Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Vladimir Coric, M.D.,	)	DATE: June 11, 1991
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-244
	)	
The Inspector General.	)	Decision No. CR135
	)	

DECISION

On April 18, 1990, the Inspector General (I.G.) informed Petitioner that he was excluded from participating in the Medicare and Medicaid programs for seven years, pursuant to section 1128 of the Social Security Act (Act).[1] The I.G. stated that Petitioner was excluded as a result of his conviction of a criminal offense related to the delivery of an item or service under the Medicaid program.

By letter dated May 1, 1990, Petitioner requested a hearing before an Administrative Law Judge (ALJ), and the case was assigned to me. On February 11, 1991, I conducted an in-person hearing in Hartford, Connecticut. I have considered the evidence of record, the parties' arguments, and the applicable laws and regulations. I conclude that the I.G. has the authority to impose and direct an exclusion against Petitioner pursuant to section 1128(a)(1) of the Act and that the minimum mandatory provisions of section 1128(c)(3)(B) of the Act apply. I also conclude that the I.G.'s determination to exclude Petitioner from participation in Medicare and Medicaid programs for seven years is excessive, and that an exclusion for five years is reasonable under the circumstances of this case.

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[1] The Medicaid program is one of three types of federally-financed State health care programs from which Petitioner is excluded. I use the term "Medicaid" to represent all three of these programs which are defined in section 1128(h) of the Act.

APPLICABLE STATUTES AND REGULATIONS

I. The Federal Statute.

Section 1128 of the Act is codified at 42 U.S.C. 1320a-7 (West U.S.C.A., 1990 Supp.). Section 1128(a)(1) of the Act requires 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) of the Act.

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 issue an exclusion notice to an individual or entity whenever the I.G. has "conclusive information" that such individual or entity has been "convicted" of a criminal offense "related to the delivery of an item or service" under the Medicare or Medicaid programs. In this case, the exclusion began 20 days from the date on the notice.[2]

PROCEDURAL BACKGROUND

On April 18, 1990, the I.G. issued a notice of determination (Notice) informing Petitioner that he was being excluded from participation in Medicare and Medicaid for a period of seven years. The I.G. stated in his Notice that this exclusion is based on Petitioner's conviction in the Hartford Superior Court of Connecticut of a criminal offense related to the delivery of an item or service under the Medicaid program. By letter dated May 1, 1990, Petitioner requested a hearing to contest the I.G.'s determination. This case was docketed and assigned to me for a hearing and decision.

Thereafter, the I.G. filed a motion for summary disposition on all issues, accompanied by a supporting brief and exhibits. Petitioner responded with a memorandum in opposition to the I.G.'s motion for summary

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[2] The I.G.'s notice letter added five days to the 15 days prescribed in section 1001.123, to allow for receipt by mail.

disposition and a cross motion for summary disposition accompanied by exhibits. The I.G. filed a reply brief.

At the time Petitioner submitted his response to the I.G.'s motion for summary disposition, he made a written request for "oral argument and an evidentiary hearing (by telephone)". In an October 16, 1990 telephone status call, Petitioner withdrew his request for oral argument and a hearing by telephone, and instead requested an in-person hearing. On February 11, 1991, I conducted and in-person evidentiary hearing in Hartford, Connecticut.

ADMISSIONS

As documented by my July 16, 1990 Prehearing Order, Petitioner admitted during the July 11, 1990 prehearing conference that he was "convicted" of a criminal offense within the meaning of section of 1128(i) of the Act. Tr. 109.[3]

ISSUES

The remaining issues in this case are:

1. Whether Petitioner's conviction was for a criminal offense "related to the delivery of an item or service"

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[3] References to the record and to Departmental Appeals Board cases in this decision will be cited as follows:

I.G.'s Exhibit	I.G. Ex. (number/page)
Petitioner's Exhibit	P. Ex. (number/page)
I.G.'s Brief	I.G. Br. (page)
Petitioner's Brief	P. Br. (page)
I.G.'s Reply Brief	I.G. Rep. Br. (page)
Transcript	Tr. (page)
Findings of Fact and Conclusions of Law	FFCL
Departmental Appeals Board ALJ decisions	DAB Civ. Rem. (docket no./date)
Departmental Appeals Board Appellate decisions	DAB App. (decision no./ date)

under the Medicaid program, within the meaning of section 1128(a)(1) of the Act.

2. Whether the I.G.'s exclusion determination amounts to an unlawful retroactive application of the mandatory exclusion provisions of the Act.

3. Whether the length of Petitioner's exclusion is reasonable and appropriate.

FINDINGS OF FACT AND CONCLUSIONS OF LAW[4]

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

1. Petitioner has been a practicing psychiatrist in Norwich, Connecticut, since January 1961. P. Ex. 1/1; P. Ex. 2/1.

2. An on-site audit of Petitioner's business records performed by Medicaid auditors on January 30, 1986 revealed a pattern of false bills submitted by Petitioner. On June 30, 1986, the Medicaid auditors referred the case to the Connecticut Medicaid Fraud Control Unit for further investigation. I.G. Ex. 4/3-5; Tr. 70.

3. The investigation of the Medicaid Fraud Control Unit revealed that during the period from January 1, 1984 through June 30, 1986, Petitioner submitted or caused to be submitted 1,995 false claims to the Connecticut Medicaid program on behalf of 99 Medicaid recipients. I.G. Ex. 4/40.

4. As a result of the submission of these false claims, Petitioner received an overpayment from the Connecticut Medicaid program in the amount of $30,028.80 during the period from July 13, 1984 through December 15, 1986. I.G. Ex. 2; I.G. Ex. 4/39, Tr. 83-85.

5. The majority of the 1,995 false claims submitted by Petitioner consisted of bills which represented that medical services had been performed by a psychiatrist when, in fact, less expensive services had actually been

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[4] Some of my statements in the sections preceding these formal findings and conclusions are also findings of fact and conclusions of law. To the extent that they are not repeated here, they were not in controversy.

performed by a health care professional who was not a psychiatrist. Tr. 85; I.G. Ex. 4.

6. Petitioner also violated Medicaid regulations by submitting bills charging for office visits where the patient had canceled the appointment or simply failed to appear for it without warning. Tr. 72; I.G. Ex. 4.

7. Petitioner also submitted bills which represented that individual psychotherapy services had been performed when, in fact, less expensive family therapy services had actually been performed. Tr. 74; I.G. Ex. 4.

8. Petitioner also violated Medicaid regulations by submitting bills charging for psychological testing by the hour rather than by the test. Tr. 76; I.G. Ex. 4.

9. On November 5, 1986, a subpoena was issued to Petitioner ordering him to turn over his medical and business records to the custody of the Medicaid Fraud Control Unit for investigation. I.G. Ex. 4/5.

10. Upon receiving the subpoena, Petitioner instructed members of his staff to fabricate their records by writing progress notes for "no-show" and canceled appointments in order to conceal that Petitioner had improperly billed these appointments to the Medicaid program. I.G. Ex. 4/13, 32-38; Tr. 64-66.

11. An application for arrest warrant, signed and attested to by an inspector with the Medicaid Fraud Control Unit on May 11, 1989, alleged that the investigation of Petitioner revealed that there was probable cause to charge Petitioner with the following offenses: (1) larceny in the first degree by defrauding a public community, and (2) tampering with or fabricating physical evidence. I.G. Ex. 4/1, 40.

