# Department of Health and Human Services

# DEPARTMENTAL APPEALS BOARD

## Civil Remedies Division

| | | |
|---|---|---|
| In the Case of: | ) | |
| | ) | |
| Yvon Nazon, M.D., | ) | DATE: December 20, 1991 |
| | ) | |
| Petitioner, | ) | |
| | ) | |
| - v. - | ) | Docket No. C-332 |
| | ) | Decision No. CR169 |
| The Inspector General. | ) | |
| | ) | |

## DECISION

On November 2, 1990, the Inspector General (I.G.) notified Petitioner that he was being excluded from participation in the Medicare and State health care programs for seven years, pursuant to section 1128(a)(1) of the Social Security Act (Act).[1] The I.G. advised Petitioner that he was being excluded as a result of his conviction of a criminal offense related to the delivery of an item or service under the Medicaid program.

By letter dated December 11, 1990, Petitioner requested a hearing and the case was assigned to me. On May 21, 1991, I held an in-person hearing in Chicago, Illinois. The parties subsequently submitted post-hearing briefs and reply briefs and they attached several proposed exhibits to their post-hearing submissions. By letter dated September 24, 1991, I established a schedule which provided the parties the opportunity to object to these exhibits and to reply to any objections. On November 5, 1991, I issued a Ruling in which I admitted the proposed exhibits attached to the parties' post-hearing submissions into evidence.

---

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

I also noted in my November 5, 1991 Ruling that on October 25, 1991, the I.G. furnished me with a copy of a published opinion from the United States Court of Appeals for the Seventh Circuit which affirmed Petitioner's underlying conviction. U.S. v. Nazon, 940 F. 2d 255 (7th Cir. 1991). The I.G. stated in an attached cover letter that this opinion "may be helpful" in reaching a decision in this matter, and indicated that he had not brought this opinion to my attention earlier because it was rendered after the parties' submissions of post-hearing briefs and that it was only recently published. I stated in my Ruling that Petitioner would have until November 20, 1991 to file written comments to the I.G.'s submission.

Petitioner subsequently filed a response in which he strenuously objected to the I.G.'s October 25, 1991 submission on the grounds that the submission was made without leave of this tribunal and that it "irreparably" prejudiced Petitioner. Petitioner therefore requested that I strike this submission from the record and that I also sanction the I.G. by dismissing these proceedings with prejudice.

I have considered Petitioner's response to the I.G.'s October 25, 1991 submission, and I deny his motions to strike it from the record and to dismiss these proceedings. The Seventh Circuit's opinion regarding Petitioner's conviction which underlies his exclusion from Medicare and Medicaid is highly relevant to the issues before me in this proceeding. In fact, had the outcome of the appeal been to overturn Petitioner's conviction, it would have set aside the underlying basis for an exclusion in this case. Since this opinion was not published until after the post-hearing briefing schedule expired, the I.G. had good cause for not bringing it to my attention at the time he submitted his post-hearing briefs. I am allowing the Seventh Circuit's affirmance of the trial court's decision to convict Petitioner to become part of this record solely for the purpose of providing additional support for the trial court's decision. Petitioner is not prejudiced by the use of the Seventh Circuit's opinion for this purpose because the trial court's decision was part of the record at the time of the May 21, 1991 hearing and Petitioner had full opportunity to rebut its findings and conclusions at that time.

I have considered the evidence, the parties' arguments, and the applicable laws and regulations. I conclude that the seven year exclusion imposed and directed against Petitioner by the I.G. is reasonable.

## ADMISSIONS

Petitioner admits that he was convicted of a criminal offense related to the delivery of an item or service under the Indiana Medicaid program within the meaning of section 1128(a)(1) of the Act. P. Post-hearing Rep. Br. 4.[2]

## ISSUES

The remaining issues in this case are:

1. Whether I, as the Secretary's delegate to hear and decide exclusion cases, have the authority to consider a request to waive Petitioner's exclusion or to recommend a waiver to the Secretary on the grounds that he is the sole source of essential specialized services in a community within the meaning of section 1128(c)(3)(B) of the Act.

2. Whether the seven-year exclusion imposed and directed against Petitioner is reasonable and appropriate under the circumstances of this case.

---

[2] References to the record will be cited in this decision as follows:

| | |
|---|---|
| I.G.'s Exhibit | I.G. Ex. (number/page) |
| Petitioner's Exhibit | P. Ex. (number/page) |
| Transcript | Tr. (page) |
| I.G.'s Post-hearing Brief | I.G. Post-hearing Br. (page) |
| Petitioner's Post-hearing Brief | P. Post-hearing Br. (page) |
| I.G.'s Post-hearing Reply Brief | I.G. Post-hearing Rep. Br. (page) |
| Petitioner's Post-hearing Reply Brief | P. Post-hearing Rep. Br. (page) |
| Findings of Fact and Conclusions of Law | FFCL |

## FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Petitioner is a Board-certified physician in obstetrics and gynecology. Tr. 51.

2. Petitioner used Clinical Diagnostics, Inc., an independent laboratory, to analyze specimens of his patients from 1985 to May 1987. During this period, Petitioner engaged in a practice in which he improperly billed Medicaid for laboratory services which were not performed in his office, but which were instead performed by Clinical Diagnostics, Inc. I.G. Ex. 3/5, 13, 14, 19, 21.

