-1 - 165-1, 196-1 - 199-1.

125. The code designation "K3798" corresponds with a procedure code designation which appears in the Blue Cross Claims Coding Manual, used internally by Blue Cross to process claims. Tr. at 98-99; I.G. Ex. 273.

126. The code designation "K3798" is described in the Blue Cross Claims Coding Manual as "perfusion technique performed in conjunction with open heart surgery." I.G. Ex. 273.

127. The inclusion of the code designation "K3798" in claims would lead a reasonable person to believe that Respondents were claiming reimbursement for perfusion services in addition to their base anesthesia charge. Tr. at 432-436.

128. Respondents did not render perfusion services in surgeries for which they presented or caused to be presented claims bearing the code designation "K3798." Tr. at 436-441, 1260-1261, 1300.

129. The code designation "K3798" did not accurately describe any items or services which Respondents rendered. Tr. at 907-908; See Tr. at 900-901.

130. Respondents claimed reimbursement in the claims listed in counts 166 and 168-173 for a specific procedure, in addition to the base anesthesia charge, which they described as "recording & monitoring of intracardiac pressures heart lung machine EKG arterial & central venous pressures cardiac output measurements." I.G. Ex. 166-1, 168-1 - 173-1.

131. The procedure description "recording & monitoring of intracardiac pressures heart lung machine EKG arterial & central venous pressures cardiac output measurements" did not accurately describe items or services which Respondents rendered. Tr. at 901-902.

132. In the claims listed in counts 121, 167, and 174, Respondents represented that two anesthesiologists were "needed at all times" during the surgery to perform "pump monitoring" and other procedures. I.G. Ex. 121-1, 167-1, 174-1.

133. Two anesthesiologists were not present at all times to render items or services for which Respondents presented the claims listed in counts 121 and 167. I.G. Ex. 121-2, 167-2, 174-2.

134. Respondents represented in the claims listed in counts 166 and 172 that the services of two anesthesiologists were needed for "recording & monitoring of intracardiac pressures heart lung machine EKG arterial & central venous pressures cardiac output measurements." I.G. Ex. 166-1, 172-1.

135. A second anesthesiologist did not perform the "recording & monitoring of intracardiac pressures heart lung machine EKG arterial & central venous pressures cardiac output measurements" described in counts 166 and 172. I.G. Ex. 166-2, 172-2.

136. Respondents represented in the claims listed in counts 167 through 171 that the services of two anesthesiologists were "needed at all times" to perform "recording & monitoring of intracardiac pressures heart lung machine EKG arterial & central venous pressures cardiac output measurements." I.G. Ex. 167-1, 168-1, 169-1, 170-1, 171-1.

137. Two anesthesiologists were not present at all times to render items or services for which Respondents presented the claims listed in counts 167 through 171. I.G. Ex. 167-2, 168-2, 169-2, 170-2, 171-2.

138. Respondents represented in the claims listed in counts 122-144 and 175-195 that "pump monitoring" had been performed by a second anesthesiologist. I.G. Ex. 122-1 - 144-1, 175-1 - 195-1.

139. Two anesthesiologists were not present to render items or services for which Respondents presented the claims represented by counts 122-144 and 175-195. I.G. Ex. 122-2 - 144-2, 175-2 - 195-2.

140. Respondents represented in the claims listed in counts 136, 137, and 139 that Respondent Loerke, along with another anesthesiologist, provided the items or services for which reimbursement was claimed. I.G. Ex. 136-1, 137-1, 139-1.

141. Respondent Loerke did not provide the items or services for which reimbursement was claimed in the claims listed in counts 136, 137, and 139. I.G. Ex. 136-2, 137-2, 139-2.

142. Respondents represented in the claim listed in count 138 that Respondent Quam, along with another anesthesiologist, provided the items or services for which reimbursement was claimed. I.G. Ex. 138-1.

143. Respondent Quam did not provide the items or services for which reimbursement was claimed in the claim listed in count 138. I.G. Ex. 138-2.

144. Items or services for which Respondents claimed reimbursement in the claims listed in counts 136-139 were provided by an anesthesiologist and by a CRNA. I.G. Ex. 136-2 - 139-2.

145. Respondents certified in the claims listed in counts 142-144, 148-157, 194-195, and 198 that the items or services for which reimbursement was claimed had been personally provided by named anesthesiologists. I.G. Ex. 142-1 - 144-1, 148-1 - 157-1, 194-1 - 195-1, 198-1.

146. For each of the claims listed in counts 142-144, 148-157, 194-195, and 198, one of the anesthesiologists who Respondents certified as having personally performed the items or services did not perform any items or

services for which reimbursement was claimed. I.G. Ex. 142-2 - 144-2, 148-2 - 157-2, 194-2 - 195-2, 198-2.

147. For each of the claims listed in counts 142-144, 148-157, 194-195, and 198, the items or services were performed either by one anesthesiologist, or by an anesthesiologist and a CRNA. I.G. Ex. 142-2 - 144-2, 148-2 - 157-2, 194-2 - 195-2, 198-2.

148. Respondents did not prove that were entitled to be reimbursed for the items or services for which they were claiming reimbursement as "pump monitoring" or "recording and monitoring of intracardiac pressures heart lung maching EKG atrerial & central venous pressures cardiac output measurements." Findings 149-150.

149. Respondents did not prove that, in the claims contained in counts 121 through 200, they rendered services in addition to anesthesia services for which they were entitled to be reimbursed. See I.G. Ex. 121-2 - 200-2.

150. Respondents did not prove that the monitoring and evaluating they performed in the cases for which they claimed reimbursement, in counts 121-200, consisted of anything other than monitoring of essential functions within the base units for anesthesia in the formula they used to claim reimbursement. See R. Ex. 2/1 and Tr. at 1299.

151. Respondents' false assertions in claims contained in counts 121-200 caused Blue Cross to reimburse Respondents for perfusion services. I.G. Ex. 237-2.

152. Respondents' false assertions contained in counts 121-200 resulted in substantial overpayments by Blue Cross to Respondents. Findings 118-151.

153. A person "knows" that an item or service is not provided as claimed within the meaning of the Act when he or she knowingly presents or causes to be presented false claims.

154. A person has reason to know that an item or service is not provided as claimed where he or she is a provider of items or services and: (1) the provider had sufficient information to place him, as a reasonable medical provider, on notice that the claims presented were for services not provided as claimed, or (2) there were pre-existing duties which would require a provider

to verify the truth, accuracy, and completeness of claims.

155. A person "should know" that an item or service is not provided as claimed, within the meaning of the Act, where: (1) that person has reason to know that items or services were not provided as claimed; or (2) is negligent in preparing and submitting, or in directing the preparing and submitting of, claims.

156. Respondents knew that the items or services for which reimbursement was claimed in the claims contained in counts 1-120 and 201-210 were primarily provided by CRNAs and not by anesthesiologists. I.G. Ex. 1-2 - 120-2; 201-2 - 210-2.

157. Respondents directed their billing agent to state in claims contained in counts 1, 6, 11, 14, 15, 16, 21, 25-47, 49-54, 56-105, 107-120, 201-206, and 210 that the items or services for which reimbursement was being claimed had been provided by an anesthesiologist. Tr. at 1127-1129, 1157-1159, 1167, 1171-1179.

158. Respondents knew that items or services in claims contained in counts 1, 6, 11, 14-16, 21, 25-47, 49-54, 56-105, 107-120, 201-206, and 208-210 were not provided as claimed. Findings 156-157.

159. Respondents knew that two anesthesiologists were not present at all times to provide the "pump monitoring" services for which they were claiming reimbursement in the claims listed in counts 121, 167, and 174. I.G. Ex. 121-2, 167-2, 174-2.

160. Respondents knew that the services of two anesthesiologists were not needed to perform "recording & monitoring of intracardiac pressures heart lung machine EKG arterial & central venous pressures cardiac output measurements," as claimed in the claims listed in counts 166 and 172. I.G. Ex. 166-2, 172-2.

161. Respondents knew that the services of two anesthesiologists were not needed at all times to perform "recording & monitoring of intracardiac pressures heart lung machine EKG arterial & central venous pressures cardiac output measurements" as claimed in the claims listed in counts 167-171. I.G. Ex. 167-2 - 171-2.

162. Respondents knew that a second anesthesiologist was not present during surgery to perform "pump monitoring"

as claimed in the claims listed in counts 122-144 and 175-195. I.G. Ex. 122-2 - 144-2, 175-2 - 195-2.

163. Respondents instructed their agent to state that two anesthesiologists were needed to provide the services for which reimbursement was claimed in the claims contained in counts 121-144, 166-172, and 175-195. Tr. at 1133, 1135-1136.

164. Respondents knew that claims for items or services contained in counts 121-144, 166-172, and 175-195, which claimed that two anesthesiologists had provided the services, were not provided as claimed. Findings 164-165.

165. Respondents directed their billing agent to state, in claims contained in counts 2, 3, 4, 5, 7-12, 13, 17-20, 22-24, 205, and 208-209, that anesthesia services for which reimbursement was claimed had been provided by a CRNA who was employed by Respondent AA. I.G. Ex. 217-4, 217-6; Tr. at 1127-1129, 1157-1159, 1167, 1171-1179.

166. Prior to May, 1984, Respondents knew that CRNAs must be employed and supervised by them in delivering anesthesia in order for Respondents to claim reimbursement from Medicare for CRNAs' services. I.G. Ex. 214-1 - 214-2, 214-4 - 214-6, 214-8; Tr. at 1817.

167. Beginning in May, 1984, Respondents knew that CRNAs must be employed by them in order for Respondents to claim reimbursement from Medicare for CRNAs' services based on 15 minute time units. I.G. Ex. 214-9; Tr. at 1122, 1740-1743; 42 C.F.R. 405.552-553.

168. Beginning in May, 1984, Respondents knew that CRNAs must comply with regulatory requirements in order for Respondents to claim reimbursement from Medicare for CRNAs' services. I.G. Ex. 214-9; Tr. at 1122, 1740-1743; 42 C.F.R. 405.552-553.

169. Beginning in May, 1984, Respondents knew that Blue Cross defined "employment" of CRNAs to mean that the employer issues W-2 forms to CRNAs working for him. I.G. Ex. 214-9; Tr. at 1122, 1740-1743.

170. Both prior and subsequent to May, 1984, Respondents knew that agreements entered into between Respondent AA and CRNAs specifically characterized the relationship with the CRNAs as an "independent contractor" relationship and specifically disavowed that an

employment relationship existed. I.G. Ex. 223-3, 225, 280, 290. Findings 103-115.