12. On October 10, 1989, the Connecticut Superior Court accepted a nolo contendere plea by Petitioner on the charge of larceny in the first degree by defrauding a public community and entered a judgment of guilty on this offense. I.G. Ex. 2.

13. The Connecticut Superior Court sentenced Petitioner to the Connecticut Correctional Institution for a term of three years, execution suspended; probation for two years; a fine of $6,000, and full restitution to the Medicaid program in the amount of $30,028.80. I.G. Ex. 2.

14. Petitioner was "convicted" of a criminal offense within the meaning of section 1128(a)(1) and 1128(i) of the Act. July 16, 1990 Prehearing Order; Tr. 109.

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

16. Sections 1128(a)(1) and 1128(c)(3)(B) of the Act provide that the minimum mandatory exclusion period is five years for an individual who has been convicted of a criminal offense related to the delivery of an item or service under the Medicaid program.

17. The Secretary of the United States Department of Health and Human Services (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. 21661 (May 13, 1983).

18. On April 18, 1990, the I.G. notified Petitioner that he was being excluded from participation in the Medicare and Medicaid programs for seven years, pursuant to section 1128(a)(1) of the Act.

19. The I.G. properly excluded Petitioner from participation in the Medicare and Medicaid programs for a period of at least five years as required by the minimum mandatory exclusion provisions of sections 1128(a)(1) and 1128(c)(3)(B) of the Act.

20. The I.G.'s exclusion determination does not amount to an unlawful retroactive application of section 1128(a)(1) of the Act to the facts of this case.

21. The remedial purpose of section 1128 of the Act is to protect federally-funded health care programs and their beneficiaries and recipients from providers who have demonstrated by their conduct that they cannot be trusted to handle program funds or to treat beneficiaries and recipients.

22. An ancillary remedial objective of section 1128 of the Act is to deter individuals from engaging in conduct which jeopardizes the integrity of federally-funded health care programs.

23. Felonies are serious criminal offenses. Larceny in the first degree by defrauding a public community, the offense which formed the basis of Petitioner's conviction, is a felony. Tr. 10.

24. The serious nature of Petitioner's offense is reflected in the sentence fashioned by the court. I.G. Ex. 2.

25. The serious nature of Petitioner's offense is also reflected in the fact that the Connecticut Department of Income Maintenance suspended Petitioner from participating in the Connecticut Medicaid program for a period of three years as a result of his criminal misconduct. I.G. Ex. 5.

26. Petitioner's criminal misconduct continued over a prolonged period of time and involved a substantial number of claims. FFCL 3.

27. Petitioner's criminal misconduct resulted in a significant amount of monetary damage to the Medicaid program. FFCL 4.

28. The fact that Petitioner's initial reaction to the threat of getting caught in wrongdoing was to falsify office records in an effort to cover up his misconduct reflects poorly on his judgment, character, and trustworthiness. FFCL 10.

29. Notwithstanding the evidence showing that Petitioner was guilty of serious misconduct, he has offered persuasive evidence which establishes that a seven year exclusion is not necessary to achieve the law's remedial objectives in this case.

30. Petitioner has never been convicted of a criminal offense prior to 1989. P. Ex. 1/1. In addition, there is no evidence that Petitioner has been sanctioned by either Medicare or Medicaid prior to 1986 when Medicaid began its investigation.

31. Petitioner's professionalism is highly regarded by the medical community in Norwich, Connecticut, and he is held in high esteem by his patients. Tr. 15, 23, 28, 36; P. Ex. 8, 11. While Petitioner's professionalism is not directly at issue in this case, it is one indicia of his trustworthiness. The fact that Petitioner has consistently provided excellent care to his patients over a period of almost thirty years reflects well on his character.

32. In addition to being admired for his professionalism, Petitioner also enjoys a reputation in the community for being an honest and trustworthy individual. Tr. 40.

33. Petitioner met a need to provide psychiatric care to indigent psychotic patients who had been discharged from the state mental hospital in Norwich, Connecticut, that few other psychiatrists in the community were either willing or able to meet. P. Ex. 4.

34. Throughout his career, Petitioner has demonstrated enormous dedication to his work and compassion for his patients. Petitioner is exceptionally committed to caring for his patients, and he has repeatedly demonstrated that he is capable of placing the needs of his patients above his personal and financial interests. P. Ex. 2; P. Ex. 6; P. Ex. 9; Tr. 18, 48.

35. Petitioner considered the administrative and financial aspects of his practice to be less important than providing quality care to his patients, and, as a result, he paid little attention to the business functions of his office. P. Ex. 2/4; P. Ex. 6/1; P. Ex. 9/2. Petitioner's billing violations were motivated by a failure to accept responsibility for adhering to Medicaid regulations rather than by a desire to steal funds from Medicaid as part of an elaborate scheme to defraud the program.

36. Petitioner often rendered services for unscheduled visits for which he did not charge the Medicaid program. I.G. Ex. 1/4; I.G. Ex. 6/3.

37. Petitioner's violations of the rules against charging for missed appointments were motivated by laziness in educating himself about relevant Medicaid regulations rather than a desire to fraudulently receive money for services that were never performed at any time. Tr. 93; I.G. Ex. 4/11-12.

38. Petitioner experienced a great deal of humiliation as a result of the criminal proceedings and conviction, and the trauma of these events will deter Petitioner from repeating his unlawful misconduct in the future. Tr. 59-60.

39. Petitioner now acknowledges that the responsibility for submitting accurate bills rests with him, and he now takes that responsibility seriously. P. Ex. 1/4.

40. Petitioner has taken steps to upgrade his office bookkeeping functions. Tr. 59-60.

41. There is little likelihood that Petitioner will repeat his unlawful misconduct in the future. FFCL 30-40.

42. The I.G. has failed to consider any of the factors which mitigate against imposing a seven year exclusion in this case. I.G. Br. 1, 2, 11, 12.

43. The seven year exclusion imposed and directed against Petitioner is excessive.

44. The remedial considerations of section 1128 of the Act will be served in this case by a five year exclusion.

DISCUSSION

I. The Mandatory Exclusion Provisions Of Section 1128 Apply To This Case.

Section 1128(a)(1) of the Act mandates an exclusion of:

> Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under . . . [Medicare] or under . . . [Medicaid].

The Act further requires, at section 1128(c)(3)(B), that in the case of an exclusion imposed and directed pursuant to section 1128(a)(1), the minimum term of such exclusion shall be five years. The I.G. asserts that "the criminal conduct in which the petitioner engaged, and the resulting conviction, were related to the Medicaid program as required by 1128(a)(1)." I.G. Br. 6. The I.G. asserts that Petitioner's exclusion therefore was mandatory and thus he must be excluded for at least five years pursuant to section 1128(c)(3)(B). I.G. Br. 14. See Tr. 109-123.

The I.G.'s authority to impose and direct an exclusion under section 1128(a)(1) is based on the fulfillment of the following statutory criteria: (1) an individual or entity must be "convicted" of a criminal offense within the meaning of sections 1128(a)(1) and 1128(i) of the Act, and (2) the conviction must be "related to the delivery of an item or service" under the Medicare or Medicaid programs.

A. Petitioner Was "Convicted" Of Criminal Offenses Within The Meaning Of Sections 1128(a)(1) And 1128(i) Of The Act.

Section 1128(i)(3) of the Act defines the term "convicted" of a criminal offense to include those circumstances in which a nolo contendere plea by an

individual has been accepted by a federal, state, or local court.