3. Petitioner also engaged in a practice in which he improperly submitted bills to Medicaid for assistant surgeon fees in instances where either there was not an assistant surgeon or the assistant surgeon was a resident physician paid by the hospital where the surgery was performed. Petitioner instructed his office staff to alter operative reports, and he submitted the altered operative reports as documentation for his fraudulent bills for surgical services. I.G. Ex. 3/5, 14, 17, 18, 20; Tr. 28-31, 34-35.

4. On October 13, 1989, the grand jury for the United States District Court for the Northern District of Indiana indicted Petitioner on 17 counts of presenting false claims to the Indiana Department of Public Welfare in violation of 18 U.S.C. 287. Counts one through eight of the indictment charged Petitioner with fraudulently billing for assistant surgeon's fees during the period from December 19, 1986 to May 15, 1987. Counts nine through 17 charged Petitioner with fraudulently billing for laboratory tests he did not perform during the period from April 4, 1986 to September 12, 1986. I.G. Ex. 1.

5. A trial was held in March 1990 and a jury found Petitioner guilty on all 17 counts contained in the indictment. I.G. Ex. 3/7; I.G. Ex. 2.

6. On May 10, 1990, the United States District Court for the Northern District of Indiana sentenced Petitioner to a period of five years' probation with a suspended sentence, ordered him to serve one year in a work release program, to contribute 1500 hours community service, and to pay restitution to the Medicaid program in the amount of $84,110.35. I.G. Ex. 2.

7. On August 15, 1991, the United States Court of Appeals for the Seventh Circuit issued a decision

affirming Petitioner's conviction. Cited as 940 F. 2d 255 (7th Cir. 1991).

8. Petitioner was convicted of a criminal offense within the meaning of section 1128(a)(1) and 1128(i) of the Act.

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

10. The Secretary of the United States Department of Health and Human Services (the Secretary) delegated to the I.G. the authority to determine, impose, and direct exclusions pursuant to section 1128 of the Act. 48 Fed. Reg. 21661 (May 13, 1983).

11. On November 2, 1990, the I.G. notified Petitioner that he was being excluded from participation in the Medicare and Medicaid programs for seven years, pursuant to section 1128(a)(1) of the Act.

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

13. I do not have the authority to consider a request for a waiver of Petitioner's exclusion or to recommend a waiver to the Secretary.

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

15. Petitioner presented a substantial number of fraudulent Medicaid claims over a period exceeding a year, a lengthy period of time. FFCL 2-5, 7.

16. The financial loss to the Medicaid program resulting from Petitioner's criminal misconduct amounted to at least $84,000, a significant amount of money. I.G. Ex. 2/1; Tr. 39, 41.

17. The serious nature of Petitioner's criminal offenses is reflected in the sentence fashioned by the court. FFCL 6.

18. The serious nature of Petitioner's offenses is reflected in the fact that on June 28, 1990, the State of Indiana permanently excluded Petitioner from participation in the Indiana Medicaid program as a result of his criminal misconduct. I.G. Ex. 10.

19. The serious nature of Petitioner's offenses is reflected in the fact that the Medical Licensing Board of Indiana issued a decision on March 5, 1991 finding that the imposition of disciplinary sanctions against Petitioner was appropriate based on his criminal conviction. I.G. Ex. 13.

20. Petitioner's testimony that his improper billing practices were the result of the poor advice of a misinformed subordinate is not credible. Instead, the weight of the evidence establishes that Petitioner deliberately violated Medicaid regulations, and he directed his staff to engage in unlawful billing practices. Tr. 53, 57, 65, 91-93, 100; I.G. Ex. 3/13, 14 20-21, 31.

21. Petitioner repeatedly initiated schemes to defraud the Medicaid program, and his unlawful acts show a high level of culpability. FFCL 20.

22. Petitioner's misstatement of the facts is strong evidence that he is untrustworthy. FFCL 20-21.

23. Petitioner's continued refusal to recognize the wrongfulness of his actions and his repeated attempts to excuse and rationalize his deceptive billing practices show that he has not fully recognized his duty to adhere to Medicaid billing requirements. Tr. 57, 59, 97.

24. The fact that Petitioner is a competent physician who has provided medical services to a community which has a serious need for these services does not establish that he can be trusted to deal with Medicare and Medicaid trust funds.

25. The fact that Petitioner provided needed medical services without cost subsequent to his criminal conviction does not establish that he can be trusted to be a program provider.

26. In this case, the need to protect the integrity of the Medicare and Medicaid programs supersedes concerns that this remedy may impair Petitioner's ability to provide needed medical services to the indigent population of the Gary, Indiana, community.

27. A lengthy exclusion is needed in this case to satisfy the remedial purposes of the Act.

28. The seven year exclusion imposed and directed by the I.G. Is reasonable.

## RATIONALE

**1. The I.G. was required to exclude Petitioner for a minimum period of five years in this case.**

Petitioner admits that he was convicted of a criminal offense related to the delivery of an item or service under the Indiana Medicaid program, within the meaning of section 1128(a)(1) of the Act. Therefore, there is no dispute as to the authority of the I.G. to impose and direct an exclusion against Petitioner pursuant to section 1128(a)(1) of the Act.

Sections 1128(a)(1) and 1128(c)(3)(B) of the Act clearly require the I.G. to exclude individuals and entities from the Medicare and Medicaid programs for a minimum period of five years, when such individuals and entities have been "convicted" of a criminal offense "related to the delivery of an item or service" under the Medicare or Medicaid programs, within the meaning of section 1128(a)(1) of the Act.

