Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
The Inspector General,	)	DATE: October 10, 1991
	)	
- v. -	)	
	)	
Timothy L. Stern, M.D.,	)	Docket Nos. C-119, C-177
	)	
Respondent.	)	Decision No. CR154
	)	

DECISION

In this case, governed by section 1128A of the Social Security Act (Act), the Inspector General (I.G.) of the United States Department of Health and Human Services (DHHS) issued a Notice of Determination (Notice) on January 18, 1989, informing Timothy L. Stern, M.D. (Respondent) that the I.G. was seeking civil monetary penalties of $425,250.00, an assessment totalling $70,648.00, and a 20 year exclusion of Respondent from participation as a medical provider in the Medicare, Medicaid, and other federally-funded State health care programs.

The I.G. alleges that Respondent violated section 1128A of the Act, the Civil Monetary Penalties Law (CMPL), and its implementing federal regulations (Regulations) when Respondent presented, or caused to be presented, 688 claims to the Medicare carrier, Blue Shield of Western New York (BSWNY), requesting Medicare reimbursement for his Medicare patients by stating that he performed either local nerve blocks, office visits, or consultations, and that Respondent knew, had reason to know, or should have known that the services were not provided as claimed. The I.G. alleges that Respondent, instead of performing the services claimed, performed acupuncture services, for which Medicare does not pay. Tr.I/5 through 10, 22.

The I.G.'s Notice was supplemented by an additional Notice, dated November 9, 1989, and was modified at the hearing. [1/2/3].

Respondent filed a timely answer (Request) denying the I.G.'s allegations, challenging the proposed sanctions, and requesting a hearing before an Administrative Law Judge (ALJ). Respondent also challenges the I.G.'s authority and the legality of this action. Respondent argues that he performed the services as claimed and

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[1]The citations to the record in this Decision are as follows:

Hearing Transcript--July-Aug.	Tr.I/(p.)
Hearing Transcript--Jan.'91	Tr.II/(p.)
Respondent's Exhibits	R.Ex. (no./p.)
Respondent's Brief	R.Br. (p.)
Respondent's Reply Brief	R.Rep.Br.I (p.)
Respondent's 2nd Reply Brief	R.Rep.Br.II (p.)
I.G.'s Exhibits	I.G.Ex.(no./p.)
I.G.'s Brief	I.G.Br. (p.)
I.G.'s Reply Brief	I.G.Rep.Br.(p.)
I.G.'s June 1990 Brief	I.G. 1990 Br.(p.)
Findings of Fact and Conclusions of Law	FFCL (no.)
Prehearing Rulings	ALJ Ruling (date/p.)

[2] Although traditional acupuncture is an ancient Chinese healing art dating back at least two thousand years, Medicare still considers it experimental and does not reimburse medical providers for performing such services to patients. See I.G. Br. 14-17.

[3]The I.G. alleged in his January Notice that 707 services were not provided as claimed and appended a schedule of services to his November Notice, but only listing 706 claims or counts. During the hearing, the I.G. withdrew 11 counts, leaving 695 in issue. On the first day of the hearing, however, the I.G. argued that there were 696 services in issue because he was not yet aware that one of the alleged services was not listed on the schedule. Tr.I/6. At the hearing, I reduced the CMPL counts from 695 to 688 because I concluded that the holding in the case of United States v. Halper, 490 U.S. 435 (1989), required that the seven services which had also been involved in Respondent's criminal conviction be eliminated from this civil action. Tr.II/810-811; see I.G. Br. 2 (fn.1), 186 (fn.37,38).

conformed with BSWNY's instructions for submitting claims. R. Br. 227-239; Tr.I/10-21.

APPLICABLE FEDERAL STATUTES AND REGULATIONS

I. Statutes.

This case is governed by the Civil Monetary Penalties Law (CMPL), Section 1128A of the Social Security Act (Act), 42 U.S.C. 1320a-7a (1988).

II. Regulations.

The governing federal regulations (Regulations) are codified in 42 C.F.R. 1003.100 through 1003.133 (1990).

BACKGROUND

I. Prehearing Motions.

On February 6, 1990, Respondent filed a motion to dismiss for lack of jurisdiction and the I.G. objected. On April 6, 1990, I issued a Ruling denying the motion and on April 24, 1990, I issued a Ruling denying reconsideration. On May 10, 1990, I issued a Ruling on Respondent's request for discovery and the I.G.'s motion to strike; on June 7, 1990, I modified the Ruling. There were dozens of other motions or disputes resolved by prehearing conferences or in miscellaneous rulings or orders issued by me. On May 11, 1990, Respondent filed a motion to dismiss; the I.G. objected to this motion on June 19, 1990. I denied Respondent's motion at the hearing on July 30, 1990. Tr.I/81-113.

II. The Hearing.

The evidentiary hearing in this case was conducted in Rochester, New York, in two parts; the first part was from July 30 through August 3, 1990, and the second part was from January 7-12, 1991. The record consists of 11 days of trial and documentary evidence submitted by the parties. Respondent proceeded pro se and on occasion was represented by his brother, Arthur L. Stern, an attorney in Rochester. The I.G. was represented by Lisa A. Foley

and Thomas Herrmann, attorneys, Office of General Counsel, I.G. Division.[4]

III. Posthearing Motions And Defenses.

Respondent renewed many of his legal and constitutional challenges to this action in his posthearing briefs. These motions and arguments will be addressed in the latter part of this decision.

ISSUES

The issues are:

I. Liability.

1. Whether the I.G. proved that the 688 Medicare services in issue "were not provided as claimed."

2. Whether the I.G. proved that Respondent "knew, had reason to know, or should have known" that the 688 Medicare services at issue were not provided as claimed, in violation of the CMPL and Regulations.

3. Whether the CMPL requires fraud on the part of Respondent for liability to attach.

II. The Amount Of The Penalties, The Assessment, And The Period Of Exclusion.

1. Whether the I.G. proved the aggravating circumstances as alleged.

2. Whether Respondent proved any circumstances that would justify reducing the amount of the penalties, the assessment, or the period of exclusion proposed by the I.G.

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[4] Respondent was originally represented by Charles E. Crimi who, unfortunately, died six months after filing Respondent's request for a hearing.

III. Constitutional, Jurisdictional, And Procedural Challenges To This Action.

1. Whether the double jeopardy clause of the Constitution of the United States prohibits the I.G. from bringing this action against Respondent.

2. Whether the I.G. is equitably estopped or otherwise barred in this case by the Plea Agreement between the United States and Respondent in Respondent's criminal trial.

3. Whether this action is barred either by the doctrine of res judicata or by the doctrine of collateral estoppel.

4. Whether this is a quasi-criminal proceeding and Respondent has the right to procedural safeguards, such as the right to trial by jury and to be found guilty beyond a reasonable doubt.

5. Whether Respondent was prejudiced or denied due process by the admission of written statements of patients obtained by the I.G. in lieu of live testimony or by the I.G.'s claim of privilege.

FINDINGS OF FACT AND CONCLUSIONS OF LAW [5]

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. For the purposes of these proceedings, I have taken judicial notice of the statutes of the United States and the State of New York, and the regulations of DHHS.

2. This proceeding is governed by section 1128A of the Act (42 U.S.C. 1320a-7a), and regulations promulgated thereunder at 42 C.F.R. 1003.100 et seq.

3. Section 1128A of the Act authorizes the Secretary to impose a civil monetary penalty, an assessment and an exclusion from program participation upon a person who presents or causes to be presented to an officer,

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[5]Some of my statements preceding these Findings of Fact and Conclusions of Law are also findings of fact and conclusions of law. To the extent that they are not repeated here, they were not in controversy.

employee or agent of the United States a claim for items or services under Medicare (Title XVIII of the Act) which the person knew, had reason to know, or should have known were not provided as claimed. 42 U.S.C. section 1320a-7a(a)(1).

4. The Secretary of DHHS has delegated to the I.G. the authority to take action under section 1128A of the Act. 49 Fed. Reg. 35247, 35250 (September 6, 1984).

5. By letter dated January 18, 1989, the I.G. notified Timothy L. Stern, M.D., Respondent, of the I.G.'s proposal to impose against Respondent civil monetary penalties totaling $425,250.00; an assessment of $70,648.00; and exclusion from participation in all federally financed State health care programs for a 20-year period.

6. The I.G. based its proposal on his determination that Respondent presented or caused to be presented to an agent of the United States claims for items or services which Respondent knew, had reason to know, or should have known were not provided as claimed.

7. Specifically, the I.G. determined that the Respondent had presented or caused to be presented claims requesting Medicare reimbursement for nerve blocks, office visits, or consultations, which are covered in certain circumstances by Medicare, when acupuncture, a non-covered service, was provided.

8. By letter dated March 15, 1989, Respondent, through counsel Charles E. Crimi, requested a hearing before an ALJ.

9. The I.G.'s January 18, 1989, Notice was subsequently modified by a supplemental Notice dated November 9, 1989. Tr.I/21.

10. The I.G. appended an attachment to the November 9, 1989 Notice which indexed the claims at issue in this case as claims 1-707; there were in fact only 706 claims listed (the number 199 was omitted); subsequently, at the hearing on July 30, 1990, the I.G. dropped claims 315-320, 475-477, and 641-642, leaving 695 claims at issue. Tr.I/21.

11. Seven of the 695 claims (528, 529, and 533-537) are identical to counts encompassed by Respondent's criminal conviction and have been eliminated by my Ruling on the applicability of U.S. v. Halper, 490 U.S. 435 (1989).

12. There are 688 claims remaining at issue in this case. FFCL 10/11.

13. The claims at issue represent approximately $35,000 in items or services Respondent claimed to have provided at Rochester Pain Medicine during the years 1983 through 1986. I.G. Ex. 1-1 through 31-1; Tr.I/550-553, 555, 593-596, 641-644; I.G. Ex. 32-2; Tr.II/102-104.

14. Although Respondent represented himself in this case, he was assisted at times by his brother Arthur Stern, an attorney.

15. During the period in which the claims at issue were presented, Respondent was licensed to practice medicine in the State of New York. Tr.II/188, 190; I.G. Ex. 84-2 /9,10.

16. During the period in which the claims at issue were presented, Respondent was the sole practitioner at his clinic, Rochester Pain Medicine. Tr.II/52, 1324, 1584; I.G. Ex. 84-2/10.

17. In each patient encounter that resulted in a claim, Respondent performed either electro-acupuncture or a procedure he called "electrical stimulation," which consisted of inserting 4-16 acupuncture needles into the skin at various areas of the body, attaching the needles to an electric current source using electrodes and wires, and applying electric current to the needles for 10-20 minutes. I.G. Ex. 1-19, 2-7, 3-4, 4-8, 5-6, 6-5, 6-6, 7-5, 7-6, 8-39, 8-40, 8-41, 10-22, 10-23, 10-24, 11-10, 11-11, 12-25, 12-26, 12-27, 13-9, 14-7, 15-11, 15-12, 15-13, 16-4, 16-5, 17-6, 17-7, 18-11, 19-4, 19-5, 19-6, 20-4, 21-7, 21-8, 22-4, 22-5, 23-7, 23-8, 24-3, 25-8, 25-9, 26-3, 27-5, 28-8, 28-9, 29-5, 31-3 59, 59-1. See Tr./I, 150, 838, 920; Tr.II/58, 63, 315; I.G. Ex. 1-16, 1-17, 1-18, 1-20, 4-6, 4-7, 8-38, 12-23, 12-24, 13-7, 15-9, 15-10, 18-10, 20-3, 22-4, 22-5, 23-5, 23-6, 40; I.G. Ex. 9-63, 22-3, 22-4, 22-5, 30-10; Tr.II/1558, 1546, 1562; Tr.II/92-98; I.G. Ex. 78-2, 78-3, 81-1, 81-3; I.G. Ex. 61-1/5,7; 64-1/6,11; 68/5,6; 69/7; 66-1/4,7; I.G. Ex. 65-1.

18. During some of the patient encounters resulting in the claims at issue, Respondent injected the electrically stimulated area with a small amount of an anesthetic agent called "marcaine," just prior to the electro-acupuncture treatments. Tr.II/1116, 1120; Tr.II/1341; see I.G. Ex. 95/2.

19. During many patient encounters, the Respondent provided additional medical services, including discussions with the patients, prescriptions, minor surgery, blood pressure checks, myelograms, and referrals for lab tests and procedures. Tr.II/1434-1440. See I.G. Ex. 1-15, 1-18/2, 2-6, 3-3, 4-5, 5-5, 8-36, 8-37, 9-61, 9-62, 9-63, 10-20, 10-21, 11-9, 12-22, 12-24, 13-6, 14-5, 15-8, 16-3, 17-4, 18-9, 19-3, 20-2, 21-6, 22-3, 23-4, 25-7, 26-2, 27-4, 28-6, 29-3, 30-9, 31-2; R. Ex. 101 A-L, N-CC; R. Ex. 63.

20. During the relevant time period, BSWNY was located in Binghampton, New York, and was the designated Medicare Part B carrier for the region in which the services at issue in this proceeding were provided. Tr.I/116-117.

21. BSWNY began investigating Respondent in 1983, after a review of his payment records indicated that he was billing an unusually large number of nerve blocks. Tr.I/150; I.G. Ex. 40. See Tr.I/919, 1011-1012; I.G. Ex. 73/4.

22. BSWNY's initial telephone contacts with beneficiaries indicated that Respondent was performing acupuncture, although he was claiming his services as nerve blocks. I.G. Ex. 40. See Tr.I/150.

23. Thereafter, BSWNY and the I.G. had a series of in-person, telephone, and written contacts with Respondent to determine what services were being claimed as nerve blocks and to educate Respondent on Medicare policies and rules for filing claims properly. I.G. Ex. 42.1; I.G. Ex. 42-2; Tr.II/920; I.G. Ex. 73/7,9; I.G. Ex. 44; Tr.I/153-154; I.G. Ex. 74/20; I.G. Ex. 47/1; I.G. Ex. 48.

24. During the course of their contacts with Respondent, BSWNY and I.G. representatives specifically informed Respondent that his patients had indicated he was performing acupuncture and that acupuncture is not a covered service. I.G. Ex. 42-2; Tr.II/920; I.G. Ex. 73/7,9.