171. Both prior and subsequent to May, 1984, Respondents were aware of the terms and conditions pursuant to which Respondent AA had contracted with CRNAs. I.G. Ex. 223-3, 225, 280, 290; Findings 103-115.

172. Both prior and subsequent to May, 1984, Respondents knew that Respondent AA did not issue W-2 forms to CRNAs with whom it had contracted. Tr. at 1791; Finding 108.

173. Both prior and subsequent to May, 1984, Respondents knew that Respondent AA had not withheld federal income taxes for the CRNAs with whom it contracted. Tr. at 915, 1790-1791; Finding 110.

174. Respondents knew that Blue Cross had directed inquiries to them concerning the employment status of CRNAs with whom Respondent AA had contracted. I.G. Ex. 217-4, 217-6.

175. Respondents answered these without asking Blue Cross for guidance as to what what Blue Cross meant by the term "employed." I.G. Ex. 217-4; 217-6.

176. Respondents instead simply informed Blue Cross that the CRNAs were employed by them. I.G. Ex. 217-4, 217-6.

177. Respondents did not know whether the CRNAs with whom Respondent AA had contracted were "employed," within the meaning of relevant Medicare reimbursement criteria. See I.G. Ex. 214-9.

178. Respondents' knowledge of Medicare reimbursement criteria, coupled with their knowledge of Respondent AA's relationship with the CRNAs with whom it had contracted and their knowledge that Blue Cross had made inquiries concerning the employment status of those CRNAs, placed Respondents under a duty to learn whether the CRNAs were "employed," within the meaning of Medicare reimbursement requirements, before Respondents claimed reimbursement from Medicare for CRNAs' services as if they were employed. Findings 38, 43, 50, 94-114, 174.

179. Respondents failed to make reasonable investigation to determine whether the CRNAs with whom Respondent AA had contracted were "employed" within the meaning of Medicare reimbursement requirements, before Respondents

claimed reimbursement from Medicare for CRNAs' services as if they were employed. Findings 174-177.

180. Respondents had reason to know that items or services in claims contained in counts 2-5, 7-13, 17-20, 22-24, 205, and 208-209 were not provided as claimed. Findings 165-179.

181. Respondents knew that the phrase "recording & monitoring of intracardiac pressures heart lung machine EKG arterial & central venous pressures cardiac output measurements," which they used to describe items or services for which they were claiming reimbursement from Medicare in the claims listed in counts 166 and 168-173, did not accurately describe services for which they were claiming reimbursement. Tr. at 901-903.

182. Respondents directed their billing agent to present claims for "recording & monitoring of intracardiac pressures heart lung machine EKG arterial & central venous pressures cardiac output measurements" in the claims contained in counts 166 and 168-173. Tr. at 1133.

183. Respondents knew that items or services in claims contained in counts 166 and 168-173 were not provided as claimed. Findings 181-182.

184. Respondents knew that the term "pump monitoring," which they used to describe items or services for which they were claiming reimbursement from Medicare in the claims listed in counts 121-165, 167, and 174-200, did not accurately describe services for which they were claiming reimbursement. Tr. at 1299-1300; Findings 122-123.

185. Respondents provided their billing agent with information which led her to claim reimbursement on Respondents' behalf in the claims listed in counts 121-165, 167, and 174-200. Tr. at 1134.

186. Respondents' knowledge that they were providing their billing agent with inaccurate descriptions of services for which they were claiming reimbursement placed them under a duty to assure that their agent did not place these inaccurate descriptions on the claims which she prepared on Respondents' behalf. Findings 184-185.

187. Respondents had reason to know that items or services in the claims listed in counts 121-165, 167, and 174-200 were not provided as claimed. Findings 184-186.

188. Respondents did not know what meaning Blue Cross ascribed to the code designation "K3798," which Respondents' agent used on the "pump monitoring" claims contained in counts 146-165 and 196-199. Tr. at 1137.

189. Respondents' agent knew that Blue Cross used the code designation "K3798" to identify a procedure for which it was authorizing reimbursement. Tr. at 1137.

190. Respondents did not know that their agent included the code designation "K3798" to reimburse claims for "pump monitoring" in the claims contained in counts 146-165 and 196-199. Tr. at 1137.

191. Respondents' knowledge that the "pump monitoring" terminology they were providing to their agent was false placed them under the duty to prevent ancillary falsehoods from being made on their behalf by their agent. Findings 184.

192. Respondents had reason to know that claims containing the code designation "K3798" were for items or services that were not provided as claimed.

193. Respondents should have known that the items or services for which they claimed reimbursement in counts 1-105, 107-206, 208-210 were not provided as claimed.

194. The Act provides for the imposition of a penalty of up to $2,000.00 for each item or service falsely claimed and an assessment of up to twice the amount claimed for each item or service falsely claimed. Social Security Act section 1128A(a).

195. The Act and regulations directs the Secretary or his or her delegate, in determining the amount or scope of any penalty or assessment imposed, to take into account both aggravating and mitigating factors. Social Security Act, Section 1128A(d). 42 C.F.R. 1003.106.

196. Factors which may be considered as aggravating or mitigating include: the nature of the claims and the circumstances under which they were presented; the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims;

and such other matters as justice may require. Social Security Act, Section 1128A(d). 42 CFR 1003.106.

197. The Act has been interpreted to permit the imposition of a penalty and assessment which exceeds the amount actually reimbursed to a respondent for items or services not provided as claimed.

198. If there are substantial or several aggravating circumstances, the aggregate amount of the penalty and assessment should be set at an amount sufficiently close to, or at, the maximum permitted by law, so as to reflect that fact. 42 C.F.R. 1003.106 (c)(2).

199. Neither the law or regulations provide for the maximum exclusion which may be imposed. However, the regulations provide that the length of the exclusion should be determined by the same criteria as employed to determine the appropriate amount of the penalty and assessment. 42 C.F.R. 1003.107.

200. In proceedings brought pursuant to the Act, the I.G. has the burden of proving, by a preponderance of the evidence, that a respondent presented, or caused to be presented, claims for items or services which the respondent knew or should have known were not provided as claimed. 42 C.F.R. 1003.114(a).

201. In proceedings brought pursuant to the Act, the I.G. has the burden of proving the existence of any aggravating factors. 42 C.F.R. 1003.1149(a).

202. In proceedings brought pursuant to the Act, a respondent has the burden of proving the existence of any mitigating factors. 42 C.F.R. 1003.114(c).

203. Respondents presented, or caused to be presented, claims over a lengthy period of time, nearly three years, for items or services which were not provided as claimed. Findings 18, 84, 91, and 119.

204. Respondents presented, or caused to be presented, a substantial number of claims for items or services, 211 in all, which were not provided as claimed. Findings 18, 84, 91, 119.

205. The total dollar value of Respondent's claims for reimbursement in the 208 false claims was nearly $100,000 I.G. Ex. 237-1; 237-2.

206. The items or services not provided as claimed comprised only a portion of the total $100,000 and did not exceed $25,000.

207. It is a mitigating circumstance that a substantial portion of the total dollar value of the $100,000 in claims for reimbursement were provided as claimed.

208. The items or services not provided as claimed were part of a pattern of false claims presented by Respondents. Findings 84, 91, 119, 156-162, 164-193.

209. The pattern of false claims by Respondents extended to Medicaid claims, which are not specifically the subject of the I.G.'s Notice letter, in which the Respondents routinely billed for CRNAs' services as if the CRNAs were employees of the anesthesiologists or as if anesthesiologists rendered the services. I.G. Ex. 265-272, Tr. 480-482, 489.

210. The fact that the claims at issue are part of a wider pattern of false claims is an additional aggravating factor.

211. The most serious aggravating factor is Respondents indifference to the truthfulness of their claims. Findings 174-177, 212-217.

212. Blue Cross frequently communicated with Respondents concerning their obligations as providers. I.G. Ex. 214-1 - 214-9.

213. Blue Cross made specific inquiries to Respondents concerning specific aspects of their claims. I.G. Ex. 217-1 - 217-9.

214. Respondents answered these inquiries without regard to the truthfulness of their responses or the reimbursement criteria which had been communicated to them. I.G. Ex. 214-1 - 214-9.

215. In using the language "pump monitoring" and "recording and monitoring of intracardiac pressures heart lung machine EKG arterial & central venous pressures cardiac output measurements," Respondents were not attempting to accurately state services which they were performing in addition to anesthesia, but rather were devising a formula by which they could convince Blue Cross to reimburse them above the base anesthesia charge. See Tr. at 901-902.

216. The practice of seeking reimbursements for "pump monitoring" and "recording and monitoring of intracardiac pressures heart lung machine EKG arterial & central venous pressures cardiac output measurements," continued until the perfusionist at DMGH complained to Respondents about having difficulty obtaining reimbursement from Medicare. Tr. at 432-434, 953-954.

217. Respondents informed Blue Cross that CRNAs were their employees because it was in their financial interest to do so. Tr., at 1742, 1817.

218. When Respondents thought it was in their financial interest, they informed Blue Cross that CRNAs were independent contractors, even though they had informed Blue Cross that they were their employees. I.G. Ex. 3-1 - 10-1, 12-1, 13-1, 17-1 - 24-1, 216-1.

219. The government incurred substantial costs in investigating, prosecuting, and trying these cases.

220. Respondents did not prove that the imposition against them of penalties in the amount of $208,000.00 and assessments in the amount of $50,000.00 would jeopardize their ability to continue as health care providers.

221. Respondents did not prove that misrepresentations contained in the 211 false claims were harmless error.

222. Penalties totalling $208,000.00 and assessments totalling $50,000.00, for a total of $258,000.00, are appropriate in this case.

223. Respondents AA, Loerke, Loerke, P.C., Nelson, Nelson, P.C., McDonough, and McDonough, P.C., are jointly and severally liable for penalties of $208,000 and assessments of $50,000.00, for a total of $258,000.

224. Respondents Barnett and Barnett, P.C. are jointly and severally liable for penalties not to exceed $118,857.00 and assessments not to exceed $28,571.00, for a total not to exceed $147,428.

225. Respondents Quam and Quam, P.C. are jointly and severally liable for penalties not to exceed $83,200.00 and assessments not to exceed $20,000.00, for a total not to exceed $103,200.

226. Respondents Sykes and Sykes, P.C. are jointly and severally liable for penalties not to exceed $11,866.00 and assessments not to exceed $2,857.00, for a total not to exceed $14,723.

227. The aggregate dollar amount of penalties that the I.G. may collect from Respondents shall not exceed $208,000.00.

228. The aggregate dollar amount of assessments that the I.G. may collect from Respondents shall not exceed $50,000.00.

229. An exclusion against Respondents AA, Loerke, Loerke, P.C., Nelson, Nelson, P.C., McDonough, and McDonough, P.C. from participating in Medicare and State health care programs for a period of three years is appropriate in these cases.