Since Petitioner was "convicted" of a criminal offense and it was "related to the delivery of an item or service" under Medicaid pursuant to section 1128(a)(1) of the Act, the I.G. was required by section 1128(c)(3)(B) of the Act to exclude Petitioner for a minimum of five years.

**2. I do not have the authority to consider a request for a waiver of the exclusion or to recommend a waiver to the Secretary.**

The only exception to the requirement that the I.G. exclude individuals and entities from the Medicare and Medicaid programs for a minimum period of five years when such individuals and entities have been convicted of a program-related offense within the meaning of section 1128(a)(1) is contained in section 1128(c)(3)(B) of the Act. That section provides that the Secretary may waive exclusions imposed pursuant to section 1128(a)(1) of the Act, "upon the request of a State," "in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community." Section 1128(c)(3)(B) further provides that

the Secretary's decision whether to waive exclusions "shall not be reviewable".

Petitioner was convicted of 17 counts of presenting false claims to the Indiana Department of Public Welfare in violation of 18 U.S.C. 287. FFCL 4-5. As part of Petitioner's sentence, the United States District Court required Petitioner to contribute 1500 hours of community service. FFCL 6. At the time of Petitioner's sentencing, Dr. Rebera Poston, the Health Commissioner of Gary, Indiana, was in the process of establishing a State-financed prenatal clinic for the indigent women of Gary, Indiana. One of the funding requirements for the clinic was that a qualified obstetrician/gynecologist be available for consultation. Dr. Poston was unable to find a physician willing to offer these services without charge until Petitioner volunteered his services, which he did in order to fulfill his court-ordered community service requirement. As a result of Petitioner's assistance, the prenatal clinic was able to begin operation. Dr. Poston testified at the May 21, 1991 hearing that Petitioner's services were "absolutely indispensable" to the operation of the prenatal clinic and that the prospects for replacing him were nil. According to Dr. Poston, the Board of Health would probably have to close the prenatal clinic if Petitioner was unavailable to provide his obstetrical services. Tr. 118-119; P. Ex. 3/61, 63, 64, 67, 72.

Dr. Poston testified Petitioner also contributed services to the sexually transmitted disease clinic and to the chronic disease clinic operated by the Gary Board of Health. Tr. 111. Although Petitioner's court-ordered community service requirement does not contemplate that Petitioner provide medical supplies, Dr. Poston testified that Petitioner voluntarily donated supplies and equipment, and he also treated patients in his own office so that he could do procedures that he would not have been able to do with clinic facilities. Tr. 117-118.

Petitioner attached to his post-hearing brief a copy of a July 19, 1991 letter addressed to Senators Richard Lugar and Dan Coats of Indiana from the Gary Board of Health which described the services provided by Petitioner to the Gary Board of Health clinic program. The Gary Board of Health asked that the letter "serve as our request that [Petitioner] be reinstated to the Medicaid/Medicare Program under such condition(s) as those agencies deem permissible". The letter also urges the senators from Indiana to "communicate with those in the administration in an effort to see to it that [Petitioner] is re-instated to the Medicare/Medicaid Programs".

Petitioner asserts that the clinic program operated by the Gary Board of Health, to which Petitioner has contributed his services, was established through the assistance of federal, State, and local funding. Petitioner therefore contends that it qualifies as a "quasi-state agency". Petitioner argues that this letter constitutes a "direct request" by the State of Indiana to the Department of Health an Human Services for a waiver of the exclusion imposed upon him. P. Post-hearing Br. 5. Petitioner also argues that this letter and Dr. Poston's testimony show that Petitioner is the "sole source of essential specialized services" in Gary, Indiana, within the meaning of section 1128(c)(3)(B) of the Act and therefore a waiver of Petitioner's exclusion is justified under this statutory standard.

The I.G. argues that the July 19, 1991 letter cannot be viewed as a request of a State that the Secretary grant a waiver in this case since it is not addressed to the Secretary. The I.G. also contends that even if the letter were to be construed as a request to the Secretary for a waiver of Petitioner's exclusion, there is nothing in the Act or the regulations which states that the Secretary has delegated to administrative law judges the authority to consider waiver requests.

Petitioner urges that, as the Secretary's delegate to hear and decide exclusion cases, I have the authority to consider a waiver request. Petitioner contends that under 42 C.F.R. 1001.128(a), which provides that administrative law judges have jurisdiction to hear and decide the issue of whether the I.G.'s exclusion in a particular case is reasonable, I have the authority to determine whether an exclusion should be waived under section 1128(c)(3)(B) of the Act. According to Petitioner, an administrative law judge who makes the determination that an exclusion is warranted in a particular case could then recommend waiver of such exclusion to the Secretary.

In my November 5, 1991 Ruling, I stated that I disagreed with Petitioner's position. I ruled that I do not have the authority to hear and decide the issue of waiver, and thus it is unnecessary for me to determine whether the July 19, 1991 letter constitutes a valid request for a waiver by "a State" to "the Secretary".[3]

---

[3] I did admit this letter for the purpose of providing evidence on the issue of whether the length of the exclusion greater than five years is reasonable.