25. During the course of their contacts with Respondent, BSWNY and I.G. representatives specifically informed Respondent that acupuncture was not the same thing as a nerve block and that Medicare covers only two nerve blocks per year, but only if nerve blocks are for diagnostic purposes, rather than for the treatment of pain. I.G. Ex. 42-2; I.G. Ex. 44; I.G. Ex 47/1; I.G. Ex. 48; I.G. Ex. 73/7,9; I.G. Ex. 74/20; Tr.I/153; Tr.II/920.

26. During the course of their contacts with Respondent, BSWNY and I.G. representatives specifically informed Respondent that claims for office visits should not be based merely on time spent with the patient, but rather on some medically necessary service being performed and documented. I.G. Ex. 44; Tr.I/153-154; I.G. Ex. 74/20; I.G. Ex. 48; I.G. Ex. 47/1,2; Tr.I/939; see I.G. Ex. 37/15 and 20.

27. During the course of their contacts with Respondent, BSWNY and I.G. representatives specifically informed Respondent that only six local infiltrations of anesthetic agent are reimbursable in a calendar year and only if medically necessary. I.G. Ex. 47/1; I.G. Ex. 48.

28. During the course of their contacts with Respondent, BSWNY and I.G. representatives specifically informed Respondent that (1) he should not resubmit claims and list the services as an "office visit" if the services listed on the claims had already been turned down as "nerve blocks" and (2) that he should not add documentation to his records, as either action could be construed as fraud. I.G. Ex. 47/2; I.G. Ex. 44; Tr.I/153; I.G. Ex. 74/20-22.

29. It was standard practice for Respondent to collect payment at the time of service, and then for Rochester Pain Medicine (RPM) staff to submit claims on behalf of patients, who had been led to believe that they would be reimbursed for Respondent's services. I.G. Ex. 61; I.G. Ex. 64/2; I.G. Ex. 66-1/4; I.G. Ex. 10-23/2; I.G. Ex. 10-24; Tr.I/429, 466, 942, 943; Tr.II/67. See I.G. Ex. 1-1 through 32-2; I.G. Ex. 82A and B.

30. BSWNY notified physicians in its region, including Respondent, about Medicare reimbursement policies by a Claims Manual issued in 1979, a Doctor's Manual released in late 1983, effective January 1984, (1984 Doctor's Manual) (which replaced the Claims Manual), and periodic policy updates. Tr.I/116, 118, 123-127, 666; See I.G. Ex. 34, 35, 36, 37.

31. All but approximately 66 of the 688 claims at issue were submitted on HCFA 1500 claim forms. I.G. Ex. 1-1 through 1-31.

32. By signing box 25 of the Medicare HCFA 1500 claim form, Respondent certified as follows: "... the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by an employee under my immediate

personal supervision ...." I.G. Ex. 12-15; I.G. Ex. 37/6,7; Tr.I/129, 554.

33. Claims for services should describe the procedure performed by means of a five character procedure code (e.g., "52980") corresponding to the services listed in the applicable Claims or Doctor's Manual and, if further clarification of the service is necessary, a verbal description of the service provided (e.g., "nerve block"). I.G. Ex. 34/8; I.G. Ex. 37/6,9.

34. Respondent had complete control over policies and procedures regarding how claims would be submitted from Rochester Pain Medicine. I.G. Ex 64; see I.G. Ex. 61; 64-1, 65-1, 66, 67-1, 68, 69.

35. Of the claims at issue in this proceeding, 343 show the verbal description "local nerve block," 339 show "office visit," four show "consultation," one shows "consultation/office visit", and one shows "flu shot/local nerve block." I.G. Ex. 1-1 through 1-31.

36. Of the 339 claims described as "office visit," 288 show the procedure code 90060 ("intermediate" office service for an established patient), 16 show code 90050 ("limited" established patient office service) seven show code 90040 ("brief" established patient office service), eight show code 90020 ("comprehensive" new patient office service), and 20 show no procedure code. I.G. Ex. 37/25; see I.G. Ex. 1-1 through 1-31.

37. Of the four claims described as consultation, three show no code, and one shows code 90610 ("extensive consultation"). I.G. Ex. 37/26; see I.G. Ex. 3-3, 5-5, 6-4, 14-5.

38. Of the 343 claims for "local nerve block," three show no code, and the rest show different codes for different time periods, breaking out generally as follows:

123 showing 52980 for the period 1/83 to 2/84;

24 showing 62274 for the period 1/84 - 1/85;

20 showing 64450 for the period 2/84 - 1/85

9 showing 64415 for the period 3/84 - 1/85

24 showing 64441 for the period 6/84 - 11/84;

3 showing 64405 (two in 4/84, and one in 1/85); and

137 showing W3600 for the period 1/85 - 6/86.

I.G. Ex. 1-1 through 1-31.

39. Medicare procedure code 52980 is listed under the term "Nerve Block" and next to the term "Paravertebral Block (Lumbar)" in the 1979 Medicare Part B Claims Manual. I.G. Ex. 34/31; Tr.I/270.

40. Medicare procedure code 64441 is listed under the term "Introduction/Injection of Anesthetic Agent (Nerve Block) ..." and next to the term "paravertebral nerves, multiple, regional" in the 1984 Doctor's Manual. I.G. Ex. 37/30.

41. Medicare procedure code 64450 is listed under the term "Introduction/Injection of Anesthetic Agent (Nerve Block) ..." and next to the term "other peripheral nerve or branch" in the 1984 Doctor's Manual. I.G. Ex. 37/30.

42. Medicare procedure code 64415 is listed under the term "Introduction/Injection of Anesthetic Agent (Nerve Block) ..." and next to the term "brachial plexus" in the 1984 Doctor's Manual. I.G. Ex. 37/29.

43. Medicare procedure code 64405 is listed under the term "Introduction/Injection of Anesthetic Agent (Nerve Block) ..." and next to the term "greater occipital nerve" in the 1984 Doctor's Manual. I.G. Ex. 37/29.

44. Medicare procedure code 62274 is listed under the term "Puncture for Injection, Drainage, or Aspiration" and next to the term "injection of anesthetic substance diagnostic or therapeutic subarachnoid or subdura" in the 1984 Doctor's Manual. I.G. Ex. 37/28.

45. BSWNY local procedure code W3600 was listed under the term "Introduction or Removal" and next to the term "Localized infiltration of anesthesia" in the 1984 Doctor's Manual. I.G. Ex. 37/27; Tr.I/272-273; Tr.I/1494.

46. Traditional or classical acupuncture is an ancient form of treatment originating in China and involving placement and manipulation of one or more thin metal needles beneath the skin at particular points. I.G. Ex. 76/5,6; Tr.I/763, 1224, 1472.

47. It is possible to use electrical current to create the effect of manual manipulation of the acupuncture needles. I.G. 76/7-8; Tr.I/1474. See Tr.II/708-709, 724, 763.

48. When electrical current is introduced to the acupuncture needles, the procedure is commonly referred to as electronic acupuncture, electro-acupuncture, or electrical stimulation. Tr.II/708, 724; I.G. Ex. 82A/1,4.

49. In an electro-acupuncture treatment, 4-16 acupuncture needles inserted beneath the skin are attached by clips and wires to an electric current source which is activated for ten to twenty minutes. Tr.II/708-711; I.G. Ex. 76/21-22.

50. Percutaneous electrical stimulation (PENS) involves the introduction of the electric current by way of an electrode which is surgically implanted in the area of a major nerve in the central nervous system. Tr.I/1237, 1242, 1485; 1594-1597. See I.G. Ex. 35/4, I.G. Ex. 37/32; I.G. Ex. 105/3; Tr.II/1659.

51. Transcutaneous electrical stimulation (TENS) involves the introduction of the electric current by way of pads placed on the skin. Tr.I/1482, 1484.

52. Faradic electrical stimulation (FES) is used in the treatment of Bell's Palsy to accelerate regeneration of facial nerves. Tr.II/1591.

53. Other types of electrical stimulation are used in diagnostic studies for purposes of measuring nerve conductivity. Tr.II/1591.

54. Acupuncture, electro-acupuncture, PENS, and TENS are all used in the treatment of pain.

55. Respondent's electrical treatments invariably consisted of inserting 4-16 acupuncture needles through the skin and attaching them by clips and wires to a generator which was turned on for ten to twenty minutes. FFCL 17.

56. Respondent used the term acupuncture and electrical stimulation synonymously when explaining his practice before a television audience in 1981. I.G. Ex. 82A/1-4, 9-10.

57. In 1982, Respondent advertised his practice as an "acupuncture and pain clinic." I.G. Ex. 80-3; Tr.II/164.

58. In 1989, Respondent applied to the State Department of Education to become licensed as an acupuncturist and stated that he had practiced acupuncture 100 percent of

the time for the last ten years. I.G. Ex. 100, 100-1; Tr.II/208-209.

59. In 1989, Respondent publicized the opening of his acupuncture clinic as the "reopening of his acupuncture practice of ten years." I.G. Ex. 62.

60. Electro-acupuncture is not traditional acupuncture and it is arguable that electro-acupuncture is not technically acupuncture if the needles are not placed at traditional acupuncture points. Tr./742-747.

61. The electrical stimulation procedure practiced by Respondent was electro-acupuncture; nevertheless, for purposes of this case, it is irrelevant whether the acupuncture needles were placed at traditional acupuncture points (when electrically stimulated) since neither electro-acupuncture nor electrical stimulation of acupuncture needles (which are not placed at traditional acupuncture points) is covered by Medicare. Tr.I/1244, 1481-1487; Tr.II/1515, 1527; FFCL 46-60.

62. The electrical stimulation procedure practiced by Respondent was not TENS, PENS, FES, or diagnostic electrical stimulation. FFCL 49-52, 54.

63. For the sake of convenience, references to electro-acupuncture in this decision include the term electrical stimulation, as practiced by Respondent.

64. At various times, Respondent practiced both traditional and electro-acupuncture. I.G. 83-3/24; Tr.I/769-770.

65. During the period involved in this case, Respondent practiced, almost exclusively, electro-acupuncture. Tr.II/1443.

66. Patients came to Respondent's office primarily for electro-acupuncture treatments. Tr.II/1440.

67. Electro-acupuncture treatments do not constitute nerve blocks. Tr.I/784-785; Tr.II/1483.

68. A nerve block is the application of a chemical substance into or around a nerve trunk so as to interrupt the transmission of impulses over that nerve trunk to or from the area of the body supplied by that nerve trunk. I.G. Ex. 77/10,13; Tr.I/1201, 1467; see I.G. Ex. 49-1, 49-2, 49-3, 49-4.

69. Administering a nerve block requires significant technical support facilities, such as oxygen, breathing mask, breathing bag, endotracheal tubes, and a laryngoscope. Tr.I/1216.

70. Nerve blocks are ordinarily administered with hollow stainless steel needles of varying diameter and length, not solid acupuncture needles. Tr.I/1217.

71. During a nerve block procedure, a patient would experience pain followed by numbness which would last from one to twelve hours. Tr.I/606-607, 1220-21.

72. A physician's record of a nerve block should include diagnosis, caliber and length of needle used, region of the body where the needle was placed; drug used and its amount and concentration, sensations experienced during the block, what happened after the block, if anything, and an individualized operative report. Tr.I/976, 1221-24, 1471; See Tr.I/1333.

73. A nerve block differs from local or superficial infiltration or injection of anesthesia, in that nerve block is a direct injection into the area of the nerve trunk, whereas local or superficial infiltration or injections involve the injection of anesthetic agent into the skin and subcutaneous tissue around specific areas of pain to block the nerve endings rather than the nerve trunk. I.G. Ex. 49-4/2; Tr.I/1211-1212, 1469, 1497. See I.G. Ex. 49-1/2; I.G. Ex. 34/15; I.G. Ex. 55-2/7.

74. While it might be arguable that a local or superficial infiltration or injection of an anesthetic agent might be called a nerve block, in a generic sense, since the pain pathway is blocked, what Respondent did was not a nerve block because the amount of anesthetic agent he used was too small. Tr.I/1241, 1297, 1249-1250; Tr.II/1513; Tr.I/785-787.

75. A diagnostic nerve block is used to determine the etiology of the patient's pain and the appropriate course for treating the pain, whereas a therapeutic nerve block is for the relief of the pain itself. Tr.I/1212-1213.

76. A local or superficial infiltration or injection of an anesthetic agent is not a diagnostic nerve block. FFCL 64-66.

77. Medicare provides reimbursement for services which are reasonable and necessary for the diagnosis or treatment of illness or injury. See Section 1862 of the Act; Tr.I/550.

78. To be considered medically necessary under Medicare, services must be consistent with the diagnosis and treatment, appropriate with regard to standards of good medical practice, not solely for the convenience of the patient or the doctor, appropriate with regard to the level of service, adequately documented, and identifiable in the patients records. I.G. Ex. 37/20; see I.G. Ex. 34/12.

79. It is a basic requirement of good medical practice to keep accurate records of provided services. Tr.I/797-798, 1224.

80. To establish that a service was medically necessary under Medicare, documentation should include some statement of the symptoms or diagnosis and a treatment which is consistent with that diagnosis. I.G. Ex. 37/20; FFCL 77-79.

81. Under Medicare, acupuncture is not considered to be reasonable and necessary and is not a covered service. I.G. Ex. 33-3, 33-5; see I.G. Ex. 33-1, 33-2, 33-5, 33-6, 33-7, 33-8.

82. Acupuncture is listed as a non-covered service in both the 1979 Medicare Part B Claims Manual and the 1984 Doctor's Manual. I.G. Ex. 34/18; I.G. Ex. 37/12; see Tr.I/131; Tr.II/41; I.G. Ex. 74/18.

83. Office visits, like all services, must be medically necessary in order to be reimbursed by Medicare. See I.G. Ex. 74/20, 21.

84. Under Medicare, office visits are subject to qualification and subject to reimbursement according to various levels of service, reflecting various levels of skill, effort, time, responsibility and knowledge. I.G. Ex. 37/14, I.G. Ex. 74/22, 23; see I.G. 34/14.

85. Under Medicare, a doctor is not entitled to reimbursement for an office visit simply based on the amount of time he spent with the patient; there must be some medically necessary service provided, including documentation of that service. Tr.I/135-139; see I.G. Ex. 37/20.