230. An exclusion against Respondents Barnett, Barnett, P.C., Quam, and Quam, P.C. from participating in Medicare and State health care programs for a period of two years is appropriate in these cases.

ANALYSIS

1. I do not have authority to decide whether the Secretary lawfully delegated to the I.G. the duty to investigate alleged violations of section 1128A of the Social Security Act, to propose penalties, assessments, and exclusions pursuant to that section, and to represent the Secretary in hearings brought pursuant to that section.

Respondents contend that the Secretary's delegation of authority to the I.G. to conduct investigations pursuant to the Act, to propose penalties, assessments, and exclusions, and to represent the Secretary in hearings on such proposals is unlawful. They argue that the complaint and the proceedings against Respondents must, therefore, be dismissed.

Respondents assert that the Inspector General Act of 1978, Appendix 3 to 5 U.S.C. 9(a)(1)(F), provides that "program operating responsibilities" shall not be transferred by the respective agencies governed by the Act to their inspectors general. They contend that the delegation from the Secretary to the I.G. pursuant to section 1128A empowers the I.G. to conduct "regulatory

investigations," and they argue that such "regulatory investigations," including the investigation which led to issuance of the Deputy Inspector General's notice to Respondents, are "program operating responsibilities." Based on this analysis, they assert that the Secretary's delegation to the I.G. and any actions undertaken pursuant to that delegation are unlawful.

The I.G. argues that I am not empowered to make determinations regarding the propriety of the Secretary's delegations of authority under section 1128A. According to the I.G., the regulations implementing the Act define the scope and extent of administrative law judges' authority to conduct hearings pursuant to the Act, and these regulations do not authorize administrative law judges to make decisions concerning the propriety of the Secretary's delegations of authority.

The I.G. further contends that the regulations explicitly describe authorities vested by the Secretary in the I.G., and also prohibit administrative law judges from deciding the validity of these regulations. Therefore, according to the I.G., a decision by me concerning the lawfulness of the Secretary's delegations would be a decision concerning the validity of the regulations and would contravene the regulatory scope of my authority.

The I.G. argues, alternatively, that should I determine that I am empowered to review the Secretary's delegation of authority to the I.G., the delegation should be affirmed. He asserts that the delegation is consistent with the I.G.'s statutory mandate of authority. The I.G. argues further that Congress expressly approved the Secretary's delegation of authority under the Act. The I.G. asserts that the Secretary's delegation is not a delegation to conduct "regulatory investigations," and the investigation which led to the I.G.'s notice of proposed penalties, assessments, and exclusions was not a "regulatory investigation." He contends that even absent a finding that Congress had approved the delegation from the Secretary to the I.G., the delegation is not a delegation of a "program operating responsibility."

I conclude that I am not empowered to decide the lawfulness of the Secretary's delegation to the I.G. because regulations enacted pursuant to the Act proscribe administrative law judges from deciding the validity of the regulations, and the Secretary's delegation to the I.G. to act in exclusion cases is embodied in those

regulations. Therefore, I make no decision as to the merits of the arguments on this issue.[3]

The Act does not specifically prescribe who shall conduct hearings, and it does not describe the ambit of an administrative law judge's authority to hear and decide cases. However, regulations adopted to implement the Act do specifically address elements of the administrative law judge's hearing and decision authority. I am required to apply these regulations.

The regulations provide, at 42 C.F.R. 1003.111, that if a respondent requests a hearing, the case will be assigned to an administrative law judge for a hearing and decision. The regulations describe the issues which may be heard and the parties' respective burdens of proof as to those issues. 42 C.F.R. 1003.114. These regulations neither state nor suggest that the issues which may be considered include questions concerning the lawfulness of the Secretary's delegations of authority. However, the regulations provide, at 42 C.F.R. 1003.115(c), that the administrative law judge "does not have the authority to decide upon the validity of Federal statutes or regulations."

The regulations also specifically describe many of the authorities delegated to the I.G. by the Secretary pursuant to the Act. The regulations authorize the I.G. to impose penalties, assessments, and exclusions. 42 C.F.R 1003.102. They authorize the I.G. to implement statutory provisions concerning the amounts of penalties and assessments. 42 C.F.R. 1003.103-104. The regulations also establish criteria to be followed by the I.G. in determining the appropriate length of exclusions to be imposed pursuant to the Act. 42 C.F.R. 1003.107. The regulations empower the I.G. to serve notices of proposed determinations and to represent the Secretary in hearings requested pursuant to the Act. 42 C.F.R. 1003.109, 1003.112.

A decision by me as to the lawfulness of the Secretary's delegation to the I.G. would necessarily encompass a determination of the validity of the aforesaid regulations. This would directly contravene the proscription against administrative law judges deciding

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[3] I make no finding as to Respondents' rights to challenge the lawfulness of the Secretary's delegations or enabling regulations on appeal.

the validity of federal regulations contained in 42 C.F.R. 1003.115(c).[4]

2. Respondents presented or caused to be presented claims for items or services which they knew, had reason to know, or should have known were not provided as claimed, in violation of Section 1128A of the Social Security Act.

The heart of these cases is whether Respondents presented or caused to be presented claims in violation of the Act. I conclude that the I.G. proved by a preponderance of the evidence that Respondents unlawfully presented or caused to be presented 208 of the 211 claims at issue.

In order to prove a violation of the Act, the I.G. must establish by a preponderance of the evidence that three elements are present. First, the I.G. must prove that a respondent presented or caused to be presented reimbursement claims for the items or services at issue. Second, he must establish that the items or services were not provided as claimed. Finally, the I.G. must prove that a respondent "knew" or "should know" that the items or services were not provided as claimed. Social

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[4] Petitioners in Medicare and Medicaid exclusion cases brought pursuant to section 1128 of the Social Security Act have raised arguments concerning the lawfulness of the Secretary's delegation of authority to the I.G. to act on the Secretary's behalf in exclusion cases. Administrative law judges are not empowered in exclusion cases to decide the lawfulness of the Secretary's delegation to the I.G. Jack W. Greene v. The Inspector General, Docket No. C-56 (1989) appeal docketed, DAB No. 89-59, Decision No. 1078 (1989). Sections 1128 and 1128A of the Social Security Act are closely related. However, at present, regulations implementing the two sections differ in some respects. Regulations adopted pursuant to section 1128 do not contain the proscriptions contained in 42 C.F.R. 1003.115(c). See 42 C.F.R. 1001.1 et seq. The Greene decision was premised on the fact that exclusion regulations neither explicitly nor impliedly authorize administrative law judges to make decisions concerning the validity of the Secretary's delegation.

Security Act, section 1128A(a)(1)(A); 42 C.F.R. 1003.102, 1003.114(a).[5]

There is no dispute in this case that Respondents presented or caused to be presented for reimbursement the 211 claims for items or services at issue.[6] The parties dispute whether the items or services were provided as claimed, and whether Respondents knew, had reason to know, or should have known that the items or services were not provided as claimed.

The cases involve two distinct types of claims which Respondents presented or caused to be presented for Medicare reimbursement. The first group (counts 1-120 and 201-211) consists of 131 claims for anesthesia services rendered by Respondents between January, 1984 and January, 1985. The second group (counts 121-200) consists of 80 claims for services rendered by Respondents during coronary artery bypass graft and other

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[5] The I.G. requested that I decide whether Respondents had "reason to know" that the 211 claims for items or services at issue were not provided as claimed. Prior to December 22, 1987, the Act's standard of liability for a party who filed a false claim was couched in terms of whether the party knew or had reason to know the item or service was not provided as claimed. On December 22, 1987, the "should know" standard was substituted for "reason to know," and Congress made this revision retroactive. However, no court has decided the validity of Congress' retroactive application of the "should know" standard to claims for items or services. In light of this unresolved issue, I use the "knows" and "should know" standard of the 1987 revision, as well as the pre-revision "has reason to know" standard, to decide Respondents' liability.

[6] My conclusion takes into account the fact that not all Respondents were associated with Respondent AA at all relevant times during the case. Respondents Barnett and Barnett, P.C. left Respondent AA on August 1, 1984. Respondents Sykes and Sykes, P.C. did not provide services on any claim at issue in these cases prior to June 18, 1984. I do not find that any individual Respondent presented or caused to be presented reimbursement claims for services which were performed on dates when that Respondent was not affiliated with Respondent AA.

cardiac surgeries performed between December, 1982 and December, 1985.

I conclude that 208 of these 211 claims contain material misrepresentations of fact. Of the 131 anesthesia claims, 128 falsely assert that anesthesia services were provided either by an anesthesiologist or by a CRNA who was employed by Respondents.[7] In fact, anesthesia was provided in the cases represented by these claims by a CRNA who was not employed by Respondents. Medicare substantially overpaid Respondents for anesthesia services as a consequence of these misrepresentations.

The 80 claims in cardiac cases each falsely assert that Respondents provided services, in addition to anesthesia, for which they were entitled to reimbursement. These claims also contain false assertions that two anesthesiologists were necessary to perform the services for which reimbursement was claimed. Respondents' false assertions in these claims caused Medicare to reimburse Respondents thousands of dollars which Respondents were not entitled to receive.

These claims evidence a pattern by Respondents of willfully ignoring both Medicare reimbursement criteria and the facts of the cases for which they were claiming reimbursement, in order to maximize their reimbursement from Medicare. By their behavior, Respondents denied any duty to Medicare to honestly and accurately claim reimbursement for their services. They treated Medicare reimbursement requirements as obstacles to be hurdled on the pathway to remuneration.

It is not a necessary prerequisite to liability under the Act to find a pattern or scheme of false claims activity. Liability depends on findings that a respondent knew, had reason to know, or should have known that <u>individual</u> claims are false. However, if there is a pattern of claims activity in a particular case, that pattern may be significant in establishing a respondent's motivation and his level of culpability. That may, in turn, be important in determining what, if any, penalties, assessments, and exclusions should be imposed.
The conclusion I draw from Respondents' conduct is that they were determined to say to Medicare whatever they

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[7] I find that, with respect to the claims contained in counts 106, 207, and 211, the records relied on by the I.G. do not establish that the claims were false.

deemed to be necessary to maximize their reimbursement, without regard to the truthfulness of their statements. Their disregard of the program's reimbursement requirements and for the truth of their assertions borders on fraud.

a. Items or services were not provided as claimed.

i. Counts 1-120 and 201-211.