The undisputed facts establish that Petitioner entered a nolo contendere plea on the charge of larceny in the first degree by defrauding a public community. On October 10, 1989, the Connecticut Superior Court accepted this plea and entered a judgment of guilty on this charge. I.G. Ex. 2.

Petitioner admitted during the July 11, 1990 prehearing conference that he was "convicted" within the meaning of the exclusion law, and I conclude that the record supports this admission. See Tr. 109.

B. Petitioner's Criminal Offenses Underlying His Conviction Is "Related To The Delivery Of An Item Or Service" under the Medicaid Program.

Having concluded that Petitioner was "convicted" of a criminal offense, I must determine whether the criminal offense which formed the basis for the conviction was "related to the delivery of an item or service" under the Medicaid program, within the meaning of section 1128(a)(1) of the Act.

Petitioner was convicted of larceny in the first degree by defrauding a public community. While the name of the offense, on its face, suggests that it involves fraud against the government rather than against an individual, it is not possible to ascertain from the name of the offense alone whether it relates to the delivery of an item or service under the Medicaid program. In order to determine the existence of a relationship between the criminal offense for which Petitioner was convicted and the delivery of an item or service under the Medicaid program, it is necessary to examine the facts underlying the conviction. Charles W. Wheeler and Joan K. Todd, DAB Civ. Rem. 61 & 63 (1989), aff'd DAB App. 1123 (1990).

The I.G. submitted the application for the warrant of arrest of Petitioner, signed and attested to by Ms. Justine M. Miller, an inspector with the Connecticut Medicaid Fraud Control Unit. According to this document, an investigation conducted by the Medicaid Fraud Control Unit revealed that during the period from January 1, 1984 through June 30, 1986, Petitioner was responsible for the submission of a total of 1,995 false claims to the Connecticut Medicaid program, on behalf of 99 Medicaid recipients, for services which were not performed as claimed. I.G. Ex 4/40. Documents submitted by the I.G. also show that as a result of his conviction for larceny

in the first degree by defrauding a public community, Petitioner was ordered to pay restitution to the Connecticut Medicaid program in the amount of $30,028.80. I.G. Ex. 2. In addition, Petitioner was suspended from participating in the Connecticut Medicaid program for three years as a result of his conviction. I.G. Ex. 5.

Petitioner does not dispute these facts. Instead, he makes the legal argument that the I.G. has mischaracterized the criminal offense which formed the basis of his conviction.

Petitioner states that the "normal starting point" in interpreting the meaning of a statute is "the actual language of the statute itself". Petitioner contends that section 1128(a)(1), when read alone, does not explain what Congress intended to encompass by the term "related to the delivery of an item or service". Petitioner therefore argues that it is necessary to look at the entire statutory scheme of the exclusion law in order to construe the meaning of the language in section 1128(a)(1). P. Br. 3-4.

Petitioner points out that section 1128(a) of the Act contains provisions requiring the exclusion of health care providers in certain circumstances, while section 1128(b) of the Act contains provisions permitting the Secretary to use his discretion to exclude providers in certain circumstances. Petitioner argues that "[s]ince the subsections on mandatory and permissive exclusion are separate and distinct, it is . . . obvious that a conviction might fit under subsection (a) or subsection (b), but not under both". Petitioner therefore reasons that since the enumerated circumstances which are grounds for a permissive exclusion under section 1128(b) of the Act cannot also be grounds for a mandatory exclusion under 1128(a), a reading of section 1128(b) provides clear guidance as to what is not encompassed by the section 1128(a) phrase "related to the delivery of an item or service". Petitioner argues that this conclusion "is necessary to avoid rendering subsection (b) at least in part a nullity, thus violating a cardinal rule of construction that effect should be given to the intent of Congress and that a legislative body does not intend to adopt useless legislation". P. Br. 3-5.

Petitioner contends that of all the provisions contained in sections 1128(a) and 1128(b) of the Act, section 1128(b)(1) "describes most precisely the circumstances of [this] case". P. Br. 5. Section 1128(b)(1) gives the Secretary discretion to exclude providers who have been convicted "in connection with the delivery of a health

care item or service or with respect to any act or omission in a program operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct". Petitioner asserts that his conviction for larceny in defrauding a public community was "financial misconduct" within the meaning of section 1128(b)(1) of the Act. Applying his premise that conduct which is grounds for an exclusion under section 1128(b) may not also be grounds for an exclusion under section 1128(a), Petitioner concludes that his criminal offenses are not governed by the mandatory exclusion provisions of section 1128(a) of the Act. P. Br. 6.

Petitioner cites another rule of statutory construction to further support his contention that section 1128(b)(1), rather than section 1128(a), applies to this case. Petitioner states that it "is an accepted rule of statutory construction that specific terms covering given subject matter will prevail over general language in the same statute which might otherwise prove controlling". P. Br. 6. Using this rule of statutory construction, Petitioner argues that the specific language of section 1128(b)(1) clearly applies to his conviction and it must therefore be treated as an exception to the more general language contained in section 1128(a)(1). P. Br. 7. Petitioner concludes that, as a matter of law, the permissive exclusion provision of section 1128(b)(1) governs this case, and it was improper for the I.G. to proceed under the mandatory exclusion provision of section 1128(a)(1). See Tr. 109-123.

The I.G. contends financial offenses such as fraud and theft directed at the Medicare or Medicaid programs are "related to the delivery of an item or service" under such programs, within the meaning of section 1128(a)1() of the Act. The I.G. argues that Petitioner was convicted of such an offense, and therefore he is subject to the mandatory minimum five-year exclusion provisions of sections 1128(a)(1) and 1128(c)(3)(B). I.G. Br. 6-9; Tr. 121-123.

Petitioner's arguments are based on a misreading of the statute. Petitioner acknowledges in his brief that the normal starting point of interpreting a law is the actual language of the statute itself, but he fails to properly apply this rule to the exclusion law. The plain meaning of the language of section 1128(a)(1) is to require exclusion from participation in the Medicare and State health care programs of those providers who commit offenses, including fraud or financial misconduct, in

connection with the delivery of an item or service rendered pursuant to these programs. The phrase in section 1128(a)(1) "related to the delivery of an item or service" conveys legislative intent to sweep within section 1128(a)(1) all "financial" offenses directed against Medicare and Medicaid programs. Charles W. Wheeler and Joan K. Todd, supra.

Petitioner's offense falls within the ambit of the offenses described by the language of section 1128(a)(1). The undisputed facts establish that Petitioner submitted false claims to the Connecticut Medicaid program which misrepresented the services that were actually delivered. As a result of these false claims, Petitioner received an overpayment from the Medicaid program in the amount of $30,028.80. Petitioner's offense, which amounts to theft or conversion of Medicaid funds, is covered by the language in section 1128(a)(1). Id.

Section 1128(a)(1) encompasses the same kinds of "financial" offenses which are described in 1128(b)(1), but is limited to those offenses which are directed against, or committed in connection with, the rendering of services pursuant to the Medicare and Medicaid programs. The legislative scheme apparent from reading 1128(a)(1) and 1128(b)(1) in conjunction with each other is to mandate exclusions of those who commit financial crimes directed against Medicare and Medicaid, and to permit exclusions of those who commit financial crimes in connection with the delivery of a health care item or service pursuant to programs, other than Medicare or Medicaid, which are financed by federal, state, or local government agencies. As the fraud committed by Petitioner was directed against Medicaid, his exclusion is mandated by section 1128(a)(1).