86. As a general rule, Medicare regulations would not provide reimbursement for an office visit if the only purpose of the visit were a non-covered service such as acupuncture; an office visit would be allowed and reimbursed for other medically necessary services rendered in addition to a non-covered service. I.G. Ex.

74/23,24, 28; Tr.I/138, 139, 212; see I.G. Ex. 37/20; I.G. Ex. 39-1; FFCL 69.

87. Under Medicare, a physician may be reimbursed for a "consultation" where he renders services pursuant to a request from the attending physician for an opinion and advice; the consultation must include a medical history, physical exam, and written report of findings filed with the patient's permanent record. I.G. Ex. 34/29; I.G. Ex. 35/2; I.G. Ex. 37/26.

88. Under Medicare, nerve blocks are reimbursable if used diagnostically rather than therapeutically. I.G. Ex. 34/15; see I.G. Ex. 35/3; FFCL 66.

89. Medicare policy provides for reimbursement of up to two diagnostic nerve blocks in a calendar year. I.G. Ex. 34/15; I.G. Ex. 35/3; I.G. Ex. 74/17, 30.

90. Medicare policy provides for reimbursement of up to six local infiltrations of anesthesia in a calendar year. Tr.I/1496; I.G. Ex 47; I.G. Ex 48.

91. Medicare policy provides for reimbursement of only discrete types of electrical stimulation for the treatment of pain: PENS and TENS. Tr.II/1481-1487, 1591.

92. Section 1320a-7(a)(1)(A) of the Act, the CMPL, prohibits the submission of claims which were not provided as described in the Medicare claim submitted; this is an exacting standard of care and an "unartful" description of medical services in a Medicare claim is a description of services that were not provided as claimed. Anesthesiologists Affiliated et al v. Sullivan, __ F.2d ___ (8th Cir., No. 90-2387, Aug. 9, 1991).

93. Respondent's medical records for the claims at issue in this proceeding do not reflect that nerve blocks were provided. Tr.I/1244, 1245, 1282; 1514, 1515, 1519-1521, 1527.

94. Respondent's medical records for the claims at issue in this proceeding do not reflect that office visits and consultations were provided. Tr.I/1514, 1515, 1519-1521, 1527.

95. Documentation in the pertinent medical records corresponding to Respondent's nerve block claims is indistinguishable from documentation corresponding to office visit claims. Tr.I/1515.

96. Notations in Respondent's medical records and operative reports attached the claims forms indicate that marcaine was injected during many electro-acupuncture treatments. See I.G. 1-11, 1-12, 2-1, 4-1, 4-2, 5-1, 5-4, 6-2, 6-3, 8-18, 8-25, 8-32, 9-19, 11-8, 12-8, 12-9, 12-10, 12-14, 12-15, 14-2, 14-3, 15-1, 15-2, 15-3, 16-1, 16-2, 18-1, 18-2, 20-1, 22-1, 22-2, 23-1, 23-2, 25-1, 25-2, 25-3, 25-4, 25-5, 27-1, 27-2, 27-3, 28-1, 28-2, 28-3, 28-4, 29-1, 29-2; Tr.I/1251; R.Ex. 94/3; R 14A, 14B;.

97. Respondent's records reflect that he was providing electro-acupuncture treatments to his patients rather than the services claimed. Tr.I/1244, 1515, 1526-1527.

98. Although Respondent's medical records are extremely sketchy and, at times, illegible, there are a number of indications that he provided other services in addition to electro-acupuncture (i.e., prescribed drugs, ordered lab work, administered flu shots, performed minor surgery, or took blood pressure readings). Tr.I/1515; I.G. Ex. 1-15, 2-6, 3-3, 4-5, 5-5, 6-4, 7-4, 8-37, 9-36, 10-21, 11-9, 13-6, 14-5, 15-8, 16-3, 18-9, 20-2, 21-6, 22-3, 23-4, 25-7, 26-2, 27-4, 28-6, 29-3, 30-9, 31-2.

99. These notations of additional services in Respondent's records sometimes occurred in conjunction with claims for office visits and sometimes in conjunction with claims for nerve blocks, but consistently in conjunction with documentation of electro-acupuncture treatments. See I.G. Ex. 1-15, 2-6, 3-3, 4-5, 5-5, 6-4, 7-4, 8-37, 9-36, 10-21, 11-9, 13-6, 14-5, 15-8, 16-3, 18-9, 20-2, 21-6, 22-3, 23-4, 25-7, 26-2, 27-4, 28-6, 29-3, 30-9, 31-2.

100. The most frequent diagnosis found for the claims at issue is arthritis. Tr.I/1247, 1254, 1259, 1261, 1268, 1271, 1274, 1275, 1280, 1289, 1296, 1297, 1299, 1300, 1303, 1306, 1307; Tr.II/1515.

101. Many of the notations of "marcaine" in Respondent's medical records were added to the records after the original notations that electro-acupuncture had been performed. Tr.I/1244, 1293.

102. Beneficiary Charlotte Gans made a written sworn statement to I.G. agent Joseph Neigsch that the only treatment she had received from Respondent was electro-acupuncture. I.G. Ex. 8-40.

103. In subsequent written statements and at the hearing, Ms. Gans recanted the sworn statement, saying that it had not been read back to her before she signed

it, that it had been obtained in a misleading manner, and that she had received other treatments from Respondent, in addition to electro-acupuncture. R. Ex. 96-2, 96-3; Tr.II/1281-1284, 1300-1306.

104. I.G. investigator Richard Chorman signed a sworn statement that he had accompanied investigator Neigsch to the interview with Ms. Gans, that Mr. Neigsch had read Ms. Gans' sworn statement back to her before she had signed it and that investigator Neigsch had not misled Ms. Gans. I.G. Ex. 8-41/2,3.

105. Ms. Gans is elderly, infirm, and at the hearing appeared at times to have been confused about the timing of certain events; Ms. Gans remains under the care of Respondent, likes the Respondent, receives treatment from Respondent at a reduced fee or no fee, and her subsequent written statements were prepared by Respondent and signed by Ms. Gans at Respondent's office. Tr.II/1300; see Tr.II/1154, 1288-1292, 1306, 1344.

106. I did not find Ms. Gans' testimony at the hearing to be credible.

107. Ms. Gans' testimony does not override her initial sworn statement; while she at times received additional services from Respondent, the purpose of her visits to Respondent was to receive electro-acupuncture. See Tr.II/1291, 1294-1295, 1308.

108. Investigator Neigsch did not mislead Ms. Gans. FFCL 106, 107.

109. Sworn statements of five other beneficiaries (or in one instance a relative who had accompanied a now deceased beneficiary to Respondent's office) were contradicted at the hearing by their own testimony or that of relatives who had accompanied them to Respondent's office; the sworn statements indicated that Respondent had provided only electro-acupuncture (with specific stated exceptions), but the testimony indicated that on occasion Respondent had provided other services as well. Tr.I/415, 482, 484-490, 532, 613-616, 621-625, 627.

110. Sworn statements of other beneficiaries were similarly contradicted by excerpts from testimony provided to a grand jury in 1986. Tr.II/835-842, 852-858, 869, 878.

111. The testimony elicited at this hearing and the excerpts from the 1986 grand jury investigation do not

override the sworn statements presented by the I.G.; while the beneficiaries received additional services from Respondent, the primary purpose of their visits to Respondent was to receive electro-acupuncture.

112. The additional services Ms. Gans and others received during their visits for electro-acupuncture therapy are not reimbursable under Medicare since the treatments were not medically necessary under Medicare standards (i.e., not sufficiently documented or inconsistent with the stated diagnoses). See FFCL 78, 80, 86.

113. Respondent presented the testimony and sworn affidavit of his employee Charlene Cook as the best factual account of events in question in this case. R.Br. 46.5; R.Ex. 94; Tr.II/1094.

114. Respondent presented Ms. Cook's testimony to establish and corroborate his version of events. See Tr.II/1099-1158.

115. Charlene Cook was Respondent's full-time office manager from 1980 through 1985, took a year off to have a child, went back to work for Respondent part-time thereafter, and at the time of this hearing was employed by Respondent. Tr.II/1091.

116. Charlene Cook's testimony was not an objective, independent version of events and was not credible; Ms. Cook has a long-standing, close affiliation with Respondent and, at the time of the hearing, was still employed by him. See FFCL 115.

117. Respondent did not prove his assertion that in 1980 Carol Durso of Blue Shield, Rochester, told Respondent to bill his office procedures as nerve blocks under code 52980. See I.G. Ex. 54-1; FFCL 113-116.

118. Respondent did not prove his assertion that in 1980 representatives of BSWNY or any Medicare carrier told Respondent to bill his office procedures under the code 52980. See FFCL 113-116.

119. Charlene Cook's notes of a March 19, 1985 meeting with BSWNY do not prove Respondent's assertion that he was told at that meeting to bill his services first for six local infiltrations of anesthesia and then all other visits as office visits. See FFCL 113-116.

120. At the March 19, 1985 meeting and in a July 16, 1985 letter confirming the results of the meeting, BSWNY

specified the number of times local infiltrations could be claimed per year and that individual claims for the services were subject to the Medicare requirement of medical necessity; BSWNY never stated that Respondent's services fit into particular categories or would be reimbursed without a determination of medical necessity. I.G. Ex. 47; I.G. Ex. 48/2.

121. Respondent did not prove that he was told at the March 19, 1985 meeting or thereafter to bill the services he was providing in his office by billing first for six local infiltrations of anesthesia and then all other visits as office visits. See FFCL 113-116, 119-120.

122. Respondent did not prove that he was billing for his service according to instructions provided by BSWNY. See FFCL 117, 118, 121.

123. The terms local and superficial nerve block have no medical meaning and are not terms used in Medicare reimbursement. Tr.I/1214-1215, 1467.

124. Nerve blocks are not appropriate treatments for arthritis. Tr.I/1247.

125. Electro-acupuncture or electrical stimulation therapeutic services performed by Respondent do not constitute diagnostic or therapeutic nerve blocks, PENS, or TENS, and thus are not reimbursable under Medicare. FFCL 18, 67, 75, 88, 91.

126. Respondent added local injections of marcaine to his electro-acupuncture therapy only after BSWNY began to reject his nerve block claims. Tr.II/1341; I.G. Ex. 95/2.

127. Respondent added local injections of marcaine to his electro-acupuncture therapy only because he felt the injection of an anesthetic agent would legitimize his claims as nerve blocks. I.G. Ex. 95/2; R. Ex. 94.

128. The injection of marcaine, when administered in conjunction with electro-acupuncture, does not convert the electro-acupuncture treatment into a nerve block. Tr.I/1241, 1247, 1249-1251, 1513; See FFCL 126, 127.

129. The injections of marcaine are not reimbursable under Medicare as nerve blocks because Medicare only reimburses diagnostic blocks, and injections of marcaine are not diagnostic blocks. FFCL 75, 76, 88.

130. The injections of marcaine are not reimbursable under Medicare as office visits, since the purpose of the visits was to receive electro-acupuncture and the injections were not medically necessary. FFCL 66, 78, 86, 126, 127.

131. The injections of marcaine are not reimbursable under Medicare as local infiltrations of anesthesia, since they were not medically necessary and were improperly described as "local nerve blocks" on the claim forms. FFCL 78, 92, 135.

132. The additional services provided by Respondent were not reimbursable as office visits under Medicare since the purpose of the visits was electro-acupuncture and since the notations do not constitute sufficient documentation to establish the medical necessity of the services, except in the fourteen instances noted in FFCL 181, below. FFCL 86.

133. The diagnosis listed on the vast majority of the claims in question is not consistent with the treatment documented in the corresponding medical records. Tr.II/1515, 1538-1541, 1545-1563.

134. Respondent's evidence was insufficient to establish the medical necessity of any treatment. Tr.II/1515.

135. The terms "local nerve block" and "superficial nerve block," were "unartful" descriptions of the services provided and, therefore, are descriptions of services not provided as claimed under the CMPL, section 1320a-7(a)(1)(A) of the Act. See FFCL 92.

136. None of the claims in question were properly described: either because the narrative description was improper for the service provided, the code was improper for the service provided, the narrative description did not correspond with the code, or the service provided was claimed at an improper level of service. FFCL 123, 125, 128, 129. 133, 135.

137. All of the 688 claims in question are false or improper under the CMPL. FFCL 123-136.

138. Respondent submitted or caused to be submitted to BSWNY the 688 Medicare claims at issue in this proceeding. Tr.I/550-553, 555, 593-596, 641-644. See I.G. 1-1 through 31-1.

139. Respondent knew that electro-acupuncture was not a covered Medicare service and, therefore, claimed his electro-acupuncture services as "nerve blocks."

140. Respondent knew that electro-acupuncture was not a covered service and, therefore, claimed the electro-acupuncture services he provided as "office visits."

141. Respondent had reason to know that electro-acupuncture was not reimbursable as a nerve block. I.G. Ex. 35/3; FFCL 26, 31, 88.

142. Respondent had reason to know that to be reimbursable as an "office visit," any additional services provided during an electro-acupuncture treatment would have to meet the criteria for medical necessity, including adequate documentation. FFCL 27, 31, 86.

143. Respondent had reason to know that the cryptic notations of additional services (prescription drugs, orders for lab work, administering flu shots, doing minor surgery, or taking blood pressure readings) would not be sufficient to convert otherwise unallowable claims for electro-acupuncture into reimbursable claims for office visits. FFCL 27, 31, 86; Tr.II/151

144. Respondent had reason to know that the additional services he was performing, except for the fourteen noted below, were not sufficiently documented so as to be considered medically necessary under Medicare. FFCL 31, 78-80.

145. Respondent had reason to know that neither the notations of "marcaine," nor the notations in conjunction with occasional operative reports, are sufficient to convert Respondent's unallowable electro-acupuncture services into reimbursable "local infiltration of anesthesia" services. Tr.I/1515, 1526-1527; FFCL 31, 131.

146. Respondent had reason to know that his local injections of marcaine services were not reimbursable under Medicare, since they did not meet the criteria for medical necessity. FFCL 31, 131.

147. Respondent acted with reckless disregard for the Medicare regulations in order to attempt to provide reimbursement for his Medicare patients. FFCL 30, 141-146.

148. Respondent submitted or caused to be submitted to BSWNY claims on behalf of 31 beneficiaries for 688 items

or services which he knew, had reason to know, or should have known were not provided as claimed. See FFCL 73, 127, 128, 130, 131, 132.