I conclude that 128 of these 131 claims are false in that they each misrepresent that services were provided, either by an anesthesiologist or by a CRNA employed by Respondent AA. The items or services on which these claims are based were, in fact, rendered by CRNAs who were not employed by Respondent AA. The I.G. failed to prove that three of the 131 claims (counts 106, 207 and 211) are false. The records relied on by the I.G. to support his contention that the claims contained in counts 106 and 207 are inconclusive. Findings 86-87. I accept as credible Respondents' explanation for the services claimed in count 211. Finding 89.

Nearly all of the 131 claims are for anesthesia rendered during surgeries.[8] Most of these claims represent that anesthesiologists provided the items or services for which reimbursement is claimed. Finding 65. Some represent that anesthesia was provided by CRNAs employed by Respondent AA. Finding 67.

The evidence which substantiates my conclusion that anesthesia in these cases was primarily provided by CRNAs, and not by anesthesiologists, consists of the operating room records prepared at DMGH by operating room personnel not affiliated with Respondents.[9] The testimony of these personnel, which I find to be credible

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[8] The exceptions are those claims contained in counts 210 and 211. The claim contained in count 210 is for emergency anesthesia. The claim contained in count 211 is for insertion of an IV line. I.G. Ex. 210-1 - 210-2, 211-1 - 211-2.

[9] The claim contained in count 210 was for an emergency. As the case which underlies count 210 did not involve surgery, no operating room record exists. However, the evidence establishes that in this case anesthesia was rendered by a CRNA and not by an anesthesiologist.

is that they were instructed to record the names of all persons in attendance at every operation. Finding 69. I am not satisfied that the operating room records which these personnel prepared were completely accurate -- the witnesses conceded that it was possible that individuals could enter the operating room during surgery, remain for a brief period, and leave without their names being recorded in the operating room records. But the witnesses agreed that the names of individuals who were principally responsible for providing services during surgery were recorded on the operating room record. Finding 71.

The operating room records which were created during the surgeries for which these claims sought reimbursement establish in every case that the principal anesthesia person was a CRNA. Records created prior to May 4, 1984, with few exceptions, show only CRNAs as having provided anesthesia.

Records created beginning May 4, 1984 show a CRNA as the first listed anesthesia provider, followed by an anesthesiologist. The presence of these anesthesiologists' names in the records does not detract from my conclusion that the CRNA whose name appears first on the operating room record in each of these claims is the individual who actually provided anesthesia. I find the inclusion of anesthesiologists' names on the operating room records beginning May 4 consistent with the testimony of operating room personnel that they were instructed to list the name of an anesthesiologist after the name of the CRNA who actually rendered anesthesia, whether or not the anesthesiologist was present, in order to demonstrate that supervision was being provided during surgeries. Finding 75.

Respondents argue that their anesthesia records are a more reliable indicator of the anesthesia personnel present during surgery and who actually rendered anesthesia than are the operating room records created by third parties. I conclude that the anesthesia records do not establish that the anesthesiologists who signed them or stamped them with their signatures actually rendered anesthesia.

The names of anesthesia personnel were often added to anesthesia records under circumstances which call into question the accuracy of the additions. Respondents conceded that they frequently signed anesthesia records after the fact. Signing of anesthesia records could

occur days or longer after the surgery took place. Signing did not occur in the operating room suite, but in the DMGH records department. Records were often signed or stamped in large groups. I.G. Ex. 227/3. The anesthesiologist signing a particular record may not have participated in the case documented by that record. Id. By contrast, the records prepared by operating room personnel were prepared contemporaneously with surgery.

Furthermore, the anesthesia records are, by and large, consistent with the operating room records in that they show that CRNAs were the primary providers of anesthesia. These records appear in the overwhelming majority of instances to have been prepared and signed by a CRNA whose name is listed in the operating room record. Signatures of anesthesiologists appear as additions to these records.

The I.G. also established inconsistencies between Respondents' assertions as to how they practiced anesthesia and Respondents' anesthesia records. For example, individual Respondents testified that, when anesthesiologists were assigned to perform open heart surgery, they would have no other anesthesia assignments which overlapped that surgery. Tr. at 1613-1614. However anesthesiologists' signatures on some records suggest that either this testimony is untrue or anesthesiologists signed records to indicate that they were present during surgeries when, in fact, they were not present. Tr. at 1654-1661.

Therefore, the preponderance of the evidence establishes that CRNAs were the principal providers of anesthesia for the claims in counts 1-105, 107-120, 201-206, and 208-210. Those claims which assert (counts 1, 6, 11, 14-16, 21, 26-47, 49-54, 56-105, 107-120, 201-206, and 208-210) or imply (counts 48 and 55) that anesthesiologists rendered the items or services for which reimbursement was claimed constitute claims for reimbursement for items or services which were not provided as claimed. In making this conclusion, I accept the possibility that in some of these claims anesthesiologists may have been present for short periods during surgery, may have actually provided some services, or may have in some respects directed the actions of CRNAs. But the claims represent that anesthesiologists rendered all of the claimed services, and that representation is false.

The CRNAs who rendered the anesthesia for which Respondents claimed reimbursement in these claims were

not "employed" by Respondents within the meaning of relevant Medicare reimbursement regulations. Thus, those claims which assert that anesthesia was rendered by CRNAs who were employees of Respondent AA (counts 2-10, 12-13, 17-20, 22-24, 205, 208, and 209) constitute claims for reimbursement for items or services which were not provided as claimed.

Medicare reimbursement regulations which became effective on October 1, 1983 provide for reimbursement for CRNAs' services where the CRNAs are "employed" by anesthesiologists. 42 C.F.R. 405.553(b)(3). Prior to October 1, 1983, Medicare provided for reimbursement for CRNAs' services incident to services provided by anesthesiologists, where the CRNAs were employed by anesthesiologists. Finding 34.

Neither statute nor regulations define the term "employed" as it applies to anesthesiologists' claims for reimbursement for CRNAs' services. The I.G. argues that Blue Cross defined "employed" by advising Iowa anesthesiologists that they must create federal W-2 forms for CRNAs associated with them, for those CRNAs to be employees. The I.G. asserts that Blue Cross' interpretation of the term is consistent with the Health Care Financing Administration's (HCFA) policy as to the meaning of the term. The I.G. also argues that CRNAs associated with Respondents would not be considered to be "employed" under applicable federal case law. Respondents assert that, in the absence of a definition, the term must be defined as it is used under Iowa common law. they argue that, under the Iowa common law test, Respondents exercised a degree of control over the CRNAS such that the CRNAS must be employees.

The Medicare program is a federal program of health care benefits. There is nothing in either statutes or implementing regulations which suggests that Congress intended to defer to the states for purposes of defining statutory or regulatory language, or for applying reimbursement criteria. To the contrary, Congress plainly intended to implement a program which uses uniform federal standards to define benefit and reimbursement criteria. I conclude that Iowa law does not define the term "employed" as it is used in federal Medicare regulations which govern anesthesia reimbursement.

In the absence of a regulatory definition, "employed" should be applied within the common and ordinary meaning

of the term under federal law. Federal courts have on many occasions ruled on the question of what constitutes an employment relationship. Decisions have been issued in a variety of contexts. Cases cited by the I.G. address the issue of what constitutes an employment relationship for purposes of application of the Internal Revenue laws. Saiki v. United States, 306 F. 2d 642 (8th Cir. 1962). Other decisions consider the question of what constitutes employment in the context of the antitrust laws. Columbia River Co. v. Hinton, 315 U.S. 143 (1942); Taylor v. Local No. 7, International Union of Journeymen Horseshoers, 353 F.2d 593 (4th Cir. 1965). Others consider the meaning of the term in the context of the National Labor Relations Act. N.L.R.B. v. A.S. Abell Company, 327 F.2d 1 (4th Cir. 1964).

These decisions state a common standard for determining whether an employment relationship exists:

> The usual test employed for determining whether one performing services for another is an independent contractor or an employee is found in the nature and the amount of control reserved by the person for whom the work is done.

Taylor at 353 F.2d 596. The extent to which a party is "controlled" is measured in terms of the degree to which the principal may intervene to control the details of the agent's performance. Saiki at 306 F.2d 651. However, the reservation of some degree of control in the principal does not necessarily establish an employment relationship. Id.; Taylor at 596, 597-599.

The test necessarily requires the weighing of several factors which may evidence the presence or absence of control. It is not unusual for a relationship to manifest some of the elements of an employment relationship as well as some of the elements of an independent contractor relationship:

> The test, however, admits much more readily of statement than of application. Resolution of the question must depend largely upon the peculiar facts of each case. Moreover, no single factor is controlling and the totality of the circumstances must be considered.

Abell at 327 F.2d 4.[10] Therefore, under applicable Medicare regulations, a CRNA is employed by an anesthesiologist where the anesthesiologist retains substantial control over the details of the performance of the CRNA's work.

I conclude that Blue Cross did not correctly state the regulatory definition of "employed" when it defined it in terms of whether anesthesiologists prepared federal W-2 forms on behalf of CRNAs. Preparation of a W-2 form is an indicator of an employment relationship, but it is not dispositive of the issue. A much broader range of factors must be considered under the standards enunciated in Saiki, Taylor, and related cases.[11]

There are elements of the relationship between Respondents and some of the CRNAs who rendered services in the cases for which the claims at issue were presented which suggest the presence of an employment relationship. Some of the CRNAs were contractually obligated to render services to Respondents for a stipulated annual fee, not dependent on the volume of work they performed or the nature and difficulty of the cases they worked on. This fee has the earmarks of a salary.

The evidence also shows that CRNAs who were associated with Respondents were expected to be available, at the Respondents' direction, to perform work assigned to them by Respondents. CRNAs associated with Respondents received time off for illness and vacation and were paid moving expenses when they agreed to associate with Respondents.

However, this evidence of control is outweighed by evidence of the day-to-day working relationship between anesthesiologists and CRNAs associated with Respondents.

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[10] Although it is federal, and not Iowa, law which determines whether the CRNAs in these cases were "employed" within the meaning of relevant Medicare reimbursement regulations, the test of employment used in Iowa appears to be very similar, if not identical, to that used by federal courts. Fernandez v. Iowa Dept. of Human Services, 375 N.W.2d 701 (Iowa 1985).

[11] On the other hand, Blue Cross' definition of "employed" served to put Respondents on notice that the relationship which they maintained with their CRNAs might not constitute an employment relationship.

The evidence is that CRNAs and anesthesiologists considered themselves to be, and operated as, interchangeable and essentially coequal elements in a single enterprise. There was no hierarchy of employer to employee or master to servant. One of Respondent's witnesses described the relationship as follows:

> I see them as interacting as nearly equal colleagues. They're all specialists in the field and they share information back and forth and share their skills much as a couple of surgeons might.