The authority of the Secretary to waive an exclusion is unrelated to the duty of administrative law judges to decide hearing requests pursuant to section 1128 of the Act. Stanley A. Bittman, Ph. D., DAB CR153 (1991). There is nothing in the law or regulations which either states or suggests that the Secretary has delegated to administrative law judges the authority to reduce or waive or to recommend the reduction of or the waiver of the five year minimum exclusion mandated by section 1128(c)(3)(B) of the Act. Michael I Sabbagh, M.D., DAB CR20 (1989) at 18. While 42 C.F.R. 1001.128(a) provides that administrative law judges have the authority to hear and decide the issue of whether the length of an exclusion is reasonable, I do not construe this to mean that the issue of waiver can be heard by administrative law judges. Instead, the administrative law judge's authority to determine the reasonableness of the length of an exclusion applies in exclusions imposed pursuant to section 1128(a)(1) only in those cases where the exclusion is greater than the minimum mandatory period of five years. In those cases, the administrative law judge's authority is limited to hearing and deciding whether an exclusion greater than the minimum mandatory five years is reasonable.[4]

---

[4] I also note that even if I had the authority to consider waiver requests or to make recommendations to the Secretary on the issue of waiver, the record as it now stands raises serious questions regarding whether a waiver would be appropriate in this case. While there is evidence that Petitioner has been the sole source of obstetrical services to the Gary Board of Health prenatal clinic, he has provided these services free of charge. An exclusion from the Medicare and Medicaid programs does not prohibit a provider from providing medical services. It merely prohibits him from billing Medicare and Medicaid for those services. Thus, Petitioner's exclusion in no way prevents him from continuing to provide the essential services he has been providing to the Board of Health prenatal clinic. See Tr. 122-123. I also note that the July 19, 1991 letter by the Gary Board of Health states that Petitioner began providing services to the prenatal clinic in the Spring of 1990 and that he continued "up until approximately two weeks ago". This implies that Petitioner no longer provides these essential services to the prenatal clinic. If this is true, the justification for a waiver would no longer exist and the waiver issue would be moot.

**3. A seven year exclusion is appropriate and reasonable in this case.**

In this case, the I.G. excluded Petitioner for a period of seven years. The exclusion provisions of sections 1128(a)(1) and 1128(c)(3)(B) of the Act require that an individual that has been convicted of a criminal offense related to the delivery of an item or service under the Medicaid program be excluded for a minimum period of five years. The issue in this case is whether the I.G. is justified in excluding Petitioner for seven years. Resolution of this issue depends on analysis of the evidence of record in light of the exclusion law's remedial purpose. Lakshmi N. Murty Achalla, M.D., DAB 1231 (1991).

Section 1128 is a civil statute and Congress intended it to be remedial in application. The remedial purpose of the exclusion law is to enable the Secretary to protect federally-funded health care programs from misconduct. Such misconduct includes fraud or theft against federally-funded health care programs. It also includes neglectful or abusive conduct against program recipients and beneficiaries. See, S. Rep. No. 109, 100th Cong., 1st Sess. 1, reprinted in 1987 U.S. Code Cong. and Admin. News 682. It has been held that the offense of intentionally submitting billings which cause an overpayment to a provider by a federally-funded health care program adversely impacts the fiscal integrity of the affected program. Daniel B. Salyer, DAB CR106 (1990); Jack W. Greene, DAB 1078 (1989).

The key term to keep in mind is "protection", the prevention of harm. See, Webster's II New Riverside University Dictionary 946 (1984). As a means of protecting the Medicare and Medicaid programs and their beneficiaries and recipients, Congress chose to mandate, and in other instances to permit, the exclusion of untrustworthy providers. Through exclusion, individuals who have caused harm, or demonstrated that they may cause harm, to the federally-funded health care programs or their beneficiaries or recipients are no longer permitted to receive reimbursement for items or services which they provide to Medicare beneficiaries or Medicaid recipients. Thus, untrustworthy providers are removed from positions which provide a potential avenue for causing future harm to the program or to its beneficiaries or recipients. See Vladimir Coric, M.D., DAB CR135 (1991).

An exclusion imposed and directed pursuant to section 1128 will likely have an adverse financial impact on the person against whom the exclusion is imposed. However,

the law places program integrity and the well-being of beneficiaries and recipients ahead of the pecuniary interests of providers. An exclusion is not punitive if it reasonably serves the law's remedial objectives, even if the exclusion has a severe adverse financial impact on the person against whom it is imposed.

The determination of when an individual should be trusted and allowed to reapply for reinstatement as a provider in the federal programs is a difficult issue. It is subject to discretion. The federal regulations at 42 C.F.R. 1001.125(b) guide me in making this determination. The regulations require the I.G. to consider factors related to the seriousness and program impact of the offense and to balance those factors against any factors that demonstrate trustworthiness. Leonard N. Schwartz, DAB CR36 (1989).

Since the exclusion remedy is not intended to be a punishment for wrongdoing, the regulations should not be applied as sentencing guidelines to the facts of a case to determine the punishment a provider "deserves". Instead, the regulations provide guidance as to the factors that should be considered in order to make inferences about a provider's trustworthiness and the length of time a provider should be excluded to ensure that a provider no longer poses a risk to the covered programs and to their beneficiaries and recipients. While I do not analyze an exclusion as redress for past harmful conduct, evidence of past harmful acts by an excluded party may demonstrate a propensity by that party to commit such acts or similar misconduct in the future.