149. In assessing Respondent's credibility, I considered that when he applied to be licensed as a acupuncturist in 1988, Respondent indicated on his application to the New York Department of Education that he had practiced acupuncture 100 percent of his time for the last ten years, but when attempting to persuade this ALJ that he should not be found liable under the CMPL, Respondent testified under oath that his was a general medical practice specializing in the treatment of pain and that electro-acupuncture was only one of several medical modalities which he used in treating pain. See FFCL 58; Tr.II/1334-1337.

150. In assessing Respondent's credibility, I considered that Respondent has more than a nine year history of drug addiction, spanning the period in question in this case and lasting at least until 1987. Tr.II/1055-1056, 1058, 1064.

151. In assessing Respondent's credibility, I considered that, in 1986, Respondent lied to the New York State Board for Professional Medical Conduct when he testified under oath that he was drug free. Tr.II/1076, 1086; I.G. Ex. 55-1/4,5; see Tr.II/1326.

152. In assessing Respondent's credibility, I considered that, in entering into a plea agreement in 1987, Respondent admitted guilt to one count of mail fraud under Indictment 86-194T, encompassing five false claims for seven services rendered to beneficiary Antoinette Pezzulo, and to one count of distribution of a controlled substance under Indictment 87-106T. I.G. Ex. 88.4/2-3, 15.

153. In assessing Respondent's credibility, I considered that the claims for services to Ms. Pezzulo corresponded to counts 528, 529, 533, 534, 535, 536, and 537 of the I.G.'s case in this proceeding. I.G. Ex. 15-1, 15-4, 15-5, 15-6.

154. In assessing Respondent's credibility, I considered that, in entering into the 1987 plea agreement, Respondent admitted under oath that he had known that acupuncture was not a covered service under Medicare and had billed Medicare for nerve block services which he had not provided as claimed, whereas in this proceeding Respondent contended that he was merely billing his

services as he had been instructed by BSWNY. I.G. Ex. 88-4/8,12; Tr.II/1340-1341, 1441.

155. In assessing Respondent's credibility, I considered that, in entering into the plea agreement, Respondent testified under oath that he had not been forced to plead guilty under the plea agreement, whereas in this proceeding, Respondent contended that he was forced to plead guilty to mail fraud involving Ms. Pezzulo because the prosecutor threatened to send him to jail on the drug charge if he did not plead guilty to the mail fraud charge as well. I.G. Ex. 88-4/15; Tr.II/1328, 1334-1335.

156. In assessing Respondent's credibility, I considered that Respondent's testimony under oath in this proceeding contradicts previous testimony given under oath. FFCL 154-155.

157. In assessing Respondent's credibility, I considered that Respondent was asked to resign from Rochester General Hospital for improper billing practices and upon his departure wrote a letter to the Executive Director of Rochester General Hospital admitting that he knew that many of his charges were improper and stating that he was seeking psychiatric care to find out why he had acted as he had, whereas in this proceeding Respondent testified that the charges against him at Rochester General were unfounded. I.G. Ex. 90-2/3-4; Tr.II/1321-23.

158. In assessing Respondent's credibility, I considered that Respondent's testimony under oath in this proceeding is inconsistent with the earlier admission made to the Executive Director of Rochester General Hospital. FFCL 157.

159. In assessing Respondent's credibility I considered that Respondent altered his medical records to show that he had administered marcaine to his patients, although BSWNY and I.G. representatives advised him not to add anything to his records. Tr.II/1119, FFCL 29.

160. In assessing Respondent's credibility, I considered that Respondent grossly misinterpreted information provided by BSWNY and Blue Shield of Rochester, disavowing any personal responsibility for his dilemma in this case and alleging that confusion within the Medicare system and personal vendettas against him created the dilemma. See FFCL 25-29, 118-122; Tr.II/1341; R.Br. at 115, 151-152; I.G. Ex. 54-1, 54-2/14-15, 17-18.

161. In assessing Respondent's credibility, I considered that Respondent initially told I.G. investigators that

both Carol Durso (of Blue Shield, Rochester) and representatives of BSWNY told him to bill under code 52980, but later testified that only Carol Durso told him to bill under code 52980, and that he thought she worked for BSWNY. I.G. Ex. 42-2/2; I.G. Ex. 73/8; Tr.I/92; Tr.II/1095-1097.

162. In assessing Respondent's credibility, I considered that Respondent distinguished acupuncture from electronic stimulation when trying to establish that his services should be reimbursed under the Medicare regulations, while during essentially the same time period, Respondent used the terms synonymously in an effort to convince the State Board of Education that he should be granted a license as an acupuncturist. I.G. Ex. 42-2/2; I.G. Ex. 73/6,9; FFCL 50.

163. In assessing Respondent's credibility, I considered that in this proceeding Respondent represented that whenever he injected marcaine he billed under procedure code W3600, local infiltration of anesthesia, whereas the claims show that marcaine was billed under various codes, including 64415, 64441, 64405, 64450, and 90610. R. Br. at 95; R. Rep. Br. I at 1-2; R. Rep. Br. II at 2; Tr.II/1339. See I.G. Ex. 1-8, 5-1, 8-18, 9-19, 11-8, 12-8, 12-9, 12-10, 16-1, 16-2, 15-1, 15-2.

164. In assessing Respondent's credibility, I considered that Respondent alleged having little or no financial resources, yet he received approximately $800,000 after taxes from his mother's 1987 will, and, at the time of the hearing, owned art, furniture, a valuable home, retained membership in a country club ($300/mo.), and had given away substantial amounts to Lisa Carlier, including over $50,000 in jewelry and $160,000 to start a business in which he participated. Tr.II/1599-1600, 1603, 1605, 1607-1610, 1616-1618, 1620-1622, 1636; I.G. Ex. 104; 107/12; R.Br. 175.

165. In assessing Respondent's credibility, I considered that Respondent reported conflicting information about his financial condition to the I.G., the New York State Supreme Court for the County of Monroe, and this ALJ. R. Br. 175; Tr.II/1603, 1605-1613, 1618, 1620-1621, 1630, 1638-1639; I.G. Ex. 106, 107.

166. Respondent is not a credible witness. See FFCL 149-165.

167. Section 1128A of the Act provides for the imposition of a penalty of up to $2,000.00 for each item or service falsely or improperly claimed, an assessment

of up to twice the amount falsely or improperly claimed, and an exclusion from Medicare and federally-financed State health care programs.

168. In determining the amount of penalty and assessment to be imposed, and the length of exclusion, Section 1128(a)(1) of the Act and regulations direct the finder of fact to consider several factors which may be of an aggravating or mitigating nature. 42 U.S.C. 1320a-7a; 42 C.F.R 1003.106.

169. The I.G. has the burden of proving the existence of any aggravating factors by a preponderance of the evidence.

170. The amount of penalties and assessment, and the length of exclusion from participation in the various medical programs, is to be determined in a CMPL case by reviewing:

a. the nature and circumstances under which the requests for payment were made;

b. the degree of a respondent's culpability;

c. the existence of prior offenses;

d. any other matters that justice may require.

42 C.F.R. 1003.106, 1003.107.

171. It is an aggravating factor that the claims at issue were presented over a lengthy period of time. FFCL 14.

172. It is an aggravating factor that there were a substantial number of claims involved in this case. FFCL 10-13.

173. It is an aggravating factor that the amount claimed for the services at issue was substantial. FFCL 14.

174. It is an aggravating factor that Respondent acted with reckless disregard for Medicare rules and regulations. FFCL 147

175. It is an aggravating factor that the Department has had to expend considerable resources in monitoring Respondent and attempting to secure his compliance. FFCL and Tr.I/168,586; see FFCL 22-29.

176. It is an aggravating factor that Respondent assured patients that electrical stimulation treatments would be reimbursed by Medicare, thereby inducing the patients to undergo electrical stimulation treatments and to pay Respondent at the time of treatment when he knew or had reason to know the services provided were not reimbursable under Medicare. FFCL 30, 141-148; I.G. Ex. 82A, 82B.

177. It is an aggravating factor that Respondent has a history of misrepresenting facts. See FFCL 149-171.

178. The I.G. did not prove all of the aggravating factors which he alleged, including that Respondent has knowingly practiced acupuncture without appropriate authorization and has resisted paying restitution under a previous plea agreement.

179. It is a mitigating factor that medical records submitted by the parties showed indications that some other medical services besides electro-acupuncture or injections of marcaine were provided in numerous patient encounters leading to the claims in question. I.G. Ex. 1-1 through 1-31; FFCL 20.

180. It is mitigating factor that Respondent provided many medical services to his patients which would have been reimbursable if properly documented. See FFCL 20, 107, 109-112, 132, 179.

181. It is a mitigating factor that one of the I.G.'s medical experts identified 14 claims which he considered to be reimbursable, although most of them at a lower level of service than claimed. Tr.II/1541, 1542, 1545-1547, 1549.

182. It is a mitigating factor that Respondent was drug addicted during the period of time in which the 688 claims at issue in this proceeding were submitted and that the addiction clouded his judgment. See Tr.II/1055-1058; FFCL 150.

183. It is a mitigating factor that many beneficiaries benefitted from Respondent's services and found him to be a good doctor. See I.G. Ex. 1-18/2, 4-5, 9-36, 12-24/2, 14-5, 21-6, 25-7.

184. The Respondent did not prove all the mitigating factors he alleged, including that his financial condition warrants a lesser penalty and assessment. FFCL 170, 171, 172.

185. The six-year statute of limitations provided by section 1128A(c)(1) of the Act is controlling in this case, because this case was initiated by the I.G. after September 1, 1987.

186. The I.G. is not barred from bringing this action by either the doctrine of equitable estoppel or collateral estoppel.

187. The I.G. is not barred in this case by the double jeopardy clause of the United States Constitution.

188. The I.G. is not equitably estopped or otherwise barred in this case by the Plea Agreement between the United States and Respondent in Respondent's criminal trial.

189. Respondent does not have the right to trial by jury and to be found guilty beyond a reasonable doubt.

190. Respondent was not prejudiced or denied due process by the admission of written statements of patients obtained by the I.G. in lieu of live testimony.

191. Respondent was not prejudiced or denied due process by the I.G.'s claim of privilege.

DISCUSSION

I. Introduction And Summary.

The I.G. proved that Respondent presented 688 Medicare claims to the Medicare carrier, BSWNY, between January 1983 and the end of 1986. [6] Since Respondent made his Medicare patients pay for treatment at the time of service, he asked Medicare to reimburse his patients. The services claimed to have been provided to these Medicare patients by Respondent were described in writing on the face of these claims. Most of the services listed on the claims are for "local nerve block" and "office visit," in approximately equal numbers. A handful are described as a "consultation," one as a "flu shot and a local nerve block," and one is described as a "consultation/office visit." None of the claims has the service described as acupuncture or electro-acupuncture. The vast majority of the claims list arthritis as the diagnosis or nature of the illness. There are also a few

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[6] See footnote 3.

diagnoses of asthma, sciatica, back pain, coronary artery disease, tendinitis, multiple sclerosis, knee pain, Parkinson's disease, and bursitis of the shoulder.

The I.G. argues that none of the claims in issue were provided as claimed and that Respondent is liable under the CMPL. I.G. Br. 185-187. The I.G. alleges that while Respondent claimed for local nerve blocks, office visits, or consultations, Respondent performed only acupuncture or electro-acupuncture services. The I.G. contends that since Respondent knew that Medicare did not pay for acupuncture or electro-acupuncture services, Respondent devised a scheme to circumvent the Medicare rules and regulations by misrepresenting the services he performed. The I.G. alleges that Respondent knew that an accurate description of the services provided would result in denial of reimbursement. The I.G. produced two expert witnesses, a variety of fact witnesses, and documentary evidence to support these allegations.

The I.G. argues, in the alternative, that (1) even if Respondent lacked actual knowledge that his claims were for services not provided as claimed, Respondent had a reckless disregard for the truth or falsity of his claims and their supporting documentation and, accordingly, (2) Respondent had reason to know or should have known that his claims were for services not provided as claimed.

Respondent contends that most patients received local infiltration of anesthesia and electrical stimulation and that this treatment constituted local nerve blocks as claimed. R.Br. 229. Respondent offered an expert anesthesiologist at the hearing, with expertise in pain management, to support his arguments. Tr.I/732-815. Respondent also argues that his claims for office visits or consultations were entirely justified by what he did during his patient encounters. R. Br. 229. He offered patient testimony and his own testimony to support these arguments. While he admits that he was a poor record keeper, Respondent argues that he performed the services listed on the 688 claims at issue and that Medicare's carrier, BSWNY, instructed him to submit the claims the way he did. He points to an earlier ALJ decision issued in his exclusion case and asks that I similarly conclude that what occurred in this case is just a difference of opinion between him and Medicare's carrier, BSWNY.

Respondent is an intelligent physician who specialized in the alleviation of pain. He appears to have the support of a caring family, friends, and patients. Unfortunately, Respondent turned to drugs to numb his own pain. His

judgment became clouded and impaired. He became arrogant and reckless with regard to Medicare rules and regulations. He began to manipulate and rationalize to attain his goals. He is still difficult and disrespectful at times. He is subject to emotional outbursts and is tenaciously unwilling to yield to rules or authority. At times, he seems to be very sincere. At other times, he engages in over-rationalizing past reckless or illegal behavior. His history of manipulating and misleading people is well documented in this record.

Based on all of the evidence in the record and based on my observation and study of Respondent's credibility and demeanor, I conclude that he believed strongly in the results produced by his form of practicing pain medicine, and believed very strongly that his pain medicine services should be covered by Medicare. So, Respondent sought to help his patients by circumventing the Medicare rules and regulations. He thought that he would be clever enough to figure out ways to bend or twist the Medicare rules and regulations. However, through clouded, obstinate, and drug-impaired judgment, he misled and knowingly or recklessly filed false claims.

Respondent knew acupuncture, including electro-acupuncture, was not a service covered by Medicare. He knew that the primary service his patients sought from him was the treatment of their pain. His principal modality for treating pain was electro-acupuncture. When speaking to patients, Respondent characterized his pain treatments as acupuncture or electrical stimulation. At other times, he characterized these same services as nerve blocks. In other words, Respondent described his services one way to induce patients to come to his office for electro-acupuncture treatments and then described what he did another way on the Medicare claims to induce the Medicare carrier to pay for his services. He told his lawyer in a letter that he began the practice of injecting his Medicare patients with a small amount of local anesthetic simply so he could "legitimately" bill his services as nerve blocks. I.G. Ex. 95/2. This letter reveals much about Respondent's practices and attitude towards Medicare's rules.

