Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	
Essa Abdulla, M.D.,	DATE: June 29, 1990
Petitioner,	
- v. -	Docket No. C-211
The Inspector General.	DECISION CR 87

DECISION

In this case, governed by section 1128 of the Social Security Act (Act), Petitioner filed a timely request for a hearing before an Administrative Law Judge (ALJ) to contest the December 11, 1989 notice of determination (Notice) issued by the Inspector General (I.G.) which excluded Petitioner from participating in the Medicare and Medicaid programs for five years.1/

Based on the entire record before me, I conclude that summary disposition is appropriate in this case, that Petitioner is subject to the minimum mandatory exclusion provisions of sections 1128(a)(1) and 1128(c)(3)(B) of the Act, and that Petitioner's exclusion for a minimum period of five years is mandated by federal law.

1/ "State health care program" is defined by section 1128(h) of the Social Security Act to cover three types of federally-financed programs, including Medicaid. I use the term "Medicaid" hereafter to represent all State health care programs from which Petitioner was excluded.

APPLICABLE STATUTES AND REGULATIONS

I. The Federal Statute.

Section 1128 of the Social Security Act (Act) is codified at 42 U.S.C. 1320a-7 (West U.S.C.A., 1989 Supp.). Section 1128(a)(1) of the Act provides for the exclusion from Medicare and Medicaid of those individuals or entities "convicted" of a criminal offense "related to the delivery of an item or service" under the Medicare or Medicaid programs. Section 1128(c)(3)(B) provides for a five year minimum period of exclusion for those excluded under section 1128(a)(1).

II. The Federal Regulations.

The governing federal regulations (Regulations) are codified in 42 C.F.R., Parts 498, 1001, and 1002 (1989). Part 498 governs the procedural aspects of this exclusion case; Parts 1001 and 1002 govern the substantive aspects.

Section 1001.123 requires the I.G. to give a party written notice that he or she is excluded from participation in Medicare, beginning 15 days from the date on the notice, whenever the I.G. has conclusive information that a practitioner or other individual has been convicted of a crime related to his or her participation in the delivery of medical care or services under the Medicare, Medicaid, or the social services program.2/

BACKGROUND

The I.G.'s Notice alleged that Petitioner was convicted of a criminal offense related to the delivery of an item or service under the Medicare program, and advised Petitioner that the law required a five-year minimum exclusion from participation in Medicare and Medicaid programs for individuals convicted of a program-related offense. Petitioner requested a hearing to contest the I.G.'s determination and the case was assigned to me for a hearing and decision.

I conducted a prehearing conference in this case on March 21, 1990 and issued a prehearing Order on March 29, 1990, which established a schedule for filing motions and responses. The I.G. filed a motion for summary disposition and a memorandum in support thereof on

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2/ The I.G.'s Notice letter allows an additional five days for receipt.

April 20, 1990. The Petitioner filed a response on May 11, 1990, to which the I.G. replied on May 23,1990.

ADMISSIONS

Petitioner admits he was "convicted" of a criminal offense within the meaning of sections 1128(a)(1) and 1128(i) of the Act, of one felony count of mail fraud. P. Br. 1.

ISSUE

The remaining issue in this case is whether Petitioner was convicted of a criminal offense "related to the delivery of an item or service" under the Medicare program within the meaning of section 1128(a)(1) of the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW 3/

Having considered the entire record, the arguments and the submissions of the parties, and being advised fully herein, I make the following Findings of Fact and Conclusions of Law:

1. Petitioner was a physician at all times relevant to this case, practicing in West Virginia. I.G. Ex. A/2.

2. Petitioner pled guilty to one count (69) of an 81 count indictment in the United States District Court for the Southern District of West Virginia. Count 69 alleged violations of 18 U.S.C. 1341 (mail fraud). I.G. Ex. C.