There is no question that if 1128(b)(1) is read in isolation, its language would literally encompass the offense for which Petitioner was convicted. However, when this section is read in context with 1128(a)(1), it becomes clear that Petitioner's exclusion is not governed by the permissive exclusion provisions. This is so because the law specifically requires a minimum five-year term for exclusions of parties who commit offenses described in 1128(a)(1).

In the case Jack W. Greene, DAB App. 1978 (1989), the petitioner was convicted of a criminal offense that is not materially different from the offense committed by Petitioner in this case. The petitioner in Greene was convicted of fraud against the Tennessee Medicaid program. His crime consisted of substituting a generic

drug for a brand name drug and billing the program for the more expensive brand name drug. In Greene and the present case, the petitioners attempted to obtain reimbursement for items or services which were not delivered as claimed. Both cases involve fraudulent acts against Medicaid programs, related to the delivery of items or services under those programs. The petitioner in the Greene case argued that his criminal offenses fell within the permissive exclusion provisions of section 1128(b)(1), rather than the mandatory exclusion provision of section 1128(b)(1), because his criminal offense related to fraud against the Medicaid program. The Departmental Appeals Board (DAB) expressly rejected this argument, holding that:

> [The] . . . offense is directly related to the delivery of the item or service since the submission of a bill or claim for Medicaid reimbursement is the necessary step, following the delivery of the item or service, to bring the 'item' within the purview of the program.

DAB App. 1078 at 7 (1989). The DAB concluded in Greene that false Medicaid billing and the delivery of an item or service to a Medicaid recipient are "inextricably intertwined" and therefore "related". The Greene decision was subsequently affirmed by the United States District Court. Greene v. Sullivan, 731 F. Supp. 835, 838 (E.D. Tenn. 1990). Thus, under Greene, it is well-settled that financial offenses directed against the Medicare and Medicaid programs such as submitting fraudulent claims for services which were not provided as claimed would be "related to the delivery of an item or service" within the meaning of section 1128(a)(1).

In view of the foregoing, I find that Petitioner was convicted of a criminal offense "related to the delivery of an item or service" under the Medicaid program, and I conclude that the I.G. properly classified Petitioner's offense as falling under the mandatory exclusion authority. Accordingly, the I.G. is required to exclude Petitioner for a minimum of five years under sections 1128(a)(1) and 1128(c)(3)(B) of the Act.

II. The I.G.'s Exclusion Determination Does Not Amount To An Unlawful Retroactive Application Of Section 1128(a)(1) Of The Act To The Facts Of This Case.

On August 18, 1987, section 1128(a) of the Act was amended by the Medicare and Medicaid Patient and Program Protection Act of 1987, Public Law 100-93, 101 Stat. 680 (1987). While the pre-August 1987 version of section

1128 provided for an exclusion for a conviction of a program-related criminal offense, there was no mandatory minimum exclusion. Congress provided for the first time on August 18, 1987 that the exclusion must be for a mandatory minimum period of five years for program-related criminal offenses.

Petitioner contends that the conduct which formed the basis of his conviction occurred during the years from 1984 through 1986. He argues that section 1128(a)(1) cannot be applied retroactively to conduct which occurred before its enactment on August 17, 1987. Petitioner contends that it "is an elementary rule of statutory construction (1) that statutes affecting substantive matters and rights are deemed to be prospective only and (2) that, in general, statutes are strongly presumed to be prospective unless their language is such as to show clearly and unequivocally that Congress intended retroactive application". Petitioner asserts that section 1128 does not unequivocally indicate that Congress intended retroactive application. In addition, Petitioner asserts that application of the 1987 Amendments to this case would violate the ex post facto clause of the United States Constitution. P. Br. 8-9.

Although I do not have the authority to declare the 1987 Amendments unconstitutional, I do have the authority to interpret and apply the federal statute and regulations. In addition, where there is room to decide how to apply the statute, I have a duty to apply it in a manner that is constitutional and valid. See Betsy Chua, M.D., DAB Civ. Rem. C-139 (1990), aff'd, DAB App. 1204 (1990).

I disagree with Petitioner that the exclusion law was applied retroactively in this case. The 1987 Amendments were enacted by Public Law 100-93, and section 15(b) of Public Law 100-93 specifically states:

> Mandatory minimum exclusions apply prospectively. Section 1128(c)(3)(B) of the Social Security Act (subsec (c)(3)(B) of this section) (as amended by this Act [Pub. L. 100-93, section 2]) which requires an exclusion of not less than 5 years in the case of certain exclusions, shall not apply to exclusions based on convictions occurring before the date of the enactment of this Act [Aug. 18, 1987].

The Senate Report discussing this provision states, "The provision establishing mandatory five year minimum exclusion periods for conviction of certain crimes would apply to convictions occurring on or after the date of

enactment." S. Rep. No. 109, 100th Cong., 1st Sess. 27, reprinted in 1987 U.S. Code Cong. & Admin. News 682, 708.

It is clear from both the language of the statute itself and its legislative history that Congress intended the mandatory minimum exclusion provisions to apply prospectively from the date of the statute's enactment to all convictions occurring on or after August 18, 1987. Obviously, if a conviction occurred on August 18, 1987 or shortly thereafter, the misconduct giving rise to the conviction would necessarily have occurred prior to August 18, 1987. Accordingly, in enacting this provision, Congress must have been aware that there would be many convictions that would be entered after the effective date of the amendments and these convictions would be based on acts that were committed prior to that date. Thus, by logical inference, Congress intended the 1987 Amendments to apply even in those cases as long as the conviction resulting from the misconduct occurred on or after August 18, 1987. This logical inference is inescapable, and the only way it could be overcome would be by specific language in the text of the statute itself or in its legislative history indicating Congressional intent not to apply the mandatory exclusion to convictions based on misconduct occurring prior to August 18, 1987.

In this case, there is no dispute that Petitioner was convicted after the effective date of the 1987 Amendments. Petitioner was convicted of a program-related offense on October 10, 1989, more than two years after the enactment of the amendments to the Act. The I.G.'s authority to impose and direct exclusions against Petitioner arose from the conviction on October 10, 1989, and that is the controlling event specified by Congress in its 1987 amendment. Therefore, the act which gave the I.G. grounds to exclude Petitioner occurred after the date that Congress enacted the 1987 statutory revisions.

I also disagree with Petitioners' assertion that the constitutional prohibition against ex post facto laws bars the I.G. from imposing the mandatory minimum exclusion in this case.

It is a well established principle that constitutional protection against ex post facto laws applies to criminal or penal laws which impose punishment. In Chua, supra, as in the instant case, the petitioner objected to application of the mandatory exclusion on ex post facto grounds. This objection is necessarily premised on the assertion that Congress intended the imposition of the five year mandatory minimum exclusion to be a punishment.

The purpose of the exclusion law is not to punish, but to protect federally funded health care programs from untrustworthy health care providers. See Chua, supra at 10, citing Orlando Ariz and Ariz Pharmacy Inc., DAB Civ. Rem. C-115 (1990). The mandatory exclusion provisions are civil remedies, and they are not punishment within the meaning of that term in the United States Constitution. Therefore, this civil remedy does not trigger the protections afforded by the Constitution which are applicable to criminal laws.