I discounted the testimony of Dr. Gilies, Respondent's impressive expert witness, because he had little familiarity with Medicare rules and regulations and, more importantly, because Dr. Gilies failed to review the medical records in issue and had no first-hand knowledge of what Respondent actually did. On the other hand, Dr. Harding was both well informed and impressive; he testified as both an expert and as one familiar with the

actual facts in the record. Dr. Tofany's testimony was also impressive, except for his lack of regard for traditional acupuncture.

I conclude that the patients in issue received electro-acupuncture and local infiltration of anesthesia. I conclude that sometimes Respondent performed additional medical services, in addition to electro-acupuncture and local infiltration of anesthesia. While these additional services might have benefitted his patients, they were not adequately documented or consistent with symptoms or diagnosis and, therefore, not "medically necessary," as defined by the Medicare rules and regulations. In addition, while there is credible testimony from Dr. Gilies that Respondent's treatments were therapeutic and useful to the Medicare patients in issue, the services were not reimbursable by Medicare and Respondent knew it or had reason to know it.

Respondent, through clouded and drug-impaired reasoning, felt justified in what he did. Now, while he appears to be drug-free (even though he is not presently active in any twelve-step or other rehabilitation programs), he appears to be adamant that he did nothing wrong except fail to keep adequate records.

Although Respondent has begun his slow road back to complete function and integrity, he has not come to the end of that journey. He lacks complete candor and appears to need additional rehabilitation. I found Respondent, when not provoking the anger of others, to engender sympathy. I did not find Respondent to be credible, because of his history of deception, the overwhelming evidence contradicting his testimony, and because of his demeanor throughout the hearing.

Based on the entire record in this case, I conclude that Respondent's patients came to him primarily for the alleviation of pain and that Respondent alleviated their pain by performing some form of electro-acupuncture. His local injection of marcaine or anesthesia was an adjunct to his electro-acupuncture treatments; it was done to assure reimbursement and was not medically necessary, within the meaning of the Medicare rules. Because I believe that Respondent was motivated, in part, to help his patients and because the evidence demonstrates that Respondent did perform some beneficial medical services to the Medicare patients in question in this case, in addition to electro-acupuncture, I have reduced the penalties and exclusion.

I have not let my personal beliefs about traditional acupuncture affect my decision in this case. My experience is that traditional acupuncture is an efficacious and beneficial healing art when performed by trained and licensed practitioners and I believe that traditional acupuncture should be reimbursable by Medicare at rates similar to office visits provided by a physician. It is ironic that Dr. Stern's actions actually impeded the result he sought, which was to have Medicare pay for the pain services he performed. It would have been better if Dr. Stern had joined others and worked within the system to effect changes in Medicare reimbursement policy.

In sum, I find and conclude that Respondent is liable for submitting false or improper Medicare claims based on the law and a preponderance of the evidence. I have reduced the amount of civil monetary penalties and period of exclusion, and I have concluded that the constitutional, jurisdictional, and procedural arguments raised by Respondent have no merit.

II. Medicare Does Not Pay For Acupuncture Services.

This is a case involving Part B of Medicare, a federal program of health insurance for the aged and disabled. Medicare covers 80 percent of the reasonable charges for physician services, tests, and medical supplies. The Secretary of DHHS contracts with entities known as "carriers" to perform functions necessary to administer the Medicare program, mainly the processing and payment of claims in accordance with Medicare rules and regulations. The Medicare carrier for the Rochester, New York area for the period in issue was Blue Shield of Western New York (BSWNY).

Traditional acupuncture, an ancient healing art, dates back more than 2,000 years and originated in China. It is effective and beneficial for the treatment of pain and a myriad of other conditions. Traditional or classical acupuncture involves the placement and manipulation of solid, thin, metal needles inserted slightly beneath the skin at various points. Traditional acupuncture does not involve injection of drugs or other substances and the needles are not hollow (like hypodermic needles used for injections).

When acupuncture needles are manipulated electronically, the procedure is commonly referred to as electronic acupuncture, electro-acupuncture, or electrical stimulation. In an electro-acupuncture treatment, 4-16

solid metal acupuncture needles are attached by clips and wires to a generator which is turned on for ten to twenty minutes. (This procedure is not traditional acupuncture.) When the acupuncture needles are not placed at acupuncture points, it is arguable that the term electrical stimulation might be a more accurate description of the treatment than electro-acupuncture. However, neither electro-acupuncture nor electrical stimulation with acupuncture needles is covered by Medicare.[7]

Medicare is rightfully concerned about the misuse of acupuncture in the United States. See I.G. Ex. 33-1. As a result of that concern, however, Medicare has taken a restrictive view of traditional acupuncture and other forms of acupuncture as an effective treatment. Medicare deems all forms of acupuncture to be experimental and not reimbursable. I.G. Br.14-17.

BSWNY formally recognized Medicare policy regarding the non-payment for acupuncture services beginning in 1979. In 1979 and in November 1983, BSWNY sent "Claims" and "Doctor's" manuals, to all physicians in the Rochester area. The two manuals contained Medicare rules and regulations, billing information, tables of procedure codes, and verbal descriptions of the proper procedure codes to use for different physician's services. The Claims and Doctor's manuals specifically list acupuncture as a non-covered service. FFCL 30.

Respondent was informed personally by BSWNY and I.G. personnel, beginning in early 1984 and continuing

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[7]Dr. John E. Harding, a physician, the Medical Director for the Medicare Division of BSWNY, and an expert witness, testified unequivocally that what Respondent did was electro-acupuncture. Tr. I/1455. I found Dr. Harding to be a credible and impressive witness. For this and other reasons stated in this Decision, I conclude that what Respondent did was electro-acupuncture. While I have concluded that what Respondent did was electro-acupuncture, it would not matter whether the service which he performed was described as electro-acupuncture or electrical stimulation, because neither service is covered by Medicare. Even if the service were called electrical stimulation, it would not be covered by Medicare because Medicare covers only specific types of electrical stimulation and what Respondent did is not one of the types covered. See I.G. Br. 28, fn. 8; Tr.I 1481-1487, 1518.

throughout the period involved in this case, that acupuncture was not covered by Medicare and that Respondent's services appeared to be acupuncture. FFCL 24.

III. Federal Law Demands That Medicare Pay Only For Physician's Services That Are "Reasonable And Necessary".

Section 1862 (a)(1)(A) of the Act provides that Medicare will pay only for physician's services if they are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Medicare carriers are instructed to pay only for "reasonable and necessary" services performed by a physician. Tr.I/550.

The Claims and Doctor's Manuals provide that physicians must document services, as an element of proving that they are medically necessary, in order to be reimbursed. I.G. Ex. 37/20; see I.G. Ex. 34/12, 16.

Thus, even if a service were performed by a physician, it would not be reimbursable by Medicare unless it were "reasonable and necessary", as required by Section 1862 of the Act and "medically necessary," as defined by the Medicare rules.

IV. The Elements Of Liability Under The CMPL.

The CMPL provides that any person who presents a false or improper claim for Medicare or Medicaid reimbursement shall be subject to (1) a civil money penalty of not more than $2,000 for each item or service, (2) an assessment of not more than twice the amount claimed for each item or service, and (3) an exclusion from participating in the Medicare and Medicaid programs.

The I.G. has the burden of proving by a preponderance of the evidence all elements of liability under the CMPL and Regulations for each claim in issue. The I.G. must prove that (1) a "claim", (2) was "presented or caused to be presented", (3) by Respondent, (4) to the Medicare or Medicaid programs, (5) for "a medical or other item or service", (6) when he "knew, had reason to know, or should have known," (7) that the items or services in issue were "not provided as claimed." CMPL 1320a-7a(1)(A)(B)(C); Regulations 1003.102(a)(1).

The elements of liability in dispute in this case are: (1) whether Respondent provided the services "as claimed" and, if not, (2) whether he "knew, had reason to know, or

should have known" that the services claimed were "not provided as claimed."

V. The I.G. Proved That The Services Listed on The Claims In Issue Were Not Provided As Claimed.

The evidence in the record proves that the Medicare requirements necessary to support claims for reimbursement for 688 services in issue were not met by Respondent. The I.G. has shown, by a preponderance of the evidence, that where Respondent sought reimbursement for office visits, consultations, and local nerve blocks, these services were not performed as claimed in 688 instances. The primary service actually provided in each of the 688 instances was electro-acupuncture and, in certain instances, local injections of anesthesia was administered in conjunction with the electro-acupuncture. Respondent admits that in most of these 688 instances, the Medicare patients received electrical stimulation or electrical stimulation in conjunction with a local injection of marcaine. R. Br. 229. He argues, however, that the services were provided and claimed in accordance with instructions from Medicare representatives.

A. Respondent Did Not Perform Nerve Blocks, As Claimed.

There are approximately 343 claims in issue where the service is described as "local nerve block". Respondent used several different procedure codes on these claims and, after early 1984, attached an operative report entitled "superficial nerve block," to many of the claims. FFCL 38.

Medicare pays only for two diagnostic nerve blocks per patient in one year and does not pay for nerve blocks for the treatment of pain. FFCL 73, 88, 89. Respondent had notice of this through contacts with BSWNY and I.G. personnel in 1984 and 1985. He also had constructive notice of these facts as early as 1979 from BSWNY. See FFCL 31. FFCL 30, 73.

Respondent argues that, with regard to each "local nerve block" claim in issue, he performed either electrical stimulation alone, or in conjunction with local infiltration of anesthesia, and that those treatments constitute "nerve blocks." R. Br. 229. This argument has no merit.

The treatments Respondent provided consisted of placing acupuncture needles at or near the site where the patient

was experiencing pain and applying electric current to the needles. Nevertheless, whether the treatment modality employed by Respondent is labelled acupuncture, electro-acupuncture, or electrical stimulation, the I.G. proved that the treatment of placing acupuncture needles into a patient and applying electrical current was not a nerve block, as that term is used in Medicare reimbursement terminology. Dr. Gilies, Respondent's own expert, testified that what Respondent did with the acupuncture needles was not a nerve block, but would be considered electrical stimulation. Tr.I/795. [8]

The medical records pertaining to the beneficiaries whose claims are at issue in this proceeding contain no documentation related to nerve blocks, as that term is used in Medicare reimbursement terminology. When submitting claims, Respondent frequently attached a form "operative report," captioned "superficial nerve block," which stated that an injection of .25 cc or 4 cc of marcaine had been administered. Respondent's form "operative reports" do not describe nerve block, or constitute sufficient documentation that a nerve block was given.

Again, based on Respondent's own expert, Dr. Gilies, Respondent did not have the proper documentation to support his claims for a nerve block. Tr. I/796-808. Drs. Tofany and Harding reviewed Respondent's medical records for the claims at issue in this proceeding and concluded that the records did not reflect that nerve blocks had been provided. Tr.I/1244, 1245, 1282; Tr.II/1514, 1515, 1519-1521, 1527. [9] The experts

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[8]Respondent argues, in the alternative, that what he did should have been reimbursable by Medicare as electrical stimulation. The type of electrical stimulation as performed by Respondent is not reimbursable by Medicare. FFCL 61, 62.

[9]The written statements and testimony of the beneficiaries on whose behalf Respondent submitted the claims at issue described the treatments as involving the insertion of multiple needles which were attached to electrodes and an electronic generating machine for periods ranging from ten to twenty minutes. Some used the term "acupuncture" to describe the treatments they received. Similarly, five of Respondent's employees during the period involved in this case testified before a grand jury that the treatments provided by Respondent either were acupuncture treatments or described the treatments in terms characteristic of acupuncture.

testified that a physician's record of a nerve block should include diagnosis, caliber and length of needle used; region of the body where the needle was placed; type, amount, and concentration of drug used; sensations experienced during the block; and, finally, what happened after the block, if anything. Documentation should also include an individualized and detailed operative report, not like the kind submitted by Respondent. Tr.I/976, 1221-24, 1471; see also Tr.I/1333.

However, in some cases Respondent also injected his patients with a small amount of marcaine, a local anesthetic agent, in conjunction with the electro-acupuncture treatments.

Dr. Gilies was of the opinion that the injection of marcaine by Respondent could be a nerve block, especially if it is injected into a trigger point. Tr.I/746. I reject this conclusion because it is refuted by the persuasive testimony of I.G.'s expert witnesses. I agree with Dr. Tofany and Dr. Harding that what Respondent did was not a nerve block. Both I.G. experts testified that Respondent's injections of .25 cc or 4 cc of marcaine was not sufficient to block a nerve, and the addition of an electro-acupuncture treatment would not itself, or in conjunction with the injection of marcaine, be considered

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Another employee, who worked for Respondent from 1980 until the fall of 1983, said in a written sworn statement that the "typical course of treatment" for Respondent's patients was a series of electro-acupuncture treatments. I.G. Ex. 65-1. Respondent himself has, on several occasions, admitted that he was engaged primarily in the practice of acupuncture. For example, when explaining his practice before a television audience, Respondent described the treatments he provided as acupuncture or electronic stimulation. I.G. Ex. 82 at 1, 4, 9,10. Additionally, as part of a plea agreement Respondent made in 1987, he admitted under oath that he had billed the Medicare program for nerve block services, when the service he had actually provided was acupuncture. Finally, in 1988, when Respondent applied to the New York State Department of Education to become licensed as an acupuncturist, he stated that he had practiced acupuncture 100 percent of the time for the last ten years.

a nerve block. Tr.I/1241, 1247, 1249-1250; Tr.II/1513. Furthermore, there is no evidence to prove that Respondent ever injected marcaine into trigger points.[10]

Even if I were inclined to accept this medical characterization of a nerve block, Medicare would not pay for it because Medicare pays only for diagnostic nerve blocks, not nerve blocks for the treatment of pain. None of Respondent's medical records for the claims at issue support a finding that Respondent performed diagnostic nerve blocks. In fact, Respondent has not alleged that any of the claims at issue were for diagnostic nerve blocks. By Respondent's own admission, he injected the marcaine superficially.