The hearing in an exclusion case is, by law, de novo. Act, section 205(b)(1). Evidence which is relevant to the reasonableness of the length of an exclusion will be admitted in a hearing on an exclusion whether or not that evidence was available to the I.G. at the time the I.G. made his exclusion determination. Evidence which relates to a provider's trustworthiness or the remedial objectives of the exclusion law is admissible at an exclusion hearing even if that evidence is of conduct other than that which establishes statutory authority to exclude a provider.

A determination of the length of time necessary to establish that a provider is no longer a threat to the covered programs and to their beneficiaries and recipients necessitates an evaluation of the myriad facts of each case, including the nature of the offense committed by the provider, the circumstances surrounding the offense, whether and when the provider sought help to

correct the behavior which led to the offense, and how far the provider has come towards rehabilitation. Victor M. Janze, M.D., DAB CR101 (1990).

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

The record shows that Petitioner engaged in a pattern of serious criminal activity over a period of several years. On August 4, 1986, the Indiana Medicaid Fraud Control Unit began an investigation of Petitioner's billing procedures. This investigation was initiated because an audit conducted by Blue Cross/Blue Shield of Indiana, the fiscal contractor for the Indiana Medicaid program, revealed that Petitioner was engaging in questionable billing practices. I.G. Ex. 3/1, 4. The Federal Bureau of Investigation (F.B.I.) subsequently joined the investigation on October 8, 1987. I.G. Ex. 3/6.

The investigation concentrated on two improper billing practices. First, the investigation focused on Petitioner's practice of billing Medicaid for laboratory services not provided by his office. The investigation also explored irregularities in Petitioner's billing for surgical fees. I.G. Ex. 3/4-5.

The investigation revealed that Petitioner began using Clinical Diagnostics, Inc. as an outside laboratory to analyze patient specimens in 1985, and that he continued to use its laboratory services until May 1987. I.G. Ex. 3/21. Dr. R. B. Shaker, president of Clinical Diagnostics, told investigators that he provided requisition forms to members of Petitioner's office staff to be used in ordering laboratory services for Petitioner's patients. Dr. Skinner instructed Petitioner's office personnel to complete the requisition forms by identifying the patient by name and checking off the laboratory services needed for a specimen. Dr. Skinner also gave instructions to put the patient's Medicaid number on the requisition form if the patient was Medicaid eligible. In those instances, Clinical Diagnostics would bill Medicaid directly for those laboratory services. If there was no number on the form, Clinical Diagnostics would assume that the patient was not covered by Medicaid and it would bill Petitioner directly for the laboratory services. I.G. Ex. 3/5, 21.

According to an investigative report of an interview with Ms. Mariom Bernice Miller, who was employed by Petitioner as a Medical Assistant from 1979 to 1987, Petitioner told his office staff that he was not going to let Clinical Diagnostics bill Medicaid directly, but that he would bill Medicaid himself for the laboratory services performed by Clinical Diagnostics for Medicaid patients. I.G. Ex. 3/13-14. Ms. Miller stated that in most instances, Petitioner's office would submit requisition forms to Clinical Diagnostics for Medicaid patients without providing their Medicaid number. I.G. Ex. 3/13. Clinical Diagnostics would then be unable to bill Medicaid directly for laboratory services performed for these Medicaid patients as required by Medicaid regulations. Instead, Clinical Diagnostics would charge Petitioner for these services.

The record shows that in order to attract Petitioner's business, Clinical Diagnostics discounted the laboratory fees charged to him. Petitioner paid Clinical Diagnostics between $12 and $18 for laboratory services performed for Medicaid patients whose Medicaid numbers did not appear on the requisition form. Petitioner then billed Medicaid for those patients as if he had performed the laboratory services in his office. The investigative summary revealed that Petitioner usually charged Medicaid between $80 and $100 for these services, and that Medicaid usually paid Petitioner approximately $60 for each claim.[5] In this way, Petitioner improperly billed Medicaid at inflated rates for laboratory work that he did not perform. I.G. Ex. 3/5, 13, 19, 21.

The record shows investigators confronted Petitioner regarding his improper billings for laboratory services on August 18, 1987 and October 15, 1987. Investigators informed Petitioner that these billing practices were abusive and illegal. Petitioner attempted to justify these practices by asserting to investigators that Clinical Diagnostics was his employee because he hired it to perform laboratory work for him. Petitioner reasoned that since the laboratory is in his employ, there is

---

[5] Although the investigative summary indicated that Petitioner usually charged Medicaid between $80 and $100 for these laboratory services, Mr. John Peters, an investigator with the Medicaid Fraud Control Unit, testified at the May 21, 1991 hearing that the amount Petitioner charged for these services ranged from approximately $90 to $160. Tr. 26. Thus, there is evidence of record that Petitioner charged from $80 to $160 for laboratory services provided by Clinical Diagnostics.

nothing wrong with paying it for its services and then billing Medicaid for these services. Petitioner also stated that the amount he charged Medicaid for the laboratory work compensates him for the overhead expenses of his office, the processing of the specimen in preparation for the laboratory work, and the interpretation of the laboratory results. I.G. Ex. 3/22, 30; Tr. 31-32.