In view of the foregoing, I conclude that since Petitioner was convicted of a program-related offense after August 18, 1987, the I.G. had no choice but to apply the mandatory minimum exclusion provisions and exclude Petitioner for at least five years. This exclusion is not an unlawful retroactive application of the law in violation of the ex post facto clause of the United States Constitution.

III. A Five Year Exclusion Is Appropriate And Reasonable In This Case.

The I.G. excluded Petitioner from participating in the Medicare and Medicaid programs for seven years. While the exclusion provisions of sections 1128(a)(1) and 1128(c)(3)(B) of the Act require that an individual or entity who has been convicted of a criminal offense related to the delivery of an item or service under the Medicaid program be excluded for a minimum period of five years, there is no mandated maximum period for exclusions imposed pursuant to section 1128. The remaining issue in this case is whether the I.G. is justified in excluding Petitioner for seven years. Since there is no statutory provision which sets the maximum exclusion period for exclusions imposed under the authority of section 1128(a)(1), it is reasonable to conclude that Congress intended that resolution of this issue be based on analysis of the evidence in a particular case in light of the legislative purposes of the exclusion statute. See Frank J. Haney, DAB Civ. Rem. C-156 (1990).

Section 1128 is a civil statute, and Congress intended it to be remedial in application. The remedial purpose of the exclusion law is to enable the Secretary to protect federally-funded health care programs from misconduct. Such misconduct includes fraud or theft against federally-funded health care programs. It also includes neglectful or abusive conduct against program recipients and beneficiaries. See, S. Rep. No. 109, 100th Cong., 1st Sess. 1, reprinted 1987 U.S. Code Cong. and Admin. News 682.

The key term to keep in mind is "protection", the prevention of harm. See, Webster's II New Riverside University Dictionary 946 (1984). As a means of protecting the Medicare and Medicaid programs and their beneficiaries and recipients, Congress chose to mandate, and in other instances to permit, the exclusion of untrustworthy providers. Through exclusion, individuals who have caused harm, or demonstrated that they may cause harm, to the federally funded health care programs or its beneficiaries or recipients are no longer permitted to receive reimbursement for items or services which they provide to Medicare beneficiaries or Medicaid recipients. Thus, untrustworthy providers are removed from a position which provides a potential avenue for causing harm to the program or to its beneficiaries or recipients. See Charles J. Burks, M.D., DAB Civ. Rem. C-111 (1989).

Congress has not mandated that exclusions from participation in the federally-funded health care programs be permanent. Instead, section 1128(g) provides that an excluded provider may apply for reinstatement into the program at the end of the exclusion period. The Secretary may then terminate the exclusion if there is no basis for a continuation of the exclusion, and there are reasonable assurances that the types of actions which formed the basis for the original exclusion have not recurred and will not recur.

By not mandating that exclusions from participation in federally-funded health care programs be permanent, Congress has allowed the I.G. the opportunity to give individuals a "second chance". The placement of a limit on the period of exclusion allows an excluded individual or entity the opportunity to demonstrate that he or she can and should be trusted to participate in the federally-funded health care programs as a provider of items and services to beneficiaries and recipients. See Thomas J. DePietro, R. Ph., DAB Civ. Rem. C-282 at 8 (1991).

The ultimate issue to be determined at a hearing pertaining to an exclusion imposed pursuant to section 1128 of the Act is whether the exclusion is reasonable. 42 C.F.R. 1001.128(a)(3). In adopting this regulation, the Secretary stated that:

> The word 'reasonable' conveys the meaning that . . . [the I.G.] is required at the hearing only to show that the length of the [exclusion] determined . . . was not extreme or excessive.

48 Fed. Reg. 3744 (January 27, 1983). An exclusion determination will be held to be reasonable where, given the evidence of the case, it is consistent with the legislative purpose of protecting federally-funded health care programs and their beneficiaries and recipients and it is not extreme or excessive as a length of time necessary to establish that the excluded provider no longer poses a risk to covered programs and their beneficiaries and recipients. See Basem F. Kandah, R. Ph., DAB Civ. Rem. C-155 at 5 (1990).

In order to be adjudged reasonable under section 1128, an exclusion must satisfy the remedial objective of protecting federally-funded health care programs and their beneficiaries and recipients from untrustworthy providers of items or services. An exclusion which satisfies this purpose may also have the ancillary benefit of deterring wrongdoing. However, an exclusion fashioned solely to achieve the objective of deterrence is punitive if it does not reasonably serve the Act's remedial objective. See Elias Goldstein, DAB Civ. Rem. C-104 (1989).

Guidance in determining the appropriate length of an exclusion is found in regulations contained in 42 C.F.R. 1001.125(b). These regulations were adopted by the Secretary prior to the enactment of the 1987 Amendments to the Act. Even though the Regulations were adopted by the Secretary to implement the law as it existed prior to the enactment of the 1987 Amendments, they are entirely consistent with congressional intent to exclude untrustworthy providers from participation in federally-funded health care programs. Thus, to the extent that they have not been repealed or modified, the Regulations are instructive as broad guidelines for determining the appropriate length of exclusions in cases such as this one, which have arisen after the enactment of the 1987 revisions.

The regulations enumerate a number of factors which should be considered in deciding how long an exclusion will be reasonable. They include: (1) the number and nature of the offenses, (2) the nature and extent of any adverse impact the violations have had on beneficiaries, (3) the amount of the damages incurred by the Medicare, Medicaid, and social services programs, (4) the existence of mitigating circumstances, (5) the length of sentence imposed by the court, (6) any other facts bearing on the nature and seriousness of the violations, and (7) the previous sanction record of the excluded party. 42 C.F.R. 1001.125(b).

Since the exclusion remedy is not intended to be a punishment for wrongdoing, the regulations should not be applied as sentencing guidelines to the facts of a case to determine the degree of a provider's culpability with a view to determining the punishment he "deserves". Instead, the regulations provide guidance as to the factors that should be considered in order to make inferences about a provider's trustworthiness and the length of time a provider should be excluded to provide the Secretary adequate opportunity to determine that a provider no longer poses a risk to the covered programs and to their beneficiaries and recipients.

The regulations do not define what factors may be considered as "mitigating." However, given congressional intent to exclude untrustworthy individuals from participation in federally-funded programs, it is reasonable to conclude that such factors would constitute those factors which would lead to the conclusion that an excluded individual is trustworthy and no longer poses a danger to covered programs and beneficiaries and recipients of program funds. Leonard N. Schwartz, R. Ph., DAB Civ. Rem. C-62 at 14 (1989). In addition, language contained in the legislative history of the Act indicates that Congress intended "the availability of alternate providers of needed health care services" be considered a "mitigating circumstance" in determining the length of an exclusion. S. Rep. No. 109, 100th Cong., 1st Sess. 2, reprinted in 1987 U.S. Code Cong. & Admin. News 682, 693.[5]

A determination of the length of time necessary to establish that a provider is no longer a threat to the covered programs and to their beneficiaries and recipients necessitates an evaluation of the myriad facts of each case, including the nature of the offense committed by the provider, the circumstances surrounding the offense, whether and when the provider sought help to correct the behavior which led to the offense, how far the provider has come towards rehabilitation, and any other factors relating to the provider's character and trustworthiness. See Thomas J. DePietro, R. Ph., DAB Civ. Rem. C-282 (1991).