Tr. at 1059. Respondents allowed CRNAs to provide anesthesia in many cases without closely supervising the CRNAs. Findings 94-96. In at least some cases, CRNAs provided anesthesia without any supervision by, or even the presence of, anesthesiologists. I.G. Ex. 226/1, 227/2. Respondents deemed the CRNAs who were associated with them to be skilled professionals and treated them as professional colleagues. In response to a question concerning the qualifications of CRNAs associated with Respondent AA, Respondent Quam, an anesthesiologist, testified that:

> The CRNAs that I work with are very capable of doing extremely fine anesthesia. In fact, I think every one of the CRNAs in our department have had the opportunity to put one of my family members to sleep and I think that's the criteria that I use as to if I want them working for me. If they are allowed to put one of my family members to sleep, then they meet the criteria for working in our department. And everyone in the department has had that opportunity to work on one of my family members.

Tr. at 1663. Respondent Quam also characterized the "supervision" he rendered of one CRNA as "observation," testifying that "Mr. . . . [Respondent] McDonough has been in practice a lot longer than I have." Tr. at 1643.

This is not to suggest that anesthesiologists associated with Respondent AA exercised no control over CRNAs. But I am satisfied from the evidence in this case that the degree of control and supervision which was retained by anesthesiologists was minimal. The working relationship between Respondent AA, its anesthesiolo-gists, and CRNAs

who were associated with them was not an employment relationship.

Additional evidence supporting this conclusion exists in documents which describe the relationship between CRNAs and Respondent AA. Some of the CRNAs, including Respondents McDonough and Nelson, were partners in Respondent AA and shared in the expenses and profits. Respondent AA entered into "independent contractor" agreements with some of the CRNAs with whom it associated, and the testimony was that Respondent maintained the same working relationship with those CRNAs who did not execute such agreements. Finding 106. The agreements explicitly stated that the CRNAs were independent contractors and not employees. Finding 104. CRNAs were free to seek other work when not involved with cases assigned by Respondents. Respondents did not withhold federal income taxes for CRNAs and made no Social Security contributions on their behalf. Findings 108, 110. CRNAs were required to obtain their own insurance.

Furthermore, Respondents described their relationship with CRNAs to third parties as an independent contractor relationship, when it suited their interests to do so. Finding 218. Indeed, the only time when Respondents appeared to have characterized the relationship as an employment relationship is when they sought Medicare reimbursement for CRNAs' services.

None of this evidence is dispositive of the issue when considered in isolation. For example, Respondents could have incorrectly characterized an employment relationship as an independent contractor relationship without altering the realities of the relationship. But I am satisfied from all of the evidence that the relationship between Respondent AA and the CRNAs was not an employment relationship.

The misrepresentations contained in the claims described in counts 1-105, 107-120, 201-206, 208-210 significantly affected the reimbursement Medicare paid for the services which were claimed. But for these misrepresentations, Medicare would have reimbursed Respondents for substantially less than Respondents received. Respondents' assertion that any misrepresentations on these claims amounted to harmless error is without merit.

Regulations adopted in 1983 provided for a higher reimbursement rate for services rendered by CRNAs who

were employed by anesthesiologists and under their medical direction than for CRNAs who were contract personnel but who were medically directed by anesthesiologists. Findings 47, 48; 42 C.F.R. 404.553(b) and (c). Anesthesiologists are reimbursed for the time expended in providing anesthesia by their medically directed CRNA employees at the same rate as if the anesthesiologists had personally provided the anesthesia. Anesthesiologists are reimbursed for the time expended in providing anesthesia by medically directed CRNA contractors at half the rate that anesthesiologists are reimbursed. Id.

All of the 128 false claims at issue here seek reimbursement for services rendered after the effective date of the 1983 regulations. All of the claims seek reimbursement as if the services rendered were either personally provided by anesthesiologists or by CRNAs employed by anesthesiologists and under their medical direction. In fact, anesthesia was primarily rendered by CRNAs who were not employed by anesthesiologists. Based on the representations in the claims, Medicare reimbursed Respondents for the time claimed as if services had been rendered by anesthesiologists. The reimbursement for anesthesia time paid by Medicare was twice the maximum reimbursement Medicare would have paid had the services on these claims been legitimately stated. Respondents were paid thousands of dollars more in reimbursement on these claims than they were entitled to receive.

Respondents argue that anesthesiologists were present throughout the anesthesia for which these claims were presented and that they were, therefore, entitled to full reimbursement regardless of whether CRNA employees or CRNA contractors performed the services. They did not prove this assertion. I have concluded that the evidence establishes that CRNAs were the primary providers of anesthesia in the cases represented by these claims. And, while it is possible that anesthesiologists may have been present for some portion of the anesthesia, the evidence does not prove that they were there for the entire procedure, rendering anesthesia on a "one on one" basis with CRNAs, as is asserted by Respondents. See Findings 81-83.

Considerable testimony was offered at the hearing in these cases as to the question of whether Respondents provided "medical direction" to CRNAs as is required by regulation. 42 C.F.R. 405.552(a). Had the I.G. established that Respondents failed to provide medical

direction in any of the claims at issue, then Respondents would not have been entitled to any reimbursement for that claim, regardless of whether the CRNA who provided the service was an employee or a contractor.

Regulations require that, in order to be reimbursed for anesthesia services, including services rendered by a CRNA, an anesthesiologist must: perform a pre-anesthesthetic examination and evaluation; prescribe the anesthesia plan; personally participate in the most demanding procedures in the anesthesia plan, including induction and emergence; ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual; monitor the course of anesthesia administration at frequent intervals; and provide indicated postanesthesia care. 42 C.F.R. 405.552(a). The evidence establishes that there existed a general pattern of behavior by Respondents in which they did not provide medical direction to CRNAs. There is credible evidence in the record of this case that, in at least some cases, CRNAs performed services on their own. Finding 95.

However, the evidence does not establish a lack of medical direction in any one of the claims at issue. There were no witnesses who testified that, with respect to any of the claims, medical direction was not provided. The medical records furnished with respect to these claims do not establish absence of medical direction. Therefore, the evidence does not establish that Respondents falsely claimed that they provided medical direction with respect to these claims.[12]

ii. Counts 121-200.

I conclude that these 80 claims contain numerous misrepresentations and false statements. As a consequence, Medicare overpaid Respondents thousands of dollars on these claims.

All of these claims are for reimbursement for services performed during cardiac or related surgery. Most of these claims involve coronary artery bypass surgery. Finding 118. The common feature of every one of these

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[12] That is not to suggest that the anesthesia records document that Respondents provided medical direction in these cases. The records fail to establish either the presence or absence of medical direction.

operations is that, at some point during the surgery, the patient's heart was induced to rest and vital respiratory and heart functions were assumed by a heart-lung machine, a pump which circulated the patient's blood and perfused it with oxygen.

The claims which Respondents presented or caused to be presented in connection with these surgeries, in effect, seek reimbursement for the operation and monitoring of the heart-lung machine -- that is to say, perfusion services. Many of the claims assert that Respondents provided a service which Respondents described as "pump monitoring." Finding 120. Some of these claims contain a Blue Cross procedure code used to identify perfusion services. Findings 124-126. Others contain a lengthy listing of services which Respondents claim to have rendered in addition to anesthesia, including monitoring the heart-lung machine. Finding 130.

These representations are false. The credible testimony was that the heart-lung machine was neither operated nor closely monitored by an anesthesiologist or a CRNA. Finding 122. That service was performed by a perfusionist. The perfusionist was not contractually associated with or employed by Respondents.

Many of the 80 claims at issue also contain false representations that a second anesthesiologist was necessary to perform perfusion services. Some claims assert that the services of two anesthesiologists were needed at all times to provide "pump monitoring." Finding 132. Many claims assert that "pump monitoring" was provided by a second anesthesiologist. Finding 138. Others contain statements certifying that named anesthesiologists personally provided the items or services which were claimed. Findings 145. However, the evidence establishes that, not only did Respondents not perform perfusion services as they claimed, but two anesthesiologists usually were not present to perform the services which were rendered. The items or services provided on the individual cases represented by these 80 claims were generally provided by an anesthesiologist and a CRNA.

There are exceptions to this general conclusion. As Respondents note, the anesthesia records in evidence do show that a second anesthesiologist participated in some of these cases. But I am satisfied from the operating room records in evidence that the primary providers of

services in most of these cases were anesthesiologists and CRNAs.

Indeed, not only were the services of two anesthesiologists not generally provided for these surgeries, but, often, two anesthesia personnel were not present at all times, as was represented by Respondents on many of the 80 claims. The least demanding part of cardiac surgery for the anesthesia personnel was that period when the patients' heart and respiratory functions were performed by the heart-lung machine. It was not unusual during that part of the surgery at DMGH for one of the anesthesia personnel in attendance to take a break and to leave the operating room. Tr. at 438.

Medicare compensates for perfusion services as a separate item or service from anesthesia services. Respondents did not provide these items or services and were not entitled to be reimbursed for them. By virtue of their false representations, Respondents were overpaid thousands of dollars on these claims. Finding 152.

Respondents argue that, even if the claims misrepresented the items or services which were claimed, Respondents were, nevertheless, not overpaid. Respondents assert that the claims legitimately seek reimbursement for anesthesia services and for unique additional services which Respondents provided and for which they were entitled to reimbursement. They argue that any false statements on the claims were simply inartful descriptions of legitimate reimbursable services.

A claim for an item or service which is not provided as claimed is a false claim pursuant to the Act, regardless of whether the party who presents the claim rendered some service for which he would be entitled to reimbursement. Respondents' claim that they were providing reimbursable, albeit inaccurately described, items or services is, therefore, not a defense on the issue of their liability under the Act.

On the other hand, proof by Respondents that the false statements in their claims amounted to nothing more than inaccurate descriptions of reimbursable services would constitute a basis to mitigate any penalties, assessments, or exclusions that might otherwise be imposed. The Act was not intended to severely penalize providers for inadvertent and harmless mistakes.

The burden is on Respondents to prove that their false statements are harmless. In order for Respondents to prevail on their assertion that they were providing reimbursable services in addition to anesthesia, they must prove that they provided the services they claimed for and that the services were not covered by the formula Respondents used in calculating the fee for anesthesia.

Central to Respondents' argument that there was no overpayment on these claims is their contention that they were providing items or services in addition to anesthesia services for which they were entitled to reimbursement. Respondent Loerke, an anesthesiologist, asserted that Respondents provided, in addition to anesthesia, "a highly intensive medical procedure" which he labeled "cardio vascular management." Tr. at 900, 902-903. He described this alleged additional service in terms of a range of monitoring and evaluating activities.