3. Petitioner's plea was accepted by the court. I.G. Ex.C.

3/ The citation to the record in this Decision and Order is noted as follows:

I.G.'s Exhibit	I.G. Ex. (number)/(page)
I.G.'s Brief	I.G. Brief (page)
I.G.'s Reply Brief	I.G. Reply Brief (page)
Petitioner's Opposition Brief	Petitioner's Brief (page)
Finding of Fact and Conclusion of Law	FFCC (number)

4. Count 69 of Petitioner's indictment concerned Petitioner's mailing of a false and fraudulent claim to Blue Cross and Blue Shield. I.G. Ex. A/15.

5. Petitioner's false and fraudulent claim consisted of an envelope containing a Summary of Medicare Benefits Form with a **Supra** bill attached. A **Supra** bill is a request for payment on an invoice for the amount of the invoice which is not reimbursed by the Medicare program. I.G. Ex.A/15.

6. The **Supra** bill submitted by Petitioner evidenced a blood test done for a Medicare patient on January 16, 1984. I.G. Ex. A/15.

7. The patient concerned in Count 69 had a Blue Cross and Blue Shield Medical Supplemental Insurance policy which paid the balance (20% of the approved reasonable charge) of medical claims not paid by Medicare. A Medicare Supplemental policy is defined in 42 C.F.R. 403.205 as a health insurance policy offered to a Medicare beneficiary, primarily designed to provide payment for expenses incurred for services and items not reimbursed under the Medicare program. I.G. Ex.A/14.

8. It is a crime to use the federal mails for the purpose of executing "any scheme or artifice to defraud." 18 U.S.C. 1341.

9. The action to which Petitioner pled guilty in Count 69 was part of a scheme or artifice to defraud the United States Department of Health and Human Services (DHHS) through its Medicare Program. I.G. Ex. A.

10. The "scheme and artifice to defraud," in this case, is stated generally in the first paragraph of the indictment. This paragraph is then realleged and incorporated by reference for all succeeding counts, including Count 69. I.G. Ex. A/ 1, 14.

11. The District Court required Petitioner to make restitution to DHHS in the amount of $20,228.56. I.G. Ex. C.

12. The offense of mail fraud to which Petitioner pled guilty was "related to the delivery of an item or service" under Medicare within the meaning of section 1128(a)(1) of the Act.

13. On December 31, 1990 the I.G. excluded Petitioner from participating in the Medicare and Medicaid programs for a period of five years. I.G. Ex. D.

14. The Secretary of DHHS (the Secretary) delegated to the I.G. the authority to determine, impose and direct exclusions pursuant to section 1128 of the Act. 48 Fed Reg. 21662 (May 13, 1983); 42 U.S.C. 3521 et seq.

15. Since the material facts are undisputed in this case, the classification of Petitioner's conviction of a criminal offense as subject to the authority of 1128(a) is a legal issue.

16. Summary disposition is appropriate in this case. See 56 F.R.C.P.

17. Petitioner was "convicted" of a criminal offense within the meaning of section 1128(a) and 1128(i) of the Act.

18. Petitioner was convicted of a criminal offense "related to the delivery of an item or service under Medicare" within the meaning of section 1128(a)(1) of the Act.

19. A minimum mandatory exclusion of five years is required in this case by section 1128(c)(3)(B) of the Act.

DISCUSSION

I. Petitioner's Conviction Was "Related To The Delivery Of An Item Or Service" Within The Meaning Of Section 1128 Of The Act.

Section 1128(a)(1) and 1128(c)(3)(B) of the Act requires the I.G. to exclude individuals and entities from the Medicare and Medicaid programs when individuals and entities have been "convicted" of a criminal offense "related to the delivery of an item or service" under the Medicare or Medicaid programs. See Greene v. Sullivan, Civ. No. 3-89-758 (E.D. Tenn. Feb. 8, 1990), affirming Jack W. Greene, DAB App. 1078 (1989).

Petitioner was convicted of one count of mail fraud. I must determine whether the evidence demonstrates a relationship between the conviction of mail fraud and "the delivery of an item or service" under the Medicare program. FFCC 2-9, 17.

The I.G. has submitted a brief and other documents in support of his motion for summary disposition. The I.G. contends that these documents, as a whole, support his

contention that Petitioner's conviction was program related.