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[5] While this language appeared in the context of a discussion of permissive exclusions, it still provides guidance regarding what factors Congress intended to be considered "mitigating" in determining the length of any exclusion.

The I.G. contends that he was justified in excluding Petitioner for two years in addition to the minimum five year exclusion period required by law due to the presence of three "aggravating factors". The three "aggravating factors" identified by the I.G. which support the addition of two years to the five year minimum exclusion are: (1) the criminal acts were committed over a lengthy period of time; (2) the Medicaid program incurred financial damages of over $30,000.00; and (3) the Connecticut Department of Income Maintenances excluded Petitioner from the Medicaid program. The I.G. also contends that there are no "mitigating factors" in this case. According to the I.G., the proposed regulations provide for only three factors that may be considered as "mitigating". The I.G. asserts that none of these three factors apply to this case, and therefore there is no basis to reduce the exclusion below seven years. I.G. Br. 1, 2, 11, & 12.

Petitioner asserts that the I.G. may not rely on the proposed regulations in defining what factors may be considered in determining the length of an exclusion because the proposed regulations are not now in effect and they were not in effect at the time Petitioner submitted the false claims between 1984 and 1986. P. Br. 22.

I agree with Petitioner that it is inappropriate to rely on the proposed regulations. The proposed regulations, if adopted by the Secretary, would establish his policy for exclusions imposed pursuant to section 1128. See 55 Fed. Reg. 12205 (April 2, 1990). These proposed regulations, however, have not been adopted and they may not finally be adopted in their current form. Additionally, it is not clear that, assuming these proposed regulations are adopted, they would apply retroactively to exclusion cases heard prior to the date of their adoption. See Joyce Faye Hughey, DAB App. 1221 (1991).

There is no precise formula which can be applied to calculate when a provider should be trusted and allowed to reapply for participation in the federally-funded health care programs. The totality of the circumstances of each case must be evaluated in order to reach a determination regarding the appropriate length of an exclusion.

The parties presented a rich an thorough record in this case. Petitioner was convicted of larceny in the first degree by defrauding a public community. This is a felony, and felonies are serious criminal offenses. Tr.

10. The seriousness of this offense is in some measure reflected in the sentence fashioned by the criminal court. The court sentenced Petitioner to the Connecticut Correctional Institution for a term of three years, execution suspended; probation for a term of two years; a fine of $6,000; and restitution to the Medicaid program in the amount of $30,028.80. I.G. Ex. 2. The seriousness of Petitioner's criminal offenses is also reflected in the fact that as a result of his conviction for larceny by defrauding a public community, the Connecticut Department of Income Maintenance determined that Petitioner should be suspended from participating in the Connecticut Medicaid program. I.G. Ex. 5.

The evidence establishes that the acts which formed the basis of Petitioner's conviction involved the submission of 1,995 false claims on behalf of 99 Medicaid recipients during the period from January 1, 1984 through June 30, 1986. I.G. Ex. 4/40. This is a substantial number of false claims. In addition, the evidence establishes that as a result of the submission of these false claims, Petitioner received an overpayment in the amount of $30,028.80 from the Medicaid program.[6] This is a substantial sum of money, and this evidence shows that Petitioner's actions resulted in significant monetary damage to the Medicaid program.[7] This evidence also shows that Petitioner's criminal misconduct occurred over

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[6] The application for arrest warrant states that Petitioner was overpaid $31,077 during this period. This figure was subsequently reduced by approximately $1,000, and Petitioner was sentenced to pay restitution to the Medicaid program in the amount of $30,028.80. I.G. Ex. 4/39; Tr. 83-85.

[7] Petitioner argues that the Medicaid program did not sustain monetary damage in this amount because Petitioner made full restitution to the Medicaid program and that "[f]rom a certain point of view, he made more than full restitution" since Petitioner had initially paid at least half of the $30,000 to allied health professionals who had performed the services under his supervision. P. Br. 21. I disagree with this reasoning. The undisputed facts establish that Petitioner received an overpayment of approximately $30,000. Regardless of the fact that Petitioner eventually reimbursed the program for this overpayment, the program sustained a monetary loss in this amount at the time it made the overpayments. This figure is relevant in determining the seriousness and gravity of Petitioner's offenses, even though the program was paid back by Petitioner.

a lengthy period of time, well in excess of one year. Thus, the record shows that Petitioner repeatedly submitted false claims over a prolonged period of time, and that this misconduct resulted in a substantial financial loss to the Connecticut Medicaid program.

The investigation of the Connecticut Medicaid Fraud Control Unit revealed that the most of these false claims consisted of bills which represented that medical services had been performed by a psychiatrist when, in fact, the services had been performed by a health care professional who is not a psychiatrist. Other false claims consisted of bills for office visits where the patient canceled the appointment or simply failed to appear for it without warning. The investigation also revealed that Petitioner submitted bills which falsely represented that he had provided individual psychotherapy services when, in fact, less expensive family therapy services had been performed. The evidence also shows that Petitioner violated Medicaid regulations requiring Petitioner to bill psychological tests by the test rather than by the hour. I.G. Ex. 4; Tr. 85, 72, 74, 76.

The circumstances surrounding the billings for canceled and "no-show" appointments is disturbing for the reason that the Medicaid Fraud Control Unit's investigation revealed that Petitioner attempted to conceal his noncompliance with these Medicaid billing regulations. On November 5, 1986, the Connecticut Judicial Inquiry[8] issued a subpoena ordering Petitioner to produce his medical and business records. I.G. Ex. 4/5. Susan Burns, Petitioner's bookkeeper since 1975, testified under oath at the Judicial Inquiry that at the time the subpoena was received by Petitioner's office, Petitioner instructed members of his staff to fabricate their records by writing progress notes for "no-show" and canceled appointments that were billed to the Medicaid program. I.G. Ex. 4/32-38; P. Ex. 6/1. Petitioner himself admitted in both his testimony before both the Judicial Inquiry and the hearing before me that he directed at least one of his employees to fabricate his records by writing medical progress notes for "no-show" and canceled appointments. Petitioner admitted that he

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[8] At the hearing before me, counsel for Petitioner described the Connecticut Judicial Inquiry as a "one-man Grand Jury" in the State of Connecticut. He explained that the Judicial Inquiry is a process by which individuals can be summoned by way of subpoena to appear before an official designated to take testimony. Tr. 100.

was aware that this was improper, and he explained that he "panicked and did not use his right judgement" when he did this. I.G. Ex. 4/13; Tr. 64-66. I agree with Petitioner that this conduct showed poor judgment. The fact that Petitioner's initial reaction to getting "caught" in wrongdoing was to attempt to cover it up through the falsification of office records reflects poorly on his character, and it is evidence that he is untrustworthy.

According to the application for arrest warrant, there was probable cause to charge Petitioner with the offense of tampering with or fabricating physical evidence in addition to the offense of larceny in the first degree by defrauding a public community. I.G. Ex. 4/40. At the hearing before me, counsel for Petitioner pointed out that the tampering with the evidence charge was dropped by the prosecution, and that Petitioner was convicted only for the larceny charge. Tr. 108. Petitioner asserts that in reaching a decision about the appropriate length of an exclusion in this case, I should consider only the larcenous conduct involving the submission of 1,995 false claims which formed the basis for his conviction. P. Br. 8. The I.G. urges that I also consider the evidence regarding Petitioner's efforts to tamper with his business records. I.G. Rep. Br. 14-15.