Finally, Respondent argues, that even if his nerve blocks were technically not reimbursable under the Medicare rules, he was instructed by Medicare to submit the claims the way he did. Respondent was not a credible witness and did not present sufficient evidence to find that he was billing for his service according to instructions provided by BSWNY. Moreover, there is credible testimony that quite the opposite is true.

Beginning in 1984, in a telephone conversation, in a meeting, and in a letter confirming the results of the meeting, BSWNY personnel informed Respondent that Medicare would cover two nerve blocks per year, but only if they were for diagnostic purposes. Respondent was also told that Medicare would reimburse up to six local infiltrations of anesthesia in a calendar year. Tr.I/1496; I.G. Ex 47; I.G. Ex 48. BSWNY personnel never stated that Respondent's services fit into either category or would be reimbursed without a determination of medical necessity. I.G. Ex. 47; I.G. Ex. 48/2.

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[10] The I.G. established by expert testimony (Victor J. Tofany, M.D. and John F. Harding, M.D.) that a "nerve block" is understood in the medical community to be the application of a chemical substance into a nerve or into the region of a nerve trunk so as to interrupt the transmission of impulses over that nerve trunk to or from the area of the body supplied by that nerve trunk. Nerve blocks are typically performed on a patient with a chronic pain problem or with a reflex sympathetic dystrophy as a result of injury or surgery. During a nerve block procedure, a patient would experience pain followed by numbness which would last from one to twelve hours.

In summary, the overwhelming evidence in the record supports the fact that Respondent did not perform nerve blocks as claimed.

B. Respondent's Local Injections Of Marcaine Were Not Medically Necessary, Within The Meaning Of The Medicare Rules.

Of the approximately 343 claims describing the service as local nerve block, there were 137 claims listing the procedure code as W3600. This is the procedure code for "local infiltration of anesthesia". In 80 of the remaining claims describing the service as local nerve block, Respondent used various other procedure codes generally describing procedures involving injections of anesthetic agents. Attached to many of the claims where operative reports entitled "superficial nerve block," indicating Respondent administered a superficial injection of the anesthetic agent "marcaine."

Respondent argues, in effect, that even if what he did was not technically considered a nerve block, when he injected marcaine and used the procedure code W3600 or any other Medicare procedure code for the injection of an anesthetic agent, he was claiming for a superficial injection of anesthesia, a service that he performed, that had medical validity, and that was reimbursable. R. Br. 231.

At first, this argument seems to have merit. This is especially so when considering Dr. Gilies testimony that the injection of marcaine had therapeutic value. However, the I.G. proved by a preponderance of the evidence that the procedure was not medically necessary under the Medicare rules. After much scrutiny and study of the entire record, it is apparent that even this procedure was designed to mislead Medicare.

To be considered medically necessary under Medicare, services must be consistent with the diagnosis and treatment, appropriate with regard to standards of good medical practice, not solely for the convenience of the patient or the doctor, appropriate with regard to the level of service, adequately documented, and identifiable in the patients records. FFCL 78.

I conclude, after careful consideration, that the injection of marcaine into these Medicare patients was not medically necessary and was performed to mislead BSWNY into reimbursing for services that were not reimbursable. Respondent actually stated in a letter to

his lawyer in January 1985 that he had started injecting marcaine so his services could "legitimately" be considered nerve blocks. I believe this candid statement reflects Respondent's true motivation for injecting his patients with marcaine. This is not what Medicare had in mind by demanding that services be medically necessary in order for them to be reimbursed. [11]

Neither the notation in the patient's medical records nor the notations in conjunction with operative reports is sufficient to convert Respondent's otherwise unallowable claims for electro-acupuncture into reimbursable claims for local or superficial injections of anesthesia, since the services were not medically necessary. While Dr. Gilies testified that the injection of marcaine had therapeutic value because it stimulated the blood flow, the I.G. established by expert testimony that the amount of marcaine was so small that its only likely effect would have been to numb a small "wheel" of skin to make the patient more comfortable while the acupuncture needles were inserted. The most credible evidence in the record establishes that Respondent performed the procedure to get reimbursed and not because of medical necessity.

C. Respondent Did Not Perform Office Visits Or Consultations, As Claimed.

In about 339 of the services at issue, Respondent described the procedure performed as "office visit," mostly with a procedure code "90060," representing an "intermediate" level of service. Four described the service performed as "consultation" and showed no code or code "90610."

Under Medicare, office visits are subject to qualification and subject to reimbursement according to various levels of service, reflecting various levels of skill, effort, time, responsibility and knowledge. FFCL 84. A doctor is not entitled to reimbursement for an office visit simply based on the amount of time he spent with the patient. There must be some medically necessary service provided, and documentation of that service. FFCL 85.

In a January 1985 telephone conversation, Mary McCarthy of BSWNY explained to Respondent that, under Medicare, office visits must be medically necessary, documented,

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[11]There is no evidence that the injection of marcaine was harmful to the patients in question.

and that Respondent should not resubmit a claim a "office visit" if the claim had already been turned down as "nerve block." Tr.I/153-154. As a general rule, Medicare regulations would not provide reimbursement for an office visit if the only purpose of the visit were a non-covered service such as acupuncture or electro-acupuncture. An office visit would be allowed by Medicare for other services rendered in addition to non-covered services, but the additional services must be medically necessary. FFCL 86. In addition to establishing medical necessity under the Medicare rules, it is a basic requirement of good medical practice to keep accurate records of the services. FFCL 77, 80.

Under Medicare, a physician may be reimbursed for a "consultation" where he renders services pursuant to a request from the attending physician for opinion and advice. The consultation must include a medical history, physical exam, and written report of findings filed with the patient's permanent record. FFCL 87.

Respondent's medical records for the claims at issue in this proceeding do not reflect that office visits and consultations had been provided. FFCL 94. Documentation in the pertinent medical records corresponding to Respondent's nerve block claims is indistinguishable from documentation corresponding to office visit claims. FFCL 95. Respondent's records reflect that he was providing electro-acupuncture treatments to his patients rather than the office visits claimed. Tr.I/1244, 1515, 1526-1527.

Respondent's medical records are incomplete, and, at times, illegible. However, there are numerous indications that he provided other services in addition to electro-acupuncture, (i.e., prescribed drugs, ordered lab work, administered flu shots, performed minor surgery, or took blood pressure readings). These notations of additional services in Respondent's records sometimes occurred in conjunction with claims for office visits and sometimes in conjunction with claims for nerve blocks, but consistently in conjunction with documentation of electro-acupuncture treatments.

Nonetheless, the cryptic notations of additional services are not sufficient to convert otherwise unallowable claims for electro-acupuncture into reimbursable claims for office visits, since the purpose of the visits was electro-acupuncture and the notations do not constitute sufficient documentation to establish the medical necessity of the additional services.

A candid statement of what Respondent claimed as "office visit" is found in a letter Respondent wrote to his attorney on January 31, 1985. This letter followed the June 1984 meeting with OIG agent Linda Lloyd, who informed Respondent that his electrical stimulation services appeared to be for acupuncture and could not be claimed as nerve blocks. I.G. Ex. 42-2; Tr.II/920; I.G. Ex. 73/7,9. It also followed the January 1985 telephone conversation with BSWNY representative Mary McCarthy, who informed Respondent that only two diagnostic nerve blocks were reimbursable in a calendar year and that he could not simply resubmit as office visits past claims which had been turned down as nerve blocks. I.G. Ex. 44; Tr. I/153-154; I.G. Ex. 74/20.

In the wake of these communications, Respondent told his attorney:

> When a patient comes to my office it is an "office visit" NO MATTER what I do to the patient .... A patient comes to me for my consultation about their problems and although I may do acupuncture or nerve block, I also am a physician and I do prescribe medicines and council them .... I am a doctor, see a patient and talk to them in my office, that in itself is an office visit no matter what else I do.

I.G. Ex. 95/2,3.

While Respondent is correct that he could bill his patients for an office visit under such circumstances, he was incorrect in assuming Medicare would reimburse him for the services. While I believe Respondent did perform other services (besides electro-acupuncture and local infections of anesthesia), he simply could not claim them as office visits, given the level of documentation in his medical records. The I.G.'s expert, Dr. Harding, identified only a handful of instances in which he considered sufficient documentation to be present in the records. Accordingly, the other services can only be considered in mitigation.

VI. <u>The I.G. Proved That Respondent "Knew," "Had Reason To Know," Or "Should Have Known" The Services Claimed Were Not Provided As Claimed</u>.

The current standard of knowledge in the CMPL required for liability to attach is that a respondent "knows or should know" that an item or service is not provided as claimed. The statute sweeps within its ambit not only the knowing, but the negligent. . . ." 48 Fed. Reg. 38827, 38831 (Aug. 26, 1983). The standard contained in

Section 1128A of the Act prior to December 22, 1987 was that a respondent "knew or had reason to know." [12]

A. Personal History

Respondent comes from a prominent Rochester family, is well-educated and intellectually talented. As a young man in the mid 1970s, he had already graduated from a prestigious University (with honors) and medical school, had young triplet boys and another infant, and had begun what appeared to be a promising career as an anesthesiologist. Tr.II/1321, 1323. By the late 1970s, he had been investigated by Medicare for misrepresenting his anesthesia billing, had resigned from the hospital where he was attending physician in anesthesia, had a drug problem which involved prescribing controlled substances for his own use, and was asked to leave two other hospitals when they discovered his drug problem. Tr.II/1323-1324.

In late 1979 or early 1980, Respondent became certified as an acupuncturist and opened his own pain clinic, called Rochester Pain Medicine. Tr.II/1324. I.G. Ex. 54-2/4. Respondent primarily provided classical and electro-acupuncture treatments as a means for treating a wide variety of pain problems. He referred to the treatments as acupuncture or electrical stimulation and told potential patients that Medicare covered such services. I.G. Ex. 82A and 82B. Throughout the early 1980's, he continued to be heavily addicted to drugs and was in and out of various drug rehabilitation programs. Tr.II/1324-1326. By 1983, Medicare had begun to

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[12]The standard of knowledge in the CMPL prior to December 22, 1987 was that a respondent "know" or had "reason to know." The "should know" standard became law on December 22, 1987, as a result of an amendment to the CMPL, enacted by section 4118(e) of the Omnibus Budget Reconciliation Act (OBRA) of 1987, Pub. L. 100-203. The legislation stated that the amendment would "apply to activities occurring before, on, or after the date of [OBRA's] enactment . . ." Section 4118(e)(3) of OBRA. See, Dean G. Hume, D.O., DAB Civ. Rem. C-50 at 18-21 (1989). Thus, on December 22, 1987, Congress retroactively substituted the "should know" standard for the "reason to know" standard. Since no court has decided the validity of this retroactive substitution, I will use both standards to determine Respondent's liability.

investigate his practice and, by 1986, he had been indicted by a federal grand jury on charges related to his drug addiction and Medicare claims for services provided at Rochester Pain Medicine. Tr.II/1327-1328. Only after the death of his parents, break up of his own family, and loss of his medical license in the late 1980's did Respondent begin to overcome his drug addiction. Tr.II/1327-1329.

B. Medicare Contacts and Respondent's Claims

In 1979, BSWNY sent all providers in the Rochester area a Claims Manual, and, in 1980, a Medicare Part B Update. FFCL 30. Both these documents state that injections of local anesthesia into specific areas of pain (i.e., toe, spot on back) are not nerve blocks, that nerve blocks are only reimbursable if they are for diagnostic purposes, and that only two such blocks are allowed in a calendar year. The 1979 Claims Manual also points out that there is a specific code which should be used for local injections, that acupuncture is not a covered service, and that documentation of services is critical to appropriate reimbursement. I.G. Ex. 34/ 15, 16, 20.

In 1980, Carol Durso of Blue Cross/Shield, Rochester (the private insurance carrier and not the Medicare carrier, BSWNY) contacted Respondent about his claims for services. She had been instructed to contact Respondent because Blue Shield could not tell what service Respondent was providing. Ms. Durso informed Respondent that acupuncture was not a covered service, that all claims for nerve blocks had to be accompanied by operative reports, and that the claims would be reviewed by the medical director who would determine whether they met the criteria for coverage. Respondent thereafter presented operative reports and claims for superficial nerve blocks which were rejected by Blue Shield, Rochester because they did not meet the requirements for reimbursement. Respondent subsequently alleged that Ms. Durso had informed him that claims for superficial nerve blocks would be reimbursed. Ms. Durso denied this in sworn testimony before a grand jury and by affidavit in this proceeding. I.G. Ex. 54-1; I.G. Ex. 54-2/ 11 through 17. I.G. Ex. 42-2/2.

Between 1980 and about January 1984, Respondent billed Medicare for his electrical stimulation services using the description "local nerve block" and the code "52980." In 1983, BSWNY sent Respondent a Doctor's Manual to replace the Claims Manual. The Doctor's Manual stated five elements were needed for a service to be considered

medically necessary, and thus reimbursable. The service had to be: 1) consistent with the diagnosis and treatment; 2) appropriate with regard to standards of good medical practice; 3) not solely for the convenience of the patient or the doctor; 4) appropriate with regard to the level of service and adequately documented; and 5) identifiable in the patients records. I.G. Ex. 37/20; see I.G. Ex. 34/12.

BSWNY began investigating Respondent in 1983, after a review of his payment records indicated that he was billing an unusually large number of nerve blocks. Tr.I/150. See I.G. Ex. 40, Tr.I/1011,1012.

During the initial review, 15 beneficiaries reported that Respondent was treating them with acupuncture and electrical stimulation; a couple of beneficiaries reported that he also performed nerve blocks. I.G. Ex 40. See Tr.I/150.

On November 18, 1983, BSWNY referred its findings to the Inspector General. I.G. Ex. 40; Tr.I/1012; I.G. Ex. 73/4; Tr.I/919.

In about January 1984, Respondent discontinued using his code 52980, began injecting the area electrically stimulated with marcaine, began using a variety of codes for injections of anesthetic agents, and began attaching a form operative report entitled "superficial nerve block" and noting the marcaine injections. FFCL 38, 96. He still called his service a "nerve block" on his claim forms.

By letter dated May 7, 1984, the I.G. notified Respondent that he had questions about Respondent's Medicare claims; that representatives wished to meet with him; and that, if satisfactory explanations were not provided, exclusions from eligibility in Medicare and Medicaid were possible. I.G. Ex. 42-1.