The investigation also explored irregularities regarding Petitioner's practice of billing for surgical fees. The investigation revealed that from 1981 to 1987, Petitioner employed Dr. Jacqueline Y. Gervais to assist him in his practice. As part of her duties, Dr. Gervais performed surgeries on Petitioner's patients. I.G. Ex. 3/17-18. Former employee Ms. Miller told investigators that beginning in 1984 and continuing into 1987, Petitioner instructed his office staff to alter copies of operative reports sent to his office by the hospital. If the operative report showed that Dr. Gervais performed surgery without an assistant, Petitioner instructed his office staff to white out her name and replace it with Petitioner's name as the head surgeon. Petitioner also instructed his staff to write in Dr. Gervais' name as the assistant surgeon in those instances. Petitioner would then use the altered operative report as documentation to bill Medicaid for the services of an assistant surgeon, even though the operation was performed without an assistant surgeon. I.G. Ex. 3/5, 14.

Ms. Miller also indicated that if the operative report showed that Dr. Gervais performed the surgery with the assistance of a resident doctor provided by the hospital, Petitioner instructed his staff to white out both names on the operative report and again replace it with Petitioner's name as the head surgeon and with Dr. Gervais' name as the assistant surgeon. The services of an assisting resident provided by the hospital were paid for by the hospital as part of the resident's training. Petitioner would use the altered operative report as documentation to bill Medicaid for the services of an assisting physician. These actions made it possible for Medicaid to be billed twice for assistant physician's services: once properly by the hospital as reimbursement for payment of the resident's services and once improperly by Petitioner. I.G. Ex. 3/14.

Mr. John Peters, an investigator with the Medicaid Fraud Control Unit, testified at the May 21, 1991 hearing that Ms. Miller's statements were corroborated by a comparison of the original operative reports maintained by the hospital with the altered operative reports that

Petitioner submitted to Medicaid to document his improper charges for assistant surgeon fees. Tr. 28-31, 34-35. In addition, investigative reports of interviews with Dr. Gervais and Ms. Denise Kuipers, R.N., Petitioner's former office manager, also corroborate Ms. Miller's account. Ms. Kuipers told investigators that, in 1986, Petitioner instructed her to retroactively bill for assistant surgeon fees for surgeries which were performed up to three years prior to that time. I.G. Ex. 3/20. Dr. Gervais told investigators that although she terminated her employment with Petitioner effective July 31, 1987, Petitioner continued to bill Medicaid for surgery performed by her after that time. Dr. Gervais stated that when she asked Petitioner about this, he offered to share monies illegally received from Medicaid with her. I.G. Ex. 3/18.

Investigators presented their findings to a federal grand jury sitting at Hammond, Indiana. I.G. Ex. 3/2. On October 13, 1989, the grand jury for the United States District Court for the Northern District of Indiana indicted Petitioner on 17 counts of presenting false claims to the Indiana Department of Public Welfare in violation of 18 U.S.C. 287. Counts one through eight of the indictment charged Petitioner with fraudulently billing for assistant surgeon's fees during the period from December 19, 1986 to May 15, 1987. Counts nine through 17 charged Petitioner with fraudulently billing for laboratory tests he did not perform during the period from April 4, 1986 to September 12, 1986. FFCL 4. A trial was held in March 1990 and a jury entered a guilty verdict on all 17 counts contained in the indictment. FFCL 5. Petitioner appealed this conviction and by decision dated August 15, 1991, the Seventh Circuit affirmed this conviction. FFCL 7.

Prior to Petitioner's sentencing hearing, investigators calculated the monetary damage to the Medicaid program resulting from Petitioner's wrongdoing. Based on documents in evidence at the trial, investigators calculated that, during the period from 1985 to 1987, Medicaid paid Petitioner $71,944.51 for improper claims for laboratory services performed by Clinical Diagnostics. I.G. Ex. 3/7.[6] Taking into account

---

[6] This figure does not include payments for urinalysis which were performed by Petitioner's office rather than by Clinical Diagnostics. In addition, it does not include payments for handling fees which are permissible under Medicaid regulations. I.G. Ex. 3/7; Tr. 39-41.

additional monetary damage to the Medicaid program resulting from the improper billing for assistant surgeon fees, investigators determined that the financial loss to the Medicaid program resulting from Petitioner's misconduct amounted to $84,119.35. I.G. Ex. 2/1; Tr. 39, 41.

The evidence shows that Petitioner's misconduct underlying his conviction involved a significant number of serious criminal offenses occurring over a lengthy period of more than a year and that these offenses involved substantial damage to the Medicaid program. The serious nature of Petitioner's offense is reflected in the sentence imposed on Petitioner by the United States District Court. On May 10, 1990, the court sentenced Petitioner to a period of five years' probation with a suspended sentence, ordered him to serve one year in a work release program, to contribute 1500 hours of community service, and to pay restitution to the Medicaid program in the amount of $84,110.35. FFCL 6, 17. The serious nature of Petitioner's offenses is also reflected in the fact that, on June 28, 1990 the State of Indiana permanently excluded Petitioner from participation in the Indiana Medicaid program. FFCL 18. In addition, the serious nature of Petitioner's criminal offense is reflected in the fact that on March 5, 1991, the Medical Licensing Board of Indiana issued a decision finding that the imposition of disciplinary sanctions against Petitioner was appropriate based on his criminal conviction. FFCL 19.

Petitioner engaged in a systematic fraud of the Medicaid program resulting in the unlawful appropriation of thousands of dollars of trust fund monies. Petitioner's unlawful acts show that he is an individual who is capable of engaging in flagrantly dishonest conduct, and that he has a propensity to commit offenses harmful to the financial integrity of federally funded health care programs. The record is replete with evidence indicating that Petitioner was the principal behind these fraudulent practices and actively directed his staff in the steps necessary to carry out the illegal billing procedures. The evidence of Petitioner's culpability demonstrates that he is an untrustworthy provider and that a lengthy exclusion is needed to satisfy the Act's remedial purpose.