I agree with the I.G. that the evidence regarding Petitioner's efforts to tamper with his business records is relevant to the issue of the appropriate length of the exclusion in this case. This evidence provides information about Petitioner's character and trustworthiness. Thus, even though this evidence relates to facts beyond the narrow scope of the offense which formed the basis for Petitioner's conviction, it pertains to the remedial consideration embodied in section 1128. It therefore is relevant to the issue of whether the length of the I.G.'s exclusion in excess of the minimum mandatory period is reasonable.

Certainly, the fact that Petitioner was convicted of a larceny offense involving $30,028.80 of Medicaid funds, raises serious questions about his ability to be trusted to handle Medicare and Medicaid funds. Petitioner's admission that he attempted to conceal this violation through the fabrication of office records leads to additional doubt about his trustworthiness. However, notwithstanding the evidence showing that Petitioner engaged in serious criminal misconduct, I conclude that Petitioner offered persuasive evidence, not considered by the I.G., which establishes that a seven year exclusion is not necessary to achieve the exclusion law's remedial

objectives in this case. Thus, I find that while a seven-year exclusion would surely serve a deterrent purpose, its effect on Petitioner would be punitive, given the circumstances of this case.[9]

The evidence establishes that Petitioner has been practicing psychiatry since 1962, and that he has never been convicted of any criminal offense prior to 1989. P. Ex. 1/1. In addition, there is no evidence that Petitioner has been sanctioned by either the Medicare program or the Medicaid program prior to the investigation of the Medicaid Fraud Control Unit in 1986. Instead, evidence gleaned from the testimony of character witnesses and from letters written on Petitioner's behalf establish that Petitioner has a reputation for competence and trustworthiness, that he enjoys the respect of his medical colleagues, that he is held in high esteem by his patients, and that he has provided a needed specialty in the Norwich, Connecticut area.

Three physicians who have worked closely with Petitioner over long periods of time testified at the hearing in this case. This testimony establishes that Petitioner is highly regarded in the medical community in Norwich, Connecticut. Petitioner's professional colleagues frequently seek his advice on difficult medical questions they are facing in their own practices, and they refer patients to Petitioner without hesitation. Tr. 15, 23, 28, 36. All three physicians testified that the quality of care that Petitioner has provided to his patients over the years is excellent. Tr. 23, 28, 36. While Petitioner's professionalism is not directly at issue in this case, it is one indicia of trustworthiness. The fact that Petitioner has consistently provided high quality care to his patients over a career of almost three decades reflects well on his character and trustworthiness.

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[9] Petitioner asserts that one of the factors which mitigate against a seven year exclusion in this case is his age. Petitioner is 60 years old and he states that a seven year exclusion is "unduly harsh" in view of the fact that he has a limited number years left to practice medicine. P. Br. 10. I did not consider Petitioner's age in determining whether a seven year exclusion is extreme or excessive in this case. Age is not a factor which bears directly on the issues of Petitioner's trustworthiness and whether the program's interests can be sufficiently protected by a shorter exclusion. See Francis Shaenboen, R. Ph., DAB App. 1249 at fn. 8 (1991).

Petitioner's medical colleagues also addressed the issue of Petitioner's character and trustworthiness in their testimony. This testimony establishes that Petitioner has a reputation in the community for being an honest and trustworthy individual. Tr. 40.

In addition to showing that Petitioner has a reputation for being a reliable physician and an honest individual, the testimony presented at the hearing also establishes that Petitioner has filled a need to provide psychiatric care to the indigent, profoundly ill segment of the population in the Norwich, Connecticut community. Prior to his exclusion from Medicare and Medicaid, Petitioner's practice consisted primarily of psychotic patients who had been discharged from the state hospital in Norwich. These patients are extremely difficult to treat because they are often assaultive and suicidal. In addition, they tend to be highly demanding of their physician's time. They have a tendency to be unreliable in keeping their scheduled appointments, and they often require medical care at unexpected, unscheduled times. They frequently need emergency medical care outside of normal business hours, including all hours of the night. While these patients are likely to be dangerous and exceptionally difficult and demanding, the financial rewards for treating them are limited. They are often from the most economically deprived segment of the population, and, in some instances, are homeless. Tr. 17, 18, 19, 22, 28, 30, 37, 46.

These patients have great difficulty finding and sustaining treatment outside the hospital setting. Most private practitioners and privately run mental health clinics refuse to treat them because it simply is not lucrative to do so. Tr. 30. Even if a practitioner is willing to accept them for treatment, they are often unsuccessful in treating them over extended periods of time because these patients are often unable to accept normal treatment protocols and they tend to be difficult to handle. The record shows that Petitioner was unusual in his willingness to accept these deinstitutionalized patients for psychiatric treatment. Not only was Petitioner willing to accept them for treatment, but he demonstrated an unusual ability to continue treating them over long periods of time. He was able to provide many individuals who were at risk for being rehospitalized with the necessary medical care and support to sustain them in the community. Thus, Petitioner's work met a need in the community that few other psychiatrists were either willing or able to meet. P. Ex. 4.

In meeting this need in the community, Petitioner has demonstrated enormous dedication and compassion. The record shows that he regularly worked seven days a week, and that many of these days he worked up to sixteen hours a day. P. Ex. 9. He was accessible to his patients at all hours of the day or night, and he often provided services for which he did not receive any payment. According to an affidavit submitted by Ms. Burns, Petitioner often treated patients outside of normal business hours if the need arose. Even if he saw a patient several times a week for unscheduled visits, he would usually bill Medicaid for only one visit that week. If he was treating a patient whose benefits ran out in the middle of the year, he would typically continue to treat that patient free of charge for the rest of the year. P. Ex. 6. In fact, Petitioner testified that after he was notified that he was going to be excluded from the Medicaid program, he continued to treat his Medicaid patients free of charge for over a year. The reason Petitioner gave for doing this was "[b]ecause nobody else would take care of them. They have developed attachments to me and they relied on my expertise and my help". Tr. 48. This testimony was corroborated by one of Petitioner's medical colleagues. Tr. 18.

Not only did Petitioner provide medical services free of charge, but he often performed personal services for his patients when he saw a need. Patients often requested him to assist them in filling out applications for housing and other government assistance programs, and he provided such assistance free of charge. P. Ex. 6/3. He has provided transportation to patients who were unable to get to and from his office without this assistance, and he has made house calls when necessary. P. Ex. 9/3. On occasion, he has invited an emotionally disturbed child to spend a day with his family so that the parents of the child would be able to "get a break for the day." P. Ex. 2/3.

While the parties presented thorough and concise arguments in this case, the I.G. characterized Petitioner's improper billing procedures as an "elaborate scheme to defraud the Medicaid program". I.G. Br. 6. In characterizing Petitioner's conduct in this manner, the I.G. implies that Petitioner is a greedy health care provider who deliberately and painstakingly set out to formulate and implement a plan to steal as much money as possible from the Medicaid program. I do not accept this characterization of Petitioner's conduct. The evidence shows that Petitioner is an exceptionally generous individual who is committed to caring for his patients and that he repeatedly placed the needs of his patients

above his own financial interests. In fact, Petitioner's commitment to patient care and his disinterest in monetary gain resulted in a woeful neglect of the financial aspects of his practice. The record shows that Petitioner's billing violations were in large part the product of poor business management practices rather than an elaborate plan to defraud Medicaid.