On June 5, 1984, OIG analyst Linda Lloyd personally told Respondent that Medicare does not pay for acupuncture and that if he was misrepresenting his services as nerve blocks he could be liable for civil monetary penalties. I.G. Ex. 42-2; Tr.II/920; I.G. Ex. 73/7 through 9.

At this meeting, Respondent stated that he had been told by Carol Durso and someone at BSWNY that he could bill for his electrical stimulation treatments as "nerve block" under code 52980. I.G. Ex. 42-2 /2; Tr.I/921; I.G. Ex. 73/8. At this meeting, Respondent stated that to administer chemical nerve block took 10-15 seconds,

electrical nerve block took several minutes, and acupuncture took about 15 minutes. I.G. Ex. 42-2/2; I.G. Ex. 73/11. At this meeting, Respondent stated that he used acupuncture on a limited basis, but that electrical stimulation was not acupuncture and the patients who said he had performed acupuncture rather than electrical stimulation must have been confused. I.G. Ex. 42-2/2. He stated that he performed electrical nerve blocks, chemical nerve blocks, and some combination of these. I.G. Ex. 42-2/2. Several days after the meeting, Respondent telephoned OIG agent Lloyd late at night at her hotel room in Rochester, and, in a loud and agitated voice, threatened to take action against her if she did not stop her investigation. Tr.I/934; I.G. Ex. 73/12, 13.

As stated earlier, in January 1985, Mary McCarthy of BSWNY received a call from Respondent asking why his claims for nerve blocks were being turned down and why when he resubmitted the same claims as office visits they were also being turned down. I.G. Ex. 44; Tr.I/153-154; I.G. Ex. 74/20. Mary McCarthy informed Respondent that Medicare would cover only two nerve blocks per year, but only if they were for diagnostic purposes. I.G. Ex. 44; Tr.I/153; See I.G. Ex. 74/20. Ms. McCarthy explained to Respondent that, under Medicare, office visits must be medically necessary, documented, and that resubmitting the same claim under a different code appeared to be a misrepresentation of the service. I.G. Ex. 44; Tr.I/153; I.G. Ex. 74/20 through 22. Ms. McCarthy sent Respondent two Medicare "Updates," further explaining how Medicare reimburses for nerve blocks and office visits. I.G. Ex. 44; I.G. Ex. 74/24.

In about January 1985, Respondent began using code W3600, but still called his services local nerve block on the claim form. FFCL 38.

On March 19, 1985, a representative of BSWNY, Jean Jerris, met with Respondent, his wife, his lawyer, and his office assistant to further clarify the appropriate way to bill Medicare. I.G. Ex. 47/1. During the March 19, 1985 meeting the BSWNY representative, Jean Jerris, told Respondent that Medicare covers two diagnostic nerve blocks per year and, based on medical necessity, up to six local infiltrations of anesthesia per year (code W3600), and that the type medication, dosage, and area injected must be documented. I.G. Ex. 47/1. During the meeting, the BSWNY representative also told Respondent that an office visit must be reasonable and medically necessary and that no less than a blood pressure, weight, temperature, physical examination of the area of

complaint, along with a history, must be documented in the medical record. I.G. Ex. 47/1; Tr.I/939; see I.G. Ex. 37/15 through 20. During the meeting, the BSWNY representative also told Respondent that office visit codes are not based on time spent with a patient, but on the service which was provided (e.g., injection); she referred Respondent to the Doctor's Manual. I.G. Ex. 47. During the meeting, Respondent requested permission to add documentation to his previous records and was informed that he should not do so as that could be construed as altering records. I.G. Ex. 47/2.

On July 16, 1985, a representative of BSWNY sent a letter confirming that Respondent had been told at the July 19 meeting that two diagnostic nerve blocks and six local infiltrations of anesthesia, if medically necessary, are reimbursable in a calendar year. I.G. Ex. 48.

C. Respondent Knew That The Claims Were For Services Not Provided As Claimed.

Almost all the services described on the claims in issue were submitted on HCFA 1500 claim forms. FFCL 31. When Respondent signed the claim form, he certified that: "The services shown on this form are medically indicated and necessary for the health of the patient, and were personally rendered by me or were rendered incident to my professional service by an employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare regulations."

A person "knows" that a service is not provided as claimed when he or she knows that the information that he or she is placing on the claim is untrue or misleading. Tommy G. Frazier and Prater Drugs, DAB Civ. Rem. C-127; aff'd, __ F 2d. __ (6th Cir. No. 90-4121, Aug. 5, 1991). As I stated in Jimmy Paul Scott, Ph.D., DAB Civ. Rem. C-15 at 27 (1986), it was decided that Congress, in using the term "knows" and the drafters of the Regulations in using the term "knew," were referring to conscious knowledge of a fact (or subjective knowledge).

Respondent knew that a true and accurate description of the services he provided would result in denial of reimbursement. Respondent knew that the electro-acupuncture treatments he was providing were not reimbursable nerve blocks but represented his treatments as nerve blocks or office visits in an attempt to obtain Medicare reimbursement for his patients. Respondent knew that Medicare would not pay for nerve blocks or office

visits if the service rendered was electro-acupuncture. He purposely did not accurately describe the visit when he submitted claims for nerve blocks or office visits.

While I would like to believe that this dispute merely involved a misunderstanding of Medicare rules with regard to a relatively novel approach to pain management, as Respondent contends, the overwhelming weight of the evidence supports a conclusion that Respondent in fact knew that the services he was claiming as "nerve block," and later as "office visit" and "nerve block," were not provided as claimed. As will be discussed below, Respondent had constructive notice as early as 1980 when BSWNY mailed all providers in the area copies of the 1979 Claims Manual and 1980 Medicare Part B Update. The record indicates to me that Respondent actually knew.

Carol Durso, who Respondent claims he thought worked for a Medicare carrier, told him in 1980 that Medicare does not cover acupuncture, that he could not claim nerve blocks without operative reports, and that his claims would be reviewed to determine if they met the requirements for coverage. Respondent followed this procedure for a while, but the claims were denied. This represents credible evidence that as early as 1980 he actually knew that electro-acupuncture was not a covered service and could not be claimed as nerve block and that adding local injections of anesthesia did not make the procedure a nerve block.

Even if Respondent did not know as of 1980, he knew as of the June 5, 1984 meeting with Linda Lloyd. By his own admission, she told him that his services could not be claimed as nerve block, so he began injecting marcaine so as to be able to legitimately claim them as nerve blocks. Moreover, his threats to Ms. Lloyd after her visit to him indicate that he knew his claims were false.

Even if Respondent did not know that he could not claim his services as office visit at this time, he knew on the first week of January 1985 after his telephone conversation with Mary McCarthy. She told him not only that Medicare covered only diagnostic nerve blocks, but also that he could not submit claims for office visit or any service unless the service was medically necessary. Nevertheless, Respondent continued to claim in the same manner, except for switching to the code for local infiltration of anesthesia (W3600) on claims for nerve block. Apparently, after this discussion with Mary McCarthy, Respondent decided that he would have to attempt to justify services in a different way.

It is also significant that one of the I.G. expert witnesses, Dr. Harding, pointed out that no matter what procedure code or service was described by Respondent on the claim forms, the treatment records are all identical and reveal that Respondent was really performing electro-acupuncture.

Respondent argues that he was simply submitting claims for the services he provided as he was instructed to do by either the private insurer, Blue Shield of Rochester, or by BSWNY. There was a great deal of testimony regarding what instructions Respondent received regarding billing for his services. However, Respondent failed to convince me that he was merely doing as he was told. Respondent did not present any credible evidence to prove his assertion that, in 1980, Carol Durso of Blue Shield of Rochester told Respondent to bill his office procedures as nerve block under code 52980. See I.G. Ex. 54-1. Similarly, Respondent did not produce any credible evidence that he switched to code number W3600 in 1985 because BSWNY informed him that he could bill for nerve blocks by using this code (local infiltration of anesthesia). See R.Ex. 94 at 3.

On various occasions, Respondent stated to employees and to at least one patient that he knew that acupuncture was not a covered Medicare service, but that if his services were described in other ways the patients could obtain reimbursement. Several of Respondent's employees stated to I.G. investigators that Respondent knew that acupuncture was not a covered service and attempted to secure reimbursement for his patients by representing the services in other ways. I.G. Ex. 64/2. In a written sworn statement, a patient stated that Respondent informed him that acupuncture was not a covered service, but that Respondent could fill out the Medicare forms in ways which would allow the electro-acupuncture treatments he received to be reimbursable. I.G. Ex. 7-6/2. I am convinced that Respondent did make such statements and that they demonstrate his knowledge that the information provided in his claim forms was untrue or misleading.

Finally, there is additional convincing evidence that Respondent knew that his services were not provided as claimed. BSWNY and I.G. representatives informed Respondent that he should not add documentation to his records or resubmit claims that had been turned down under a different procedure designation, as either action could be construed as fraud. The evidence in the record supports a finding that Respondent ignored Medicare and altered his records. When Respondent produced documents in the discovery phase of this proceeding, they were

altered. Agent Niegsch testified credibly that there are markings on the produced records that are not on the records previously submitted to BSWNY. Tr.II/179-182.

C. Respondent Had Reason To Know.

Respondent knew that acupuncture was not a covered Medicare service. He also had constructive notice of Medicare coverage policy from written policy statements issued by the carrier. BSWNY notified physicians in its region about Medicare reimbursement policies by a Claims Manual issued in 1979, a 1984 Doctor's Manual, released in 1983, and periodic policy updates. Acupuncture is listed as a non-covered service in both the 1979 Medicare Part B Claims Manual and the 1984 BSWNY Doctor's Manual. Thus, even if Respondent did not have actual knowledge that his claims were false, he had notice of documents which put him on notice of the rules.

The "reason to know" standard contained in the CMPL prior to December 22, 1987 employs the "reasonable person" (objective knowledge) concept. The "reason to know" standard attaches where (1) a respondent had sufficient information, as a reasonable medical provider, to create an obligation to investigate and find out whether certain services are billable under the Medicare or Medicaid programs; or (2) there were pre-existing duties which would require a provider to verify the truth, accuracy, and completeness of claims. See George A. Kern, DAB Civ. Rem. No. C-25 at 6 (1987); and the Restatement of Torts (2d) (at section 12) (1965).

Respondent acted with reckless disregard for the Medicare regulations in order to attempt to allow reimbursement for his Medicare patients. The verbal descriptions (and sometimes the procedure codes) entered on the claim forms for Respondent's services were sufficiently different from the services Respondent was providing that a reasonable medical provider would have investigated to ascertain whether the services were artfully described to the Medicare carrier. Moreover, Respondent had knowledge of other facts which would have caused a reasonable medical provider to investigate. In 1980, Carol Durso told him that his claims for nerve blocks had to be accompanied by operative reports and such claims were denied thereafter. Again on May 7, 1983, he had notice when the I.G. notified him that it had questions about his claims. I am not persuaded by Respondent's arguments that he did investigate and was given conflicting information. The Claims Manual, Doctor's Manual, and

Part B Updates gave all the information needed to determine that his services were not provided as claimed.

A duty also arises by reason of Medicare instructions issued by BSWNY to all Medicare providers. I held in Kern, supra (at pp. 60-62), that another duty, the duty to investigate the accuracy of the claims submitted, springs from the certifications of truth and accuracy on the claim form itself.

Thus, to the extent that Respondent submitted improper claims which he should have known were improper had he investigated, he is liable under the CMPL for presenting claims in which the services were "not provided as claimed." He is liable under this standard whether or not his awareness at the time he signed or submitted a claim would support a finding that he knew the services were not provided as claimed.

D. Respondent Should Have Known.

As I stated in the case of Corazon C. Hobbs, DAB Civ. Rem. C-55 (1990), the "should know" standard is quite similar to the "reason to know" standard, except that the duty to inquire (the duty to ascertain the truth and accuracy of a claim) exists at all times and does not require any special circumstances to bring attention to the duty. The Restatement of Torts (2d) (at section 12) states:

> The words "should know" are used throughout the Restatement of this Subject to denote the fact that a person of reasonable prudence and intelligence or of the superior intelligence of the actor would ascertain the fact in question in the performance of this duty to another, or would govern his conduct upon the assumption that such fact exists.

In enacting the "should know" amendment in 1987, Congress indicated in the legislative history that the legislation was a clarification of the existing standard and that the "should know" standard of knowledge placed on Medicaid and Medicare providers the duty to ascertain the truth and accuracy of claims submitted by them:

> Providers who bill the Medicare, Medicaid and MCH programs have an affirmative duty to ensure that the claims for payment which they submit, or which are submitted on their behalf by billing clerks or other employees, are true and accurate representations of the items or services actually provided.

H. R. Rep. No. 391, 100 Cong., 2d Sess., pp. 533-535 (1987).

The "should know" standard subsumes the other two standards and includes negligence in submitting, or in directing the preparation and submission of claims. Anesthesiologists Affiliated, supra, at 56; Frazier, supra. Respondent should have known that what he was doing was not a nerve block as the term is commonly used in accepted medical practice. I.G. Ex. 55-2/7.

For the reasons stated above, Respondent should have known that what he was doing was not a nerve block, an office visit, or a consultation as the terms are used for purposes of Medicare reimbursement. He should have known that the services he claimed for were not medically necessary.

Respondent made no attempt to prepare his Medicare claims in a manner that reflected his services accurately. Rather, he disregarded Medicare rules and regulations and Medicare personnel and thought only of securing reimbursement.

I am not persuaded by Respondent's arguments that Medicare rules were ambiguous or that BSWNY misled him. The "should know" standard includes reckless disregard for the consequences of a person's acts and simple negligence in preparing, presenting, or in supervising the preparation and presentation 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).

Respondent's tiresome pattern of refusing to honor Medicare's rules for submitting accurate claims for reimbursement is at best characterized as obstinacy. Respondent failed to honor his duty to Medicare to accurately and honestly claim reimbursement for his services. Anesthesiologists, supra. At the very least, Respondent should have known that his claims for nerve blocks, office visits, and consultations were not provided as claimed.