Essentially, Respondents claim that they wore two hats when participating in cardiac cases. They contend that they performed the full range of anesthesia services which anesthesiologists provide in such cases. They argue that, additionally, they provided "cardio vascular management" as a service above and beyond their anesthesia services which was not included in their base anesthesia charge. Respondents assert that this service required the presence of a second anesthesia professional. According to Respondents, it was this service that was claimed under the sobriquets "pump monitoring" and "recording & monitoring of intracardiac pressures heart lung machine EKG arterial & central venous pressures cardiac output measurements." Tr. at 901-903.

Medicare regulations do not prescribe a formula which anesthesiologists must employ to claim reimbursement for their services. However, the regulations acknowledge that many anesthesiologists do use a formula, generally derived from documents prepared by anesthesiologists' professional associations, known as "relative value" guides. Findings 44-46. These formulas classify anesthesia procedures in terms of procedure-specific base value units. Id. Base units are a function of the difficulty and complexity of the procedures. Anesthesiologists utilizing these formulas to charge for their services charge a specific number of base units, depending on the procedure performed, and add to the base units time units derived from the amount of time it took

to perform the procedure. The sum is then multiplied by a conversion factor to establish the fee to be charged.

The principle which underlies these formulas is that the base units established for a specific procedure encompasses all of the services rendered by anesthesiologists during that procedure (there are exceptions, such as the insertion of a swan-ganz catheter or an arterial line). The base unit includes all "monitoring" activities performed by an anesthesiologist.

Respondents argue that Medicare regulations do not require them to claim anesthesia reimbursement pursuant to a formula. That is true. However, Respondents did use a formula, derived from the Iowa Relative Value Index, to calculate their fees in the 80 claims at issue. R. Ex. 2/1; Tr. at 1299; Finding 150. Having done so, they cannot now credibly argue that the veracity of their claims should not be judged pursuant to the criteria contained in that formula. The base units they charged for anesthesia in the 80 claims encompassed all of the items or services rendered in connection with providing anesthesia.

I am not persuaded that Respondents were providing items or services in addition to the kinds of items or services which should have been included in their base anesthesia fee. First, Respondents failed to prove that they actually provided the ostensibly additional services which they alleged to have provided in the individual cases at issue.

Respondent Loerke asserted that Respondents were performing, as "cardio vascular management," a series of monitoring functions and tests which did not fall within the definition of anesthesia services and which required the presence of a second anesthesia professional during surgery. Tr. at 883-889. These ostensible additional items or services include monitoring of arterial blood gases, electrolytes, central venous pressures, pulmonary artery pressure, cardiac output, pulmonary capillary wedge pressure, urine output, core temperature, multi-lead EKG, activated coagulation times, hematocrit, and development of a heparin dose response curve. Tr. at 898-899.

Respondent Loerke's assertions were generalized claims that such items or services were provided by Respondents. The anesthesia records in evidence in these case do not

demonstrate systematic documentation of the items or services Respondents alleged to have provided in addition to anesthesia.[13] I do not accept Respondents' assertions that they provided such items or services in specific cases, in the absence of credible documentation that such services were provided.

Second, I find nothing in the evidence offered by Respondents which establishes that the monitoring and evaluating functions they claimed to have performed consisted of items or services other than anesthesia services which should have been included in the base units Respondents charged.[14] The Iowa Relative Value Index Guide, which Respondents used as a basis for determining their fees for cardiac anesthesia, provides that:

> The total value for anesthetic services includes usual pre and post operative visits, administration of anesthesia, monitoring of essential functions, plus administration of fluids, blood and medications required.

R. Ex. 2/1 (emphasis added). There is no credible evidence of record which proves that the items or services provided by Respondents, even assuming they provided all of the items or services they alleged to have provided, consisted of anything other than "monitoring of essential functions." Tr. at 571-573, 669.

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[13] There are a few scattered exceptions. For example, the anesthesia records for the claim contained in count 135 document a heparin dose response curve. I.G. Ex. 135-2. But these are exceptions and not the rule. Furthermore, even these exceptional cases do not document the range of additional services Respondents alleged to have provided.

[14] Respondents separately claimed reimbursement on these claims for insertion of swan-ganz catheters and arterial lines. They were entitled to be compensated for these items or services in addition to their base anesthesia reimbursement, and the I.G. does not contend that their reimbursement claims for these additional services were false.

b. Respondents knew, had reason to know, or should have known that the items or services were not provided as claimed.

Respondents knew that many of the items or services in the 211 claims at issue were not provided as claimed. To the extent Respondents did not know that items or services were not provided as claimed, they either had reason to know or should have known that they were not provided as claimed.

A person "knows" that an item or service is not provided as claimed within the meaning of the Act when he or she knows that the information that he or she is placing or causing to be placed on a claim is untrue. The Inspector General v. Thuong Vo, M.D. and Nga Thieu Du, Docket No. C-45 (1989). It is not necessary for a respondent to personally make a false claim in order to satisfy the "knows" test. All that is necessary to satisfy the test is that a respondent issue instructions concerning the preparation of claims which he or she knows will result in the inclusion of false information in the claims.

Respondents' Medicare claims were prepared for them by an agent, Donna Elliot Henderson. Findings 51, 55, 57. The evidence establishes that Ms. Henderson generally used little or no initiative in determining what information to place on claims. I conclude that she prepared claims based on both the general directions Respondents gave to her and on specific information that Respondents transmitted to her for preparing individual claims. Findings 57. With few exceptions, to the extent that the claims at issue contained false statements, these statements were the consequence of directives and information given to Ms. Henderson by Respondents.

Respondents attempted to disassociate themselves from Ms. Henderson's claim preparation activity. Respondents testified that they did not prepare or even review claims. In their post-hearing brief, Respondents averred that they did not know what information was contained in the claims that Ms. Henderson submitted on their behalf. But these assertions beg the question of whether Respondents knew that items or services were being provided as claimed. Respondents knew that they were transmitting incorrect information to Ms. Henderson. They, therefore, necessarily knew that she would submit false claims on their behalf.

Respondents issued many directives to Ms. Henderson and provided her with much information which they knew would result in the creation of false claims. Respondents knew that the items or services provided in the claims contained in counts 1, 6, 11, 14-16, 21, 26-47, 49-54, 56-105, 107-120, 201-206, and 208-210 were not primarily provided by anesthesiologists but were, in fact, provided by CRNAs. Finding 156. However, Respondents provided Ms. Henderson with documentation which led her to assert on these claims that the items or services for which reimbursement was being claimed had been provided by anesthesiologists. Finding 157.

Respondents knew that the phrase "recording & monitoring of intracardiac pressures heart lung machine EKG arterial & central venous pressure cardiac output measurements" did not accurately describe items or services which they had provided. Finding 181. Notwithstanding, they directed Ms. Henderson to record this statement on claims. Respondents thus knew that the items or services in the claims contained in counts 168-172 were not provided as claimed.

Respondents knew that two anesthesiologists did not provide the items or services in the surgeries for which they caused to be presented claims contained in counts 121-200. Findings 159-162, 164. Notwithstanding, they directed Ms. Henderson to tell Blue Cross that two anesthesiologists had participated in these surgeries and that their services were necessary. Finding 163. Ms. Henderson testified that she was directed by Dr. Conally, a deceased former member of Respondent AA, to state in claims for anesthesia reimbursement for cardiac cases that the services of two anesthesiologists were needed. Tr. at 1135, 1188. Respondent Loerke testified that the intent was to communicate that "two people," rather than two anesthesiologists, were involved in the surgery. Respondent Loerke's testimony is not credible on this issue. Therefore, Respondents knew that the assertions in claims contained in counts 121-200, that two anesthesiologists provided the items or services, were false.

The I.G. asserts that Respondents also knew that their representations as to the employment status of CRNAs were false. For reasons described infra, Respondents had reason to know and should have known that the CRNAs were not "employed," within the meaning of Medicare reimbursement criteria. But I conclude that they did not know that the CRNAs were not employed by them.

There is no evidence in the record which establishes that Medicare or Blue Cross ever communicated an accurate definition of "employed" to Respondents. Blue Cross did tell Respondents that "employed" meant preparing a W-2 form on the CRNAs' behalf, but, as I have held supra, at part 2 (a)(1) of this Analysis, that definition misstated the employment test. Therefore, Respondents did not have actual knowledge that the CRNAs were not employed by them.

The I.G. asserts that, even if Respondents did not know the definition of "employed," Respondents had sufficient knowledge to know that Blue Cross defined the term in a manner inconsistent with the relationship that Respondents maintained with the CRNAs with whom they were affiliated. Notwithstanding this, Respondents continued to represent that the CRNAs were their employees. The I.G. argues that this action by Respondents constitutes reckless disregard of the truth or falseness of their statements and, according to the I.G., such reckless disregard satisfies the "knows" test of the Act.

There are decisions issued pursuant to the Act which state that reckless disregard of the truth or falseness of information presented in claims amounts to knowledge that the claims are false. See The Inspector General v. George A. Kern, M.D., Docket No. C-25 (1987). I disagree with this analysis. A party does not have to know that a claim is false in order to be held liable under the Act. However, the meaning of the term "knows" is plain and its application should be limited to those situations where the party has actual knowledge that the information he is presenting or causing to be presented is false. Vo, supra, at 18-19.

Respondents had reason to know that many of the items or services for which they claimed reimbursement were not provided as claimed. The "reason to know" standard contained in the Act prior to December 22, 1987 created a duty on the part of a provider to prevent the submission of false or improper claims where: (1) the provider had sufficient information to place him, as a reasonable medical provider, on notice that the claims presented were for services not provided as claimed, or (2) there were pre-existing duties which would require a provider to verify the truth, accuracy, and completeness of claims. Vo, supra at 19; Kern, supra,at 5-7.

Although Respondents did not know whether the CRNAs with whom they were affiliated were "employed" by them within the meaning of Medicare regulations, they knew that an employment relationship was a prerequisite to claiming reimbursement at the rates which Respondents were claiming. Findings 166-167. They knew that Blue Cross defined "employed" by stating a condition that Respondents did not satisfy. They also knew that Blue Cross had raised questions in some cases concerning the employment status of CRNAs affiliated with Respondents. Finding 174. Given this knowledge, Respondents had an obligation to find out whether their relationship with the CRNAs met the regulatory definition of employment before they billed for the CRNAs' services as if they were employees. Respondents continued to file claims for items or services, including the claims contained in counts 2-5, 7-10, 12-13, 17-20, and 22-24, which expressly and falsely represented that the CRNAs were their employees. Respondents had reason to know that these items or services were not provided as claimed. Finding 180.