Petitioner devoted virtually all of his time and attention to patient care and he paid little attention to what he considered was the less important recordkeeping and administrative functions of his office. P. Ex. 2/4. According to one of Petitioner's medical colleagues, Petitioner was notoriously disorganized. He failed to keep adequate records, tried to remember everything "in his head", and often forgot to inform his office staff of whom to bill. Office cleanups often uncovered uncashed checks and unopened business correspondence. P. Ex. 9/2.

Ms. Burns stated in her affidavit that Petitioner relied on her to prepare bills properly and to read and understand Medicaid bulletins. She explained that when she first began to work for Petitioner in 1975, she did not receive any training in Medicaid billing procedures. P. Ex. 6/1-3. Ms. Burns states in her affidavit that Petitioner often signed invoices without reading what he signed. P. Ex. 6/1. Petitioner also admitted that he delegated billing matters to Ms. Burns and did not take time to inform himself of Medicaid regulations or to train or supervise Ms. Burns. P. Ex. 1/6.

In testimony before the Judicial Inquiry, Petitioner explained his policy to charge for "no-show" or canceled appointments by stating that he provided additional services which offset the billing for missed appointments. Petitioner indicated that while he charged for missed appointments, he often saw patients in unscheduled visits once or twice a week for regulation of medication or night calls, and that he did not charge for these visits. I.G. Ex. 4/11-12. This testimony was corroborated by Ms. Burns. I.G. Ex. 6/3. According to testimony by an investigator with the Medicaid Fraud Control Unit, there are procedures which can be followed to reimburse a provider in instances where a patient is treated in an emergency or when he needs treatment more than once a week. Tr. 94-95. Due to his lack of interest in the technicalities of Medicaid billing regulations, Petitioner failed to learn about and follow these procedures. Instead, he charged for missed visits on the theory that these billings would be offset by the other services for which he was not paid.

While this explanation does not excuse Petitioner from violating the Medicaid prohibition against charging for missed appointments, it does offer insight into why Petitioner violated this rule. In violating the rule against charging for "no-shows", Petitioner was motivated by laziness in acquainting himself with relevant Medicaid regulations which would enable him to be properly compensated for services he actually performed rather than by a desire to fraudulently receive money for services that were never performed.

Similarly, Petitioner's violations of Medicaid regulations regarding the correct procedure codes to be used in billing for the services of Allied Health Professionals and for family therapy services and his violation of the Medicaid requirement that psychological services be billed by the test rather than by the hour appears to be the result of Petitioner's failure to accept his responsibility to adhere to Medicaid regulations rather than an "elaborate scheme" to bilk the Medicaid program for as much money as possible.

The picture of Petitioner that emerges from the record is that of an exceptionally dedicated medical practitioner who devoted his attention to patient care at the expense of the administrative aspects of his practice. Petitioner apparently considered his ability to provide excellent psychiatric care to his patients to entirely supersede his duty to adhere to Medicaid billing regulations. Petitioner's overriding interest was the care of his patients, and he did not want to be bothered with clerical duties or paperwork which he considered to be far less important than the needs of his patients. As a result, Petitioner cavalierly ignored Medicaid regulations, and instead admits that he made billing decisions on an ad hoc "shoot from the hip" basis. P. Ex. 1/6. While Petitioner is guilty of disregarding Medicaid regulations, he did not engage in an "elaborate scheme" to defraud the Medicaid program.

I recognize that false billings motivated by a failure to accept responsibility for adhering to Medicaid rules are as harmful to the financial health of the Medicaid program as false billings motivated by a desire to steal funds as part of an elaborate scheme to defraud the government. Petitioner's disregard of the law and his misconduct cannot be excused. In spite of this, I find that an examination of Petitioner's motivation for his misconduct is relevant in determining the length of the exclusion because it sheds light on the likelihood that he will repeat the offenses of which he was convicted. Since inferences regarding Petitioner's trustworthiness

and his propensity to repeat the criminal offenses can be drawn from the circumstances leading to the criminal offense, including the reasons Petitioner committed the offenses, these facts are relevant in determining the length of an exclusion.

The facts of this case lead to the conclusion Petitioner is unlikely to repeat his criminal offenses. Petitioner enjoyed an unblemished record and the high regard of his colleagues, his patients, and the community at large for the almost thirty years that he has been practicing as a psychiatrist. The record also shows that Petitioner is an individual who takes a lot of pride in his work, and that he experienced a great deal of pain and humiliation as a result of his criminal conviction. Petitioner testified at the hearing before me that the criminal proceedings and conviction were so painful and traumatic that he will never engage in the same type of criminal misconduct again. I find this testimony to be convincing, and I find that Petitioner has learned that it is unacceptable to cavalierly ignore Medicaid billing regulations. Petitioner testified that he has upgraded his office procedures and that he has new secretarial help to assist him in the bookkeeping functions of his office. Petitioner also acknowledges that the ultimate responsibility for accurate bills rests with him, and that he now takes that responsibility seriously. Tr. 59-60; P. Ex. 1/4-6.

Based on a review of all the evidence before me, I conclude that a seven year exclusion would be excessive in order to assure Petitioner's trustworthiness to submit accurate Medicaid claims. Petitioner has conscientiously provided high quality health care to his patients for almost three decades. He is an individual who has repeatedly placed the interests of his patients above his personal financial interests. While Petitioner has failed to adhere to Medicaid billing regulations, this failure resulted from a lack of interest in the administrative aspects of his practice rather than an "elaborate scheme" to defraud the government. Petitioner has also admitted his wrongdoing, and has demonstrated by his demeanor and statements that he has become fully aware of his responsibilities to the Medicare and Medicaid programs. All of these factors reflect well on Petitioner's character and lead to the conclusion that he can be trusted not to repeat his criminal offenses. Moreover, Petitioner's unusual willingness to treat deinstitutionalized psychotic patients and his rare success at maintaining them in the community has filled a pressing medical need in the Norwich, Connecticut area. While the fact that Petitioner provides a needed

specialty does not necessarily lead to the conclusion that Petitioner is trustworthy, it is a factor which can be considered to be "mitigating", according to the legislative history.

The I.G. abused his discretion in failing to consider any of these factors in reaching his decision to exclude Petitioner for seven years. See Leonard P. Harman, D.O., DAB Civ. Rem. C-162 at 10 (1990). Accordingly, I find that the exclusion of seven years would be unreasonably punitive when applied to Petitioner.

I conclude that the circumstances of this case, coupled with my observation of Petitioner during his testimony, convince me that the exclusion should be modified in this case to a term of five years. A five year exclusion will, given the circumstances of this case, be sufficient to demonstrate that he no longer poses a threat to the integrity of federally funded health care programs.

CONCLUSION

Based on the law and evidence in this case, I conclude the I.G. properly excluded Petitioner from the Medicare and Medicaid programs pursuant to section 1128(a)(1) of the Act, and that a minimum period of exclusion of five years is mandated by section 1128(c)(3)(B) of the Act. In addition, I conclude that the seven year exclusion imposed against Petitioner is excessive and unreasonable, and I modify it to five years.

/s/

Charles E. Stratton
Administrative Law Judge