VII. The Appropriate Amount Of The Penalty, Assessment, and Exclusion.

Once liability is proven by a preponderance of the evidence, the ALJ must determine the appropriate amount of penalties, assessment and length of exclusion. To make this determination, the CMPL and Regulations require

the ALJ to consider aggravating and mitigating circumstances.

Specifically, the CMPL and Section 1003.106 of the Regulations require me to examine: (1) the nature of the claims or requests for payment and the circumstances under which they were presented, (2) the degree of culpability of Respondent, (3) the history of prior offenses of Respondent, (4) the financial condition of Respondent, and (5) such matters as justice may require. Section 1003.106(b) of the Regulations contains some general guidelines for the interpretation and application of these aggravating and mitigating factors.

The I.G. must prove, by a preponderance of the evidence, any aggravating circumstances. Respondent must prove, by a preponderance of the evidence, any mitigating circumstances. 42 C.F.R. 1003.114(a), 1003.114(c). The Regulations provide that, in cases where mitigating factors are greater in weight, quantity, or importance, the penalties and assessment should be set below the maximum permitted by law, and where aggravating factors preponderate, the penalty and assessment should be set at or close to the maximum permitted by law. 42 C.F.R. 1003.106(c)(2). Therefore, in determining the appropriate penalty, assessment, and period of exclusion, I must apply these factors to the 688 services for which liability has been established.

While the CMPL and Regulations require consideration of aggravating and mitigating factors to determine the appropriate amount of the penalty, assessment, and the length of exclusion to be imposed in a given case, there is no formula set forth for computing them, and there is little guidance to be found in the CMPL and its legislative history (except with regard to an assessment, see 48 Fed. Reg. 38827 (Aug. 26, 1983). Hume, supra, at pp. 21-29. The preamble to the Regulations state that "fixed numbers" have been "eliminated" as "triggering devices." This emphasizes that discretion is preferable to a mechanical formula. Id. The preamble further states: "as we gain more experience in imposing sanctions under the statute, we may further refine the guidelines, but at this early stage we believe that increased flexibility is preferable."

The ALJ must also keep in mind that the purpose of a civil monetary penalty in a CMPL case is protection of the Medicare and Medicaid programs, rather than retribution or punishment. See Mayers v. U.S. Department of Health and Human Services, 806 F.2d (11th Cir. 1986), cert. denied, 484 U.S. 822 (1987); Chapman v. United

States of America, Department of Health and Human Services, 821 F.2d 523 (10th Cir., 1987). The dual purpose of deterrence is to encourage others to comply with the law and to discourage a respondent from committing the wrong again. Thus, to arrive at an appropriate penalty that would be a deterrent, rather than retribution, the ALJ must consider the factors outlined in the Regulations, weigh the gravity of the wrong done by a respondent, and attempt to prevent the wrong from being committed again by a given respondent and other providers.

The purpose of the assessment in a CMPL case is to enable the United States to recover the damages resulting from false or improper claims. The evaluation of an appropriate assessment includes estimates of amounts paid to a respondent by the Medicare and Medicaid programs and the costs of investigating and prosecuting unlawful conduct. See 48 Fed. Reg. 38831 (Aug. 26, 1983). See H.R. Rep. No. 158, 97th Cong., 1st Sess. 329, 461-462 (1981), 1981 U.S. Code Cong. & Admin. News 727-28.

A. The I.G. Proved Significant Aggravating Factors.

1. The I.G. Proved That the Nature and Circumstances of the Claims and Services at Issue Were Aggravating Circumstances.

The guidelines at section 1003.106(b)(1) of the Regulations state that an aggravating circumstance exists where the requests for payment were of several types, occurred over a lengthy period of time, were large in number, indicated a pattern of making such requests for payment, or the amount was substantial. The guidelines do not indicate what period constitutes a "lengthy" period, what number of requests is a "large" number, or what amount is a "substantial amount." See 48 Fed. Reg. 38827 (Aug.26, 1983). These judgments are left to the discretion of the ALJ.

The guidelines, at section 1003.106(b) of the Regulations, state that it is a mitigating circumstance if the nature and circumstances of the requests for payment were all of the same type, occurred within a short period of time, were few in number, and the total amount requested from Medicaid recipients was under $1,000. The Regulations do not specify what constitutes a "short period of time" or how to evaluate the number of claims.

Although the I.G. did not prove all of the aggravating circumstances which he alleged, he did establish more than one aggravating circumstance in this case. The I.G. proved that the claims for services at issue were provided over a lengthy period of time, were a substantial number, and involved a substantial amount claimed.

2. The I.G. Proved That the Degree of Culpability of Respondent Was an Aggravating Circumstance.

As I said in Hobbs, supra, one of the most complex of the factors to be considered by the ALJ in determining the amount of the penalty is the "degree of culpability." Hume, supra, at p. 24. The guidelines in the Regulations indicate that this factor relates to the degree of a respondent's knowledge and intent. Knowledge is an aggravating factor and "unintentional or unrecognized error" is a mitigating factor if a respondent "took corrective steps promptly after the error was discovered." Regulations, section 1003.106(b)(2). Thus, the determination of the degree of culpability involves an inquiry into the degree of a respondent's knowledge. See 48 Fed. Reg. 38831 (Aug. 26, 1983).

The I.G. proved that Respondent "knew" that the services claimed by Respondent were not provided as claimed. He also had reason to know and should have known that the claims in issue were not provided as claimed. It is an aggravating circumstance that Respondent had a reckless disregard for the Medicare rules in that he knowingly ignored the requirements when presenting claims to Medicare. See Anesthesiologists, supra, at 60-61.

I conclude that Respondent did not prove that his presentment of claims was a result of unrecognized and unintentional error, nor did he prove that corrective steps were taken promptly after the error was discovered.

Justice requires that I consider other factors as aggravating, such as the high costs associated with the investigation and prosecution of this case, and the negative impact that Respondent's actions had on Medicare beneficiaries.

B. Respondent Proved Mitigating Circumstances.

As I stated in Hobbs, supra, and Hume, supra, at p. 27, the CMPL and the Regulations contain an umbrella factor: "other matters as justice may require." Justice requires

that certain mitigating factors proven by Respondent be considered in reducing the amount of the penalty and assessment and the length of the exclusion proposed by the I.G.

The medical records submitted by the parties show that, in a significant number of the claims in question, some other medical services besides electro-acupuncture or injections of marcaine were provided. These notations in the medical records were corroborated by testimony from Respondent's patients, including those patients testifying on behalf of the I.G. See FFCL 98, 103,109 110, and 111. Also, one of the I.G.'s medical experts identified 14 services on claims which he considered to be sufficiently documented to be reimbursable, although most of them at a lower level of service than claimed. Tr.II/1541, 1542, 1545-1547, 1549. Thus, I have mitigated primarily because I believe that Respondent indeed provided many medical services to his patients which would have been reimbursable if properly documented.

I am also influenced by the fact that many of Respondent's patients found his treatments to be beneficial and were very satisfied with Respondent's services. In addition, I am influenced by what I consider to be Respondent's concern for his patients.

Even though I have found that Respondent's injections of marcaine were not medically necessary, it is a mitigating factor that these injections, according to Dr. Gilies testimony, were beneficial because they increased the blood flow to the area injected. It is also a mitigating factor that Respondent considered his electro-acupuncture and injections of marcaine to be an effective treatment for pain.

While Respondent's drug addiction does not excuse his behavior or change the fact that he violated the CMPL, it is a mitigating factor in considering the amount of the penalties and assessment that Respondent was drug addicted during the period of time in which the 688 claims at issue in this proceeding were submitted. See Tr.II/1055-1058. Had Respondent been drug-free, I doubt that this case would have occurred.

While I consider Respondent's drug-impaired judgment to be mitigating for purposes of the penalties and assessment, I must consider it differently for purposes of the length of exclusion. In determining the length of the exclusion, it is important to consider the degree to which Respondent is trustworthy and rehabilitated. As I

stated earlier, while there is evidence that Respondent has remained drug-free for several years and has made progress, Respondent still has work to do before he is totally rehabilitated. See Greene v. Sullivan, 731 F. Supp. 835 (E.D. Tenn. 1990).

The regulations state that the financial condition of a respondent should constitute a mitigating circumstance if the penalties or assessment, without reduction, would jeopardize the ability of a respondent to continue as a health care provider. Thus, it is clear that the ALJ may consider a respondent's financial condition. Furthermore, the guidelines at section 1003.106 (b)(4) note that the ALJ must consider the resources available to a respondent. This indicates that financial disclosure by a respondent is a key requirement in evaluating a respondent's financial condition.

Respondent has the burden of proving by a preponderance of the evidence that his financial condition would prevent him from being able to pay the penalties and assessment imposed in this case.

While Respondent produced some credible testimonial evidence pertaining to his current financial condition, the I.G. elicited testimony from Respondent which casts doubt on his assertions. Also, Respondent declined to participate in the I.G.'s requests for discovery of documentation concerning his finances. Accordingly, there is no basis in the record upon which to limit the sanctions proposed on grounds of financial condition.

B. The Amount of the Penalties, Assessment, and Exclusion, as Modified Here, is Supported by the Record.

After reviewing all of the evidence in the record, including aggravating and mitigating factors in this case, I conclude that civil monetary penalties of $140,000, an assessment of $45,000, and an exclusion from Medicare and Medicaid programs for seven years is sufficient to protect the Medicare program and its beneficiaries and sufficient to serve the remedial purposes of the CMPL. See Hume, supra, at 29-30; Tr. II/1329; Berney R. Keszler, M.D., DAB Civ. Rem. C-167 (1990) at pp. 34-39.

VIII. The Double Jeopardy Clause of the Constitution of the United States Does Not Prohibit The I.G. From Bringing This Action Against Respondent.

Respondent argues that since he pled guilty to one count of an eight count indictment in the United States District Court involving 26 mailings of Medicare claims, the double jeopardy clause of the Constitution of the United States protects him from this civil action and prevents the I.G. from recovering any penalties or assessment under the CMPL. R. Br. 2,8-17. Respondent argues that double jeopardy relates to the entirety of the "scheme" which he allegedly perpetrated, and not merely to the specific "mailings" involved in the indictment. R. Br. 2. Respondent relies upon the United States Supreme Court's holding in the case of United States v. Halper, 490 U.S. 435 (1989). Respondent also relies on the holding in the case of Albernaz v. United States, 101 S. Ct. 1137 (1989) and argues that the attempt by the I.G. to subject him to this action is contrary to Congress' intent and amounts to a cumulative penalty. R. Br. 2, 15-17.

For the reasons expressed at the hearing, I find and conclude that Respondent's reliance on Halper and Albernaz is misplaced and that the I.G. had authority to bring, and properly brought, this action. Tr.I/81-110. See Keszler, supra, at pp. 39-42.

IX. The I.G. Is Not Equitably Estopped or Otherwise Barred In This Case By The Plea Agreement.

Respondent asserts that we need not deal with the merits of this case because this proceeding is barred by the Plea Agreement he entered into with the United States in connection with the resolution of the criminal charges brought against him. R. Br. 4-5, 30-35. He argues that the doctrine of equitable estoppel, principles of fairness, and principles of the law of contracts are applicable to this agreement. Id.

There is no merit to Respondent's arguments. The doctrine of equitable estoppel does not apply in this case. There has been no proof of any misstatement or affirmative misconduct on the part of any United States Government official, and no showing of detrimental reliance. Heckler v. Community Health Services of Crawford County, 467 U.S. 51 (1989); Wagner v. Director Federal Emergency Management Agency, 847 F.2d 515, 519 (9th Cir. 1988). Moreover, Respondent testified that it was his understanding that the government could recover

from him, in a separate civil suit, up to $190,000. Tr. II/1329.

This action was initiated after September 1, 1987, and all the claims in issue were presented within six years preceding the I.G.'s Notice. Congress intended the new six-year statute of limitations to apply in all CMPL actions initiated after September 1, 1987. Accordingly, I conclude that the six-year statute of limitations applies to this action. Donald O. Bernstein, D.O., DAB Civ. Rem. C-40 (1989); aff'd, F2d (C.A.10, 1990).

X. This Action Is Not Barred By The Doctrine Of Res Judicata Or By The Doctrine Of Collateral Estoppel.

On January 13, 1989, ALJ Joseph G. Medicis suspended Respondent from Medicare and Medicaid programs for five years (commencing on May 2, 1988), pursuant to Section 1862 (e) of the Act. Respondent argues that because of this, the I.G. is barred from bringing this action by the doctrines of res judicata and collateral estoppel.

This argument has no merit, because the CMPL is an alternative remedy to criminal or other civil action. See Tr.I/87-110; Mayers, supra.

XI. Respondent Does Not Have The Right To Trial By Jury Or To Be Found Guilty Beyond A Reasonable Doubt.

Respondent's argument that this is a quasi-criminal proceeding is groundless. Scott v. Bowen, 845 F. 2d 856 (C.A. 9, 1988); Marcus v. Hess, 350 U.S. 148 (1956).

XII. Respondent was not prejudiced or denied due process by: (1) the admission of written statements of patients obtained by the I.G. in lieu of live testimony; or (2) the I.G.'s claim of privilege.

Respondent argues that he was denied due process and prejudiced by the admission of written statements of patients obtained by the I.G. in lieu of live testimony. R. Br. 35-45. Respondent asserts that he did not have the "financial resources or the time to subpoena the government's witnesses." Id. at 38.

Respondent's arguments have no basis in fact or in law. The record in this case is replete with offers to accommodate Respondent's need to cross-examine adverse witnesses. The leading case of Richardson v. Perales,

402 U.S. 389 (1971), holds that a party is not denied due process if he or she is given the right to cross-examine witnesses giving written statements in lieu of live testimony and the party fails to exercise that right. As in Perales, Respondent failed to subpoena the witnesses in question for cross-examination, despite my repeated offers to subpoena them. At the hearing, I specifically inquired about this and was told that most of the witnesses resided in the Rochester area. The cost for them to appear would have been less than $500. Respondent's stated reason for not calling these witnesses was not convincing.

ORDER

Based on the entire record, the CMPL, and the Regulations, it is hereby Ordered that:

(1) Respondent pay civil monetary penalties totalling $140,000.00;

(2) Respondent pay an assessment totalling $45,000.00; and

(3) Respondent be excluded for a period of seven years from the Medicare and Medicaid programs.

/s/

Charles E. Stratton
Administrative Law Judge