Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	
Bruce G. Livingston, D.O.,	DATE: May 22, 1992
Petitioner,	Docket No. C-404
- v. -	Decision No. CR202
The Inspector General.	

DECISION

In this case, governed by section 1128 of the Social Security Act (Act), the Inspector General (I.G.) of the Department of Health and Human Services notified Petitioner by letter dated June 7, 1991, that he was being excluded from participation in the Medicare and State health care programs for eight years.[1] The I.G. advised Petitioner that his exclusion was based on his conviction in the U.S. District Court for the Northern District of Illinois, of a criminal offense related to the delivery of an item or service under Medicare. Petitioner was further advised that his exclusion was authorized by section 1128(a)(1) of the Act and that section 1128(c)(3)(B) of the Act provides that such exclusions be for a period of not less than five years.

Petitioner timely requested a hearing before an administrative law judge (ALJ), and the case was assigned to me for hearing and decision. The parties have filed various prehearing motions, including cross motions for summary disposition. On October 9, 1991, I issued the following Ruling: (1) the I.G. had authority to exclude Petitioner pursuant to section 1128(a)(1) of the Act and (2) the constitutional prohibition against double

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[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.

jeopardy did not preclude the I.G. from excluding Petitioner. In a subsequent Ruling on November 22, 1991, I denied Petitioner's requests to amend the date of his suspension and for certain types of discovery and I advised the parties that even though Petitioner was waiving his right to an in-person evidentiary hearing, the parties would be afforded the opportunity to make a complete record.[2] I set a schedule for the parties to brief the issue of the reasonableness of the exclusion beyond five years.

On December 2, 1991, I received Petitioner's undated "Motion to Reconsider Ruling with Respect to Date of Initiation of Exclusion," with supporting brief. On December 17, 1991, I denied Petitioner's motion.

By letter dated February 18, 1992, the parties were informed that the Secretary published new regulations on January 29, 1992 containing procedural and substantive provisions at 57 Fed. Reg. 3298 et seq. Only the I.G. submitted a brief concerning the potential impact of these regulations. Their application to this case is addressed in this decision. At Petitioner's request, on March 26, 1992, I conducted oral argument by telephone.

Based on the record and on the applicable law, I conclude that the new regulations do not apply to this proceeding. I further conclude that the I.G. had authority to exclude Petitioner and that the exclusion imposed and directed against Petitioner by the I.G. is reasonable under the circumstances of this case.

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[2] Petitioner argued that he was convicted of a criminal offense on January 24, 1990 and it was not until June 7, 1991 that the I.G. notified him of his exclusion from the Medicare and Medicaid programs. Petitioner contended that it was unconscionable as well as arbitrary and capricious for the I.G. to have imposed the exclusion 17 months after his conviction. Petitioner argued that the exclusion should have begun at the time of his conviction, the time of sentencing, or at a reasonable time following either of those events. I ruled that since the I.G. had authority to exclude Petitioner under section 1128(a)(1) of the Act, he was required to exclude Petitioner for a minimum of five years. I also ruled that I had no discretion to reduce the minimum mandatory exclusion period or to decide when that exclusion is to begin. Samuel W. Chang, M.D., DAB 1198 (1990).

ADMISSIONS

During the prehearing conference conducted on August 23, 1991, Petitioner admitted that he was convicted of a criminal offense related to the delivery of a health care item or service, within the meaning of sections 1128(i) and 1128(a)(1) of the Act.

ISSUE

The remaining issue is whether the eight-year exclusion imposed and directed by the I.G. against Petitioner is reasonable.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Petitioner was a licensed osteopathic physician in the State of Illinois at the time of the offense underlying the conviction. I.G. Ex. 1/1; I.G. Ex. 59.[3]

2. Petitioner operated weight loss clinics under the names Medical Weight Loss Centers, Inc. and Orland Park Family Practice, which maintained offices in Chicago, Orland Park, and other cities in Illinois. I.G. Ex. 1/1; I.G. Ex. 59.

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[3] Citations to the record and to Departmental Appeals Board (Board) cases in this decision are as follows:

I.G.'s Exhibits	I.G. Ex. (number/page)
I.G.'s Brief	I.G. Br. (page)
I.G.'s Supplemental Brief	I.G. Supp. Br. (page)
Petitioner's Exhibits	P. Ex. (number/page)
Petitioner's Brief	P. Br. (page)
Findings of Fact and Conclusions of Law	FFCL (number)
Departmental Appeals Board ALJ Decisions	DAB CR(decision no.) (date)
Departmental Appeals Board Appellate Panel Decisions	DAB (decision no.) (date)

3. Petitioner also had a general osteopathic practice treating elderly patients. Medicare was responsible for paying the medical bills, including laboratory tests, for eligible elderly patients. I.G. Ex. 1/1.

4. A 69-count indictment was filed against Petitioner in the United States District Court, Northern District of Illinois, charging him with participating in a scheme to defraud and to obtain money by false and fraudulent pretenses, representations, and promises, knowing at the time that the pretenses, representations, and promises would be false when made. I.G. Ex. 1.

5. After a bench trial that lasted over two weeks, Petitioner was found guilty of and convicted of 65 counts: 37 counts of mail fraud and 28 counts of making false statements in applications for Medicare payments. I.G. Ex. 2; I.G. Ex. 59/4.