In addition, I am particularly disturbed by Petitioner's persistent refusal to accept responsibility for his actions and his reliance on weak rationalizations in the face of overwhelming evidence that he repeatedly initiated schemes to defraud the Medicaid program. This

is additional evidence of a lack of trustworthiness and it provides additional support for a lengthy exclusion.

During the May 21, 1991 hearing, Petitioner testified that he was "a very busy guy" with multiple responsibilities for running two offices, teaching, researching, and treating patients. As a result, Petitioner asserted that he was unable to devote adequate attention to the billing functions of his medical practice. Tr. 57. Petitioner repeatedly stated at the hearing that he delegated the billing functions of his office to his office manager at the time, Ms. Kuipers, and that he placed undue reliance on her advice regarding Medicaid billing requirements. Petitioner did not admit that he intended to defraud the Medicaid program, but instead he characterized his conduct as being the result of "negligence". Tr. 91.

Petitioner's portrayal of himself as an overworked health care provider who was the victim of poor advice provided by a misinformed office manager is unpersuasive. During the hearing, Petitioner testified that Ms. Kuipers told him that Dr. Shaker of Clinical Diagnostics told her that Petitioner could pay Clinical Diagnostics as a subcontractor and bill Medicaid for these services. Petitioner testified that Ms. Kuipers thought that this was "a good idea", and that he relied on her opinion that it was proper to bill Medicaid for services performed by an independent laboratory. Tr. 53, 91-93. This testimony is not credible because it is contradicted by statements made to investigators by Dr. Shaker. Dr. Shaker told investigators that he told members of Petitioner's office staff to provide Medicaid numbers for Medicaid patients in order to make it possible for Clinical Diagnostics to bill Medicaid for these services. I.G. Ex. 3/21, 31. These statements were corroborated by statements made by former employee Ms. Miller. I.G. Ex. 3/13.

Petitioner tried to explain his improper billing for patient specimens as being the result of "confusing" and "frustrating" Medicaid regulations and requirements. Tr. 92-95. At one point in his testimony, Petitioner asserted that he never paid attention to the provider manual until his federal prosecution nor was the manual in his office during the period in issue. Tr. 93. Yet in an effort to explain his illegal billing for patient specimens, he testified that the 1985 Medicaid manual permitted such billing until a change in policy in the 1987 manual made such billing unlawful. Tr. 93-95. Petitioner cannot have it both ways -- he cannot credibly assert that he was not aware of the regulations and at the same time argue they were inconsistent.

With regard to the improper billing for surgical fees, Petitioner again offered the explanation that he was the victim of poor advice provided by his office manager. According to his explanation, Petitioner's office manager suggested that he alter operative reports so that he could be reimbursed for Dr. Gervais' services during a 19 month period beginning in 1985 when he was waiting for Medicaid to assign Dr. Gervais a provider number. Tr. 65, 100. This explanation is inconsistent with statements made by Ms. Kuipers to investigators indicating that Petitioner directed her to alter operative reports dating back three years and rebill Medicaid for each surgery to include an assistant's fee. Ms. Kuipers also told investigators that she felt that this was "wrong". I.G. Ex. 3/20. Ms. Kuipers' account is also substantiated by statements made to investigators by Ms. Miller and Dr. Gervais.

I recognize that the damaging statements contained in the investigative reports are not sworn statements which have been subjected to cross-examination. Notwithstanding this, I find that these statements are reliable because they corroborate each other. When read together, these statements consistently portray Petitioner as an individual who was actively involved in the billing procedures of his office. Moreover, such reports were designated by the I.G. as exhibits prior to the hearing and made available to Petitioner. Despite this, Petitioner offered no evidence other than his own version of the events to rebut these clearly incriminating reports.

Although Petitioner attempted to disguise his involvement with the billing activities of his office by blaming his office manager for the billing violations, there is ample evidence that he deliberately disregarded Medicaid requirements and that he personally directed his staff to engage in illegal billing practices. I am troubled by Petitioner's failure to admit his role in carrying out his fraud against the Medicaid program, and I find that his tendencies to mischaracterize and to misstate the facts is strong evidence that he was and continues to be untrustworthy.

I am also disturbed by Petitioner's persistent refusal to fully appreciate the wrongfulness of his actions. I recognize that Petitioner has paid lip service to the claim that he now fully understands his obligations to the Medicaid program. Tr. 78. However, his repeated attempts to rationalize his misconduct and his failure to show any remorse for his offenses leads me to conclude

that Petitioner has failed to provide any meaningful assurance that he will not engage in future wrongdoing.

Petitioner's testimony at the May 21, 1991 hearing reveals that he still does not accept that his criminal offenses constituted fraud rather than negligence or billing oversights. Instead, Petitioner expressed the view that his actions were not fraudulent because "the service was always rendered". He stated that it "boggle[d] [his] mind" that he was convicted for fraud since he filed claims for services that were actually rendered. He further testified that his billing of Medicaid amounted to "inflation, maybe, of the bill, but not probably a fraud." Petitioner characterized his actions as a misinterpretation of an array of confusing Medicaid regulations issued by a program which is "a frustration". Tr. 57, 59, 97.