The specific act to which Petitioner pled guilty was having mailed an invoice, a Supra bill, in the amount of $450 to Blue Cross and Blue Shield. This **Supra** bill referenced a blood test done on a Medicare patient. Petitioner's action, however, cannot be seen to stand alone. Rather, it must be seen in a larger context, as a part of Petitioner's scheme to defraud the Medicare system.

As I held in Clarence H. Olson, DAB Civ. Rem. C-85 at 7 (1989), and as I reiterated in Hai Nuh Bui, DAB Civ. Rem. C-103 (1990), the issue of whether a conviction is program-related should not be decided in a vacuum, or with a strict hypertechnical interpretation of the term, "related to." All relevant documents pertaining to the trial court proceeding must be considered. Id. This includes any evidence which explains or assists me in understanding the criminal charge brought against Petitioner, the criminal offense to which he pled guilty, and how it relates to the Medicare or Medicaid programs.

In the instant case, the essence of the crime to which Petitioner pled guilty, mail fraud, is that there be a "scheme or artifice to defraud." Here, the indictment on its face identifies the scheme in question as having been directed against "the United States Department of Health and Human Services through its Medicare Program." I.G. Ex. A/1. This paragraph is then realleged and incorporated by reference for all succeeding counts, including Count 69, the count to which Petitioner pled guilty. FFCC 4-11.

Moreover, even if Count 69 were not simply one element of a general scheme involving Medicare, the "item or service" in question in Count 69 was necessarily delivered under Medicare, because the Blue Cross/Blue Shield policy referred to in Count 69 was specifically identified as a Medicare Supplemental Policy, issued solely to Medicare patients, to pay only that portion of medical bills not covered by Medicare. I.G. Ex. A/14, paragraphs 3, 4.

Finally, the judgment of the District Court specifically recognized the Department of Health and Human Services as an "aggrieved" party, and directed the Petitioner to make restitution in the amount of $20,228.56. I.G. Ex. C.

The cumulative effect of the evidence contained in the I.G.'s exhibits is irrefutable. I conclude that the I.G.

has demonstrated the necessary relationship between Petitioner's "conviction" and the "delivery of an item or service" under the Medicare program. Accordingly, I find that Petitioner was convicted of a criminal offense related to the delivery of an item or service within the meaning of section 1128(a)(1) of the Act.

II. A Minimum Mandatory Five Year Exclusion Is Required In This Case.

Section 1128(c)(3)(B) of the Act provides for a minimum exclusion period of five years for program-related exclusions. As I have concluded, the I.G. correctly determined that Petitioner was convicted of a criminal offense as defined by sections 1128(a)(1) and 1128(i) of the Act. Congressional intent on this matter is clear:

> A minimum five-year exclusion is appropriate, given the seriousness of the offenses at issue.... Moreover, a mandatory five-year exclusion should provide a clear and strong deterrent against the commission of criminal acts.

S. Rep. No. 109, 100th Cong., 1st Sess. 2, reprinted in 1987 U.S. Code Cong. & Admin. News 682, 686. Accordingly, I conclude that the I.G.'s exclusion of Petitioner for a period of five years is required by section 1128(c)(3)(B) of the Act.

III. Summary Disposition Is Appropriate In This Case.

The issue of whether the I.G. had the authority to exclude Petitioner under Section 1128(a)(1) is a legal issue. I have concluded as a matter of law that Petitioner was properly excluded and that the length of his exclusion is mandated by law. There are no genuine issues of material fact which would require the submission of additional evidence, and there is no need for an evidentiary hearing in this case. Accordingly, the I.G. is entitled to summary disposition as a matter of law. See Charles W. Wheeler and Joan K. Todd, DAB App. 1123 at 10 (1990), and Rule 56 F.R.C.P.

CONCLUSION

Based on the law and undisputed facts in the record of this case, I conclude the I.G. properly excluded Petitioner from the Medicare and Medicaid programs for the minimum mandatory period of five years.

IT IS SO ORDERED.

/s/

Charles E. Stratton
Administrative Law Judge