Respondents had reason to know that claims for "pump monitoring" services contained in counts 121-167 and 174-200 were for items or services that were not provided as claimed. The I.G. did not prove that Respondents directed Ms. Henderson to inscribe the phrase "pump monitoring" in the claims she submitted, or that they knew that she was inscribing that phrase on the claims. Respondents used the phrase as a form of shorthand to instruct Ms. Henderson to make claims "recording & monitoring of intracardiac pressures heart lung machine EKG arterial & central venous pressures cardiac output measurements." Respondents did not review the claims Ms. Henderson prepared on their behalf. Therefore, Respondents did not know that Ms. Henderson was copying "pump monitoring" onto claims, rather than inscribing the longer phrase which they intended "pump monitoring" to signify.

However, the I.G. proved that "pump monitoring" was a misstatement of the items or services which Respondents intended to claim. Findings 122-123. The I.G. also proved that Respondents knew that the phrase was inaccurate. The fact that Respondents knowingly transmitted inaccurate terminology to Ms. Henderson placed them under a duty to ensure that Ms. Henderson did not use this terminology in the claims she prepared and presented. Respondents did not review her work.

Respondents had reason to know that the procedure code "K3798," which Ms. Henderson inscribed in claims contained in counts 146-165 and 196-199, constituted a claim for reimbursement for items or services which were not provided as claimed. Ms. Henderson testified that her decision to incorporate procedure codes in claims was based on information provided to her by Blue Cross explaining its decision to credit claims. It was Ms. Henderson's practice in filing claims not to place procedure codes next to claims for items or services where she did not know how Blue Cross characterized the items or services. Once Blue Cross provided her with a procedure code to identify a service, she would continue to use that code. Finding 63.

Ms. Henderson testified that she assumed that she began using the code designation "K3798" in conjunction with "pump monitoring claims" when Blue Cross assigned that code to an explanation of benefits for "pump monitoring." Tr. at 1134. Based on this evidence, Respondents did not instruct Ms. Henderson to use the procedure code designation. There is no evidence that they knew she was using it on the claims. Therefore, Respondents did not know that this false representation was being made on their behalf.

But Respondents did know that they were providing Ms. Henderson with false statements concerning the "pump monitoring" for which they were directing her to make claims. Not only were they under a duty to assure that Ms. Henderson did not file false claims on their behalf for "pump monitoring," but their knowledge that the "pump monitoring" terminology was false placed them under the additional duty to prevent ancillary falsehoods from being made on their behalf. Respondents made no effort to review the claims Ms. Henderson prepared for them. Had they done so, they would have known that she was also using the code designation "K3798" with these claims.

The broadest standard of liability under the Act is "should know." This standard subsumes reckless disregard for the consequence of a person's acts. It subsumes those situations where a respondent has reason to know that items or services were not provided as claimed. "Should know" also subsumes negligence in preparing and submitting, or in directing the preparing and submitting of, claims. Mayers v. U.S. Dept. of Health and Human Services, 806 F.2d 995 (11th Cir. 1986), cert. denied, 484 U.S. 822 (1987); Vo, supra, at 20.

Respondents made no effort to review claims preparation or to check reimbursement explanations against their own records and their claims. By their own admission, they had no knowledge of the specific contents of the claims that were submitted on their behalf. They were indifferent to what Ms. Henderson put in their claims, so long as her statements on their behalf succeeded in obtaining reimbursement from Medicare for what they thought they were entitled to receive.

Respondents had a duty to accurately and honestly claim reimbursement for their services. See Finding 56. See I.G. Ex 277. Their indifference to the accuracy of their claims, coupled with their tolerance of the submission of palpably false information on their behalf, constituted a breach of that duty. Respondents should have known that the items or services contained in all of the 208 false claims were not provided as claimed. Finding 193.

3. The remedy of exclusion is not precluded in this case.

Respondents argue that regardless of whether they are found to have violated the Act, exclusions cannot lawfully be imposed against them. They premise this argument on their assertion that Congress amended the Act in 1987 by adding the exclusion remedy. They contend that any imposition of exclusion in these cases would constitute an unlawful retroactive application of the Act.

Respondents' premise is incorrect and their argument is without merit. The 1981 enactment of the Act contained the exclusion remedy, and the remedy has been consistently retained in all subsequent revisions to the Act. Congress intended that exclusion be a remedy when it enacted the 1981 version of the Act. H.R. Rep. No. 158, 97th Cong., 1st Sess. 328 (1981). Implementing regulations have provided for exclusion as a remedy since their original promulgation in 1983. See 48 Fed. Reg. 38827 (1983), at 38830, 38837. Decisions applying the Act to individual cases have imposed exclusion as a remedy since the original enactment of the Act. Mayers, supra. Thus, the 1987 revisions did not add exclusion as a remedy. Exclusion has been, and continues to be, a remedy which is an integral part of the remedies provided for by the Act.

4. Penalties, assessments, and exclusions are appropriate in these cases.

The remedial purpose of the Act is to protect government financed health care programs from fraud and abuse by providers. Mayers, supra, 806 F.2d at 997; Vo, supra, at 22. The assessment and penalty provisions of the Act are designed to implement this remedial purpose in two ways. One is to enable the government to recoup the cost of bringing a respondent to justice and the financial loss to the government resulting from the false claims presented by that respondent. The other is to deter other providers from engaging in the false claims practices engaged in by a particular respondent. Mayers, supra, at 999; Vo, supra, at 22.

The exclusion remedy is designed to protect the Medicare and Medicaid programs from future misconduct. It is thus distinguishable from assessments which compensate the government for wrongs already committed. Medicare has a contractual relationship with those providers of items or services who treat beneficiaries and present claims for reimbursement. Medicare is no more obligated to continue to deal with dishonest or untrustworthy providers than any purchaser would be obligated to deal with a dishonest or untrustworthy supplier. The exclusion remedy allows the Secretary to suspend his contractual relationship with those providers of items or services who are dishonest or untrustworthy. One purpose of any exclusion, therefore, is to protect the integrity of the Medicare and Medicaid programs for a sufficient period of time to assure that they will not continue to be harmed by dishonest or untrustworthy providers of items or services.

Exclusion serves an ancillary purpose of deterring providers of items or services, including those providers against whom the remedy is imposed, and other providers as well, from engaging in the same or similar misconduct as that engaged in by the excluded providers. In that respect, it is an exemplary remedy which reinforces the penalties which may be imposed pursuant to the Act.

The Act and implementing regulations provide that a penalty of up to $2,000 and an assessment of not more than twice the amount claimed may be imposed on a respondent for each item or service which is established as not having been provided as claimed. Social Security Act, section 1128A(a); 42 C.F.R. 1002.103-104. The maximum penalty which I may impose against Respondents in

these cases is $416,000.00, based on their presentation for payment of 208 claims containing items or services which were not provided as claimed. The maximum assessment which I may impose against Respondents in these cases is $199,438.00, which is twice the aggregate dollars claimed in the 208 false claims.

Neither the law nor regulations provide for a maximum exclusion which I may impose. However, the regulations provide that the length of the exclusion should be determined by the same criteria that I employ to determine the appropriate amount of the penalty and assessment. 42 C.F.R. 1003.107.

Regulations prescribe that, in determining the amount of a penalty and assessment, I must consider, as guidelines, factors which may either be mitigating or aggravating. 42 C.F.R. 1003.106. These include: (1) the nature of the claim or request for payment and the circumstances under which it was presented, (2) the degree of culpability of the person submitting the claim or request for payment, (3) the history of prior offenses of the person submitting the claim or request for payment, (4) the financial condition of the person presenting the claim or request for payment, and (5) such other matters as justice may require. 42 C.F.R. 1003.106(a).

The I.G. has the burden of proving the presence of aggravating factors. 42 C.F.R. 1003.114(a). A respondent has the burden or proving the presence of mitigating factors. 42 C.F.R. 1003.114(c). The regulations provide that, in cases where mitigating factors preponderate, the penalty and assessment should be set sufficiently below the maximum permitted by law. 42 C.F.R. 1003.106(c)(1). The regulations also provide that, in cases where aggravating factors preponderate, the penalty and assessment should be set close to the maximum permitted by law. 42 C.F.R. 1003.106(c)(2).

The Act has been interpreted to permit the imposition of a penalty and assessment which exceeds the amount actually reimbursed to a respondent for items or services not provided as claimed. Chapman v. U.S. Dept. of Health & Human Services, 821 F.2d 523 (10th Cir. 1987); Mayers, supra, 806 F.2d at 999. This reflects the legislative determination that activities in violation of the act "result in damages in excess of the actual amount disbursed by the government to the fraudulent claimant." Mayers, supra, 806 F.2d at 999.

There exist many aggravating factors in these cases. 42 C.F.R. 1003.106(b)(1). The false claims were presented over a lengthy period of time, nearly three years. Finding 203. The 208 false claims constitute a substantial number of such claims. Finding 204. Respondents false claims caused overpayments of thousands of dollars.

The most serious aggravating factor in these cases is Respondents' attitude towards Medicare reimbursement requirements. Blue Cross sent frequent communications to anesthesiologists, including Respondents, concerning their obligation to comply with Medicare reimbursement requirements. Findings 213, 214. Respondents dealt with these requirements by telling Blue Cross what would suffice to generate reimbursement. They were indifferent to the truthfulness of their representations.

Thus, when Respondents were advised that CRNAs had to be employed by them in order for Respondents to receive reimbursement for CRNAs' services at the same rate as for anesthesiologists' services, Respondents simply told Blue Cross that the CRNAs were their employees. Respondents also made efforts to assure that records at DMGH contained statements which made it appear as if Respondents' relationships with CRNAs conformed with Medicare reimbursement requirements. However, they made no effort to ascertain whether their relationship with CRNAs was an employment relationship under Medicare criteria.

In fact, Respondents knew that they had characterized their relationship with CRNAs as an independent contractor relationship. Finding 170. On one occasion, when Respondents thought that it was in their interest to tell Blue Cross that the relationship with the CRNAs was an independent contractor relationship, then they asserted that the CRNAs were independent contractors. Finding 218.

Similarly, it is evident that Respondents made no effort to determine whether their "pump monitoring" claims were legitimately reimbursable. Their objective never was to accurately state the unique services they were ostensibly providing in addition to anesthesia. Rather, it was to devise a claims formula which would convince Blue Cross to reimburse them above their base anesthesia charge. Finding 215. This strategy involved the dual falsehoods of claiming for "pump monitoring" services and asserting

that a second anesthesiologist was needed to provide that service.