Petitioner repeatedly attempted to justify and excuse his fraudulent activities by pointing out deficiencies in the administration of the Medicaid program. For example, Petitioner asserted that his practice of billing Medicaid for services performed by an independent laboratory actually saved Medicaid money, and he made the incredible assertion that "every little gesture I do the goal has been to save money to the third party". Tr. 107. He also justified billing for laboratory services he never performed on the grounds that he had overhead office expenses to cover and that he deserved to be compensated for his analysis of the test's results. Tr. 55-56; I.G. Ex. 3/22, 30. In justifying his improper billing for surgical fees, Petitioner stated that he deserved to be compensated for Dr. Gervais' services during the lengthy period he was waiting for Medicaid to assign her a provider number. Tr. 64 - 65, 68.

At the hearing, Petitioner explained his billing philosophy for billing his patients and submission of bills to Medicaid, as follows:

> My philosophy has been that if a private patient is charged one hundred and thirty-four dollars, why not charge the Medicaid patient the same whether or not the reimbursement is the same, never they could say -- I say hey, the money is not enough, I always accept that as a fact, but I want them to know this is what the current, it is for everybody, what they are being charged, so we call that inflation. Tr. 60.

It is apparent that Petitioner, despite a criminal conviction for fraudulent billing of Medicaid and a hearing to determine his length of exclusion from Medicare and Medicaid, continues to consider his personal billing philosophy to be paramount to the requirements of the Medicaid program.

His espoused billing philosophy and expressed rationalizations for wrongdoing demonstrate that Petitioner possesses an arrogant disrespect for the regulations governing his participation in federally assisted health care programs. Rather than following Medicaid regulations, Petitioner has repeatedly chosen to "rewrite" Medicaid regulations in accordance with his own personal opinion of how the program should be administered, and he has repeatedly engaged in deceptive and illegal billing practices when he felt that he was entitled to additional money from Medicaid. Petitioner's repeated failure to show any respect for Medicaid billing requirements raises serious concerns about his ability to adhere to Medicaid regulations in the future.

I infer from this evidence a propensity on Petitioner's part to engage in conduct which is harmful to the Medicare and Medicaid programs in the future. I conclude that Petitioner is an untrustworthy individual. In reaching this conclusion, I have considered the evidence of record which shows that Petitioner is a competent physician who provides quality care to his patients. Dr. Poston stated that Petitioner is an excellent clinician who can be trusted to provide skillful medical services and that she has used Petitioner for obstetrical care for herself and has also referred her sister to Petitioner. Tr. 115-116, 120; P. Ex. 3/66. The record also contains statements by Dr. Bharat Barai, a colleague of Petitioner, that Petitioner has a record of providing competent medical care. P. Ex. 1/37, 41. I do not question Dr. Poston's and Dr. Barai's opinions regarding Petitioner's medical skills. While Drs. Poston's and Barai's favorable assessment of Petitioner's ability to care for patients may be accurate, they do not derogate the strong evidence in this case that Petitioner cannot be trusted to file truthful bills for his services with Medicare and Medicaid.

Dr. Poston has also testified that Petitioner has provided medical services to the Indiana Board of Health clinic program in order to satisfy his court-mandated community service requirement. Dr. Poston indicated that Petitioner's services are essential, and that the very existence of the clinic program for prenatal women might be jeopardized if Petitioner stops contributing his

services. Petitioner contends that Petitioner's service to the Board of Health Clinic should be a basis for reducing the length of the exclusion in this case.

Petitioner's obligatory service to the Board of Health clinic programs can in no way be considered as evidence of his trustworthiness and good character. I am cognizant of the evidence showing that Petitioner voluntarily contributed medical supplies and made his private office available to clinic patients on occasion. While this is laudable, it has no bearing on the issue of whether Petitioner can be trusted to handle Medicare and Medicaid monies honestly. In addition, I note that Petitioner's exclusion does not prevent him from continuing to provide his services to the Board of Health clinic program because he does not bill Medicare and Medicaid for those services. In view of the foregoing, I do not agree that Petitioner's contributions to the Indiana Board of Health clinic program should be a basis for shortening his seven year exclusion.

I am also cognizant of the evidence of record showing that the Gary, Indiana metropolitan area served by Petitioner is under served by practicing obstetricians. According to the July 19, 1991 letter written by the Gary Board of Health, there are less than six board certified obstetricians/gynecologists serving approximately a quarter of a million women in this area. In addition, this community has the second highest infant mortality rate in the United States. P. Ex. 4. The fact that Petitioner has demonstrated a willingness to provide services to indigent women in a community that has a vital need for those services does not detract from the conclusion that, in light of his offenses, Petitioner cannot be trusted to participate in federally-funded health care programs. I recognize that an exclusion impairs Petitioner's ability to provided vitally needed services to the indigent population in Gary, Indiana. However, the purpose of the exclusion sanction is to effectuate the public policy of protecting the integrity of the Medicare and Medicaid programs. I find that under the facts of this case, the need for Petitioner's medical services in Gary, Indiana, must yield to the overriding need to impose a meaningful remedy to protect the integrity of the Medicare and Medicaid programs.

## CONCLUSION

Based on the law and the evidence, I conclude that the seven-year exclusion from participating in Medicare and Medicaid imposed and directed against Petitioner is reasonable. I therefore sustain the exclusion.

/s/

**Edward D. Steinman**
**Administrative Law Judge**