Respondents assert that they never received complaints from Blue Cross concerning the way in which they were claiming reimbursement. They suggest that Blue Cross owed a duty to Respondents to scrutinize their individual claims and to tell Respondents if there were problems with the claims. I emphatically disagree with this assertion. Medicare carriers are not obligated to pore over the myriad of individual provider claims they process in order to tell providers which claims contain possible errors or misstatements. Respondents owed a duty to Blue Cross and Medicare to accurately and honestly claim reimbursement for their services, and Blue Cross and Medicare were entitled to rely on the assumption that Respondents were performing that duty. In these cases the breach of duty rests entirely with Respondents.

An additional aggravating factor is the fact that the claims at issue comprise a pattern of false claims. The evidence establishes that Respondents routinely filed claims for CRNAs' services as if the CRNAs were employed by anesthesiologists, or as if anesthesiologists rendered the services. I am certain that Respondents would have continued this practice had not the I.G. responded to complaints and initiated an investigation. Similarly, Respondents were routinely generating false reimbursement claims for "pump monitoring." This practice only ceased when the perfusionist at DMGH began experiencing difficulties in obtaining reimbursement from Medicare for his legitimate services and complained to Respondents. Finding 216.

The pattern of false claims by Respondents extended to Medicaid claims which are not specifically at issue in these cases. Finding 209. The fact that the claims at issue are part of a wider pattern of false claims is an additional aggravating factor. Mayers, supra; Vo, supra.

a. Penalties and assessments.

I impose total penalties of $208,000.00. That sum is only one half the amount which the law permits, given the 208 false claims. It is amply justified by the aggravating factors which I have cited. Respondents offered no mitigating evidence which would justify reducing the total penalty. Respondents did not allege that the amount of the penalty would jeopardize their

ability to continue as health care providers. I am not persuaded by Respondents' arguments that the false claims were mere harmless error and that no loss to Medicare resulted from Respondents' actions.

Furthermore, I find that it is necessary to impose a substantial penalty in these cases as a deterrent to others from engaging in the conduct engaged in by Respondents. Respondents' disregard for Medicare reimbursement requirements strikes at the heart of the relationship between the Medicare program and providers. Medicare depends on provider honesty and good faith. If Medicare were forced to audit the millions of claims it receives each year, it would cease to function. Yet Respondents have, in effect, asserted that it is not their concern whether their claims were honest or accurate. Respondents' attitude would be an invitation to anarchy, were it to prevail.

There is a need to impose substantial assessments in these cases. The I.G. proved that, as a consequence of Respondents' false claims, Blue Cross overpaid Respondents by thousands of dollars. The costs of auditing Respondents' claims and investigating Respondents was substantial. The hearing in these cases consumed nearly two weeks, and the costs of the hearing are only a small percentage of the total cost to the government of prosecuting and deciding these cases.

The evidence does not support imposing the assessments proposed by the I.G. The I.G. proposes that total assessments in this case be twice the amount claimed by Respondents in the 211 claims at issue. However, the I.G. did not prove that three of these 211 claims were false. Furthermore, while the 208 false claims resulted in substantial overpayments, they also encompassed legitimate charges for anesthesia services. Thus, while the claims requested nearly $100,00.00, the overpayments totalled about $23,000.00

I conclude that assessments of $50,000.00 should be imposed in these cases. These assessments are somewhat more than twice the amount overpaid to Respondents. When aggregated with the penalties I have determined to impose, the total sum should also fairly compensate the government for the costs of investigating and litigating these cases.

It would not be reasonable to make Respondents jointly and severally liable for the full amount of the penalties

and assessments. One Respondent, Respondent Barnett, retired on August 1, 1984, and had no responsibility for presenting any of the claims for items or services which Respondents presented or caused to be presented after his retirement. Respondent Quam did not become a partner in Respondent AA until August 1, 1984. I recognize that his contractor status prior to that date does not immunize him from liability on any claims he presented or caused to be presented. But there is no evidence that Respondent Quam had any say in directing the policies of Respondent AA prior to the inception of his partnership in Respondent AA. Similarly, Respondent Sykes did not become a partner in Respondent AA until September, 1985. Respondent Sykes' name appears on none of the claims which were presented prior to August, 1984, and on only a few claims after that date.

The false claims were presented between December, 1982 and October, 1985, a 35 month period. I apportion each Respondent's liability for penalties and assessments based on his length of tenure as a partner in AA. Accordingly, I find as follows:

Respondent Loerke was a partner during the entire 35 month period. Respondents Loerke and Loerke, P.C. are liable for up to the entire penalties of $208,000.00 and assessments of $50,000.00;

Respondent Nelson was a partner during the entire 35 month period. Respondents Nelson and Nelson, P.C. are liable for up to the entire penalties of $208,000.00 and assessments of $50,000.00;

Respondent McDonough was a partner during the entire 35 month period. Respondents McDonough and McDonough, P.C. are liable for up to the entire penalties of $208,000.00 and assessments of $50,000.00;

Respondent Barnett was a partner during 20 months of the entire 35 month period. Respondents Barnett and Barnett, P.C., are liable for 20/35 of the total liability. Respondents Barnett and Barnett, P.C., are liable for penalties not to exceed $118,857.00, and assessments not to exceed $28,571.00;

Respondent Quam was a partner during 14 months of the entire 35 month period. Respondents Quam and Quam, P.C., are liable for 14/35 of the total liability. Respondents Quam and Quam, P.C., are liable for penalties

not to exceed $83,200.00, and assessments not to exceed $20,000.00; and

Respondent Sykes was a partner during two months of the entire 35 month period. Respondents Sykes and Sykes, P.C., are liable for 2/35 of the total liability. Respondents Sykes and Sykes, P.C., are liable for penalties not to exceed $11,886.00, and assessments not to exceed $2,857.00.

Respondent AA is liable for up to the entire penalties of $211,000.00 and assessments of $50,000.00. The total penalties collected by the I.G. from all Respondents shall not exceed $208,000.00, and the total assessments collected by the I.G. from all Respondents shall not exceed $50,000.00.

b. Exclusions.

An exclusion imposed pursuant to the Act will have an adverse financial impact on the person against whom the exclusion is imposed. However, the law places the integrity of the Medicare and Medicaid programs ahead of the pecuniary interests of providers. Thus, in determining to impose an exclusion, the primary consideration must be the degree to which the exclusion serves the law's remedial objectives. An exclusion is remedial if it does reasonably serve these objectives, even if it has a severe adverse impact on the person against whom it is imposed.

There is a legitimate remedial purpose for exclusions in these cases. Respondents are untrustworthy providers. The 208 claims contain blatantly false statements of services. The false claims were perpetrated over a period of years. They involve a substantial sum of money. And, the circumstances surrounding the presentation of these claims establish that Respondents were utterly indifferent to their obligations to Medicare.

Exclusions in these cases will serve as a remedy in two respects. First, it will assure that these Respondents will not be in a position to do further damage to the integrity of the Medicare and Medicaid programs. Second, it will warn Respondents and other providers of services that their obligations to Medicare cannot be ignored.

The I.G. did not offer proof as to why ten year exclusions, as opposed to exclusions of shorter or longer

duration, are reasonable remedies in these cases. It is not necessary to exclude any of Respondents for ten years. A maximum exclusion of three years satisfies the law's remedial objectives. First, it provides a reasonable period of protection for the Medicare and Medicaid programs against repetition by these Respondents of their unlawful conduct. Second, it serves as a powerful deterrent against Respondents and other providers engaging in similar conduct to that in these cases.

My decision to impose an exclusion for substantially shorter duration than that sought by the I.G. is in part based on the I.G.'s failure to present persuasive evidence justifying the ten year exclusion which he sought. It is also based on my evaluation of the misconduct engaged in by Respondents.

The companion law to the Act, section 1128 of the Social Security Act, requires a minimum five year exclusion of parties convicted of criminal offenses related to the delivery of an item or service under Medicare or Medicaid. Social Security Act, section 1128(a)(1); (c)(3)(B). Had the I.G. established a scheme by Respondents to defraud Medicare, then the I.G. would have proven misconduct which is criminal in character. Based on such evidence, I would have felt compelled to impose an exclusion for at least five years.

However, the evidence in this case does not establish that degree of misconduct by Respondents. The evidence proves that Respondents told Medicare whatever they thought was necessary to maximize their reimbursement. Respondents were indifferent to the truth or falsity of their representations. But the evidence does not establish that Respondents schemed to defraud Medicare by basing their reimbursement claims on deliberate falsehoods. Therefore, although an exclusion is certainly necessary to remedy the misconduct established in this case, I do not believe that it is appropriate, based on the evidence of record, to impose an exclusion of a duration normally reserved for individuals or entities convicted of criminal misconduct, or found to have engaged in misconduct of equivalent severity.

Respondents undoubtedly will suffer severe economic impact from these exclusions. But that is a necessary consequence of the remedy. The adverse effect exclusions will have on Respondents is outweighed by the benefits which the programs will obtain by imposition of the remedy.

There is no proof of Respondents' claim that exclusion of them will force DMGH to close. DMGH may very likely need to obtain other providers of anesthesia. But there is no evidence in the record of these cases that DMGH will be unable to accomplish that.

Not all Respondents should be excluded for the same length of time. As with the penalties and assessments I have imposed, the exclusions should in some respect reflect the length of time that individual Respondents were partners in Respondent AA and were in a position to influence the actions of the enterprise. Therefore, I exclude Respondent AA for three years, and I exclude individual Respondents as follows:

Respondent Loerke and Respondent Loerke, P.C., are excluded for three years;

Respondent Nelson and Respondent Nelson, P.C., are excluded for three years;

Respondent McDonough and Respondent McDonough, P.C., are excluded for three years;

Respondent Barnett and Respondent Barnett, P.C., are excluded for two years; and

Respondent Quam and Respondent Quam, P.C., are excluded for two years.

Respondent Sykes and Respondent Sykes, P.C., should not be excluded. This Respondent was a partner in Respondent AA for only the final two of the 35 months during which false claims were presented. The I.G. presented no evidence as to his involvement in the policy determinations of Respondent AA. Respondent Sykes bears responsibility for the damages caused by the claims presented while he was a partner in Respondent AA. However, the evidence is insufficient to establish that Respondent Sykes is so untrustworthy as to require imposition of an exclusion as an additional remedy.

CONCLUSION AND ORDER

For the reasons set forth in this decision, I impose aggregate civil monetary penalties of $208,000.00, and aggregate assessments of $50,000.00 to be apportioned among Respondents as set forth hereinabove. I impose an

exclusion from participating in Medicare and Medicaid of three years against Respondent AA, and certain additional Respondents, and lesser exclusions against other Respondents as set forth hereinabove. I impose no exclusion against Respondents Sykes, and Sykes, P.C.

/s/

Steven T. Kessel
Administrative Law Judge