6. As a result of his conviction, Petitioner:

(a) received a suspended sentence and was placed on probation for four years;
(b) was ordered to reside in and participate in the work release program of the Salvation Army Men's Work Release Center for one year;
(c) was ordered to perform 600 hours of community service at the Maryville City of Youth;
(d) was fined $50,000;
(e) was ordered to make restitution in the amount of $100,000;
(f) was prohibited from practicing medicine for remuneration during the term of probation; and
(g) was prohibited from practicing medicine for remuneration during the term of work release.

I.G. Ex. 2.

7. As part of Petitioner's scheme, he submitted over 60 separate false Medicare or private insurance claims for payment, totaling in excess of $100,000 for services never rendered. I.G. Ex. 1/2.

8. As part of Petitioner's scheme, he also submitted Medicare insurance payment claims for medical and laboratory tests which were never performed or which were not medically necessary; he submitted diagnoses which were false and for which he did not tender treatment in order to induce Medicare to pay for such medical and laboratory tests. I.G. Ex. 1/2.

9. As part of the scheme, Petitioner submitted Medicare insurance payment claims for medical and laboratory tests which had been performed but the results of which were never reviewed or discussed with his patients. I.G. Ex. 1/2.

10. Petitioner also directed his employees to bill Medicare for a complete physical, including a battery of tests, whether or not the patient received a complete physical or battery of tests. I.G. Ex. 1/2.

11. In furtherance of his scheme, Petitioner induced Dr. Chris Casten to allow him to use Dr. Casten's name on billings and to negotiate checks issued by Medicare in Dr. Casten's name. I.G. Ex. 1/2.

12. Petitioner submitted false Medicare payment claims under the name of Dr. Casten, although Dr. Casten did not treat the patients. I.G. Ex. 1/2.

13. As part of the scheme, Petitioner directed Medicare to send checks to a post office box which Petitioner controlled and from which he took the checks. Petitioner caused the checks to be endorsed with a stamped endorsement in the name of Chris Casten, and Petitioner deposited the checks in his own account. I.G. Ex. 1/2.

14. As part of the scheme, Petitioner used Dr. Casten to conceal his Medicare income, by billing Medicare claims under Dr. Casten's name. I.G. Ex. 1/3.

15. In furtherance of the scheme, Petitioner submitted false insurance claims to private insurance carriers, in order to obtain reimbursement for expenses supposedly connected to his treatment of patients for problems other than weight loss. I.G. Ex. 1/3.

16. As part of the scheme, Petitioner directed his employees to tell prospective weight loss patients that each patient was required to pay only approximately $100 and that the patient's insurance carrier would pay the remainder of the fee for the weight loss program. I.G. Ex. 1/3.

17. Petitioner submitted false insurance claim forms containing false medical diagnoses to justify the fee for the weight loss program, knowing that the insurance carriers would not make reimbursement for expenses associated solely with weight loss. I.G. Ex. 1/3 - 4.

18. As part of the scheme, Petitioner represented his fraudulent insurance claim scheme as a legitimate "weight

loss" business and sold it at a price in excess of $65,000. I.G. Ex. 1/4.

19. Petitioner's fraudulent activities occurred from approximately January 1983 through November 26, 1986. I.G. Ex. 1.

20. Petitioner was convicted of a criminal offense as defined by section 1128(i) of the Act.

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

22. The Medicare program suffered pecuniary loss as a result of Petitioner's fraud. I.G. Ex. 1; I.G. Ex. 2; I.G. Ex. 59.

23. In late 1986 and 1987, the Illinois Department of Registration and Education (Department of Registration) filed complaints against Petitioner and charged him with eight counts of misdiagnosis and false billing for tests and services not actually rendered, not needed, or rendered inadequately. I.G. Ex. 57; I.G. Ex. 59/4.

24. The Department of Registration also charged Petitioner with failing to prepare or maintain adequate medical records, and some of the charges involved cases in which Petitioner billed under the name of Chris Casten. I.G. Ex. 59/4.

25. On November 17, 1987, Petitioner entered into a stipulation and agreement with the Department of Registration. Although he did not admit to any particular violation of the Illinois Medical Practice Act, Petitioner agreed that a violation of the Illinois Medical Practice Act could be found by the Medical Disciplinary Board. Petitioner and the Department of Registration agreed that his license to practice medicine in the State of Illinois would be suspended for a two-year period beginning on February 3, 1988, to be followed by an additional one-year period of probation. I.G. Ex. 59/4.

26. The Secretary 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. 21662 (May 13, 1983).

27. On June 7, 1991, the I.G. excluded Petitioner from participating in Medicare and directed that he be excluded from Medicaid, pursuant to section 1128(a)(1) of the Act. I.G. Ex. 58.

28. The exclusion imposed and directed against Petitioner is for eight years. I.G. Ex. 58.

29. The I.G. had authority to impose and direct an exclusion against Petitioner pursuant to section 1128(a)(1) of the Act, because Petitioner had been convicted of a criminal offense related to the delivery of an item or service under Medicare. Social Security Act, § 1128(a)(1).

30. The minimum mandatory exclusion which the I.G. must impose and direct against an individual pursuant to section 1128(a)(1) of the Act is five years. Social Security Act, § 1128(c)(3)(B).

31. Regulations published on January 29, 1992 establish criteria to be employed by the I.G. in determining to impose and direct exclusions pursuant to sections 1128(a)(1) and (2) and (b) of the Act. 42 C.F.R. Part 1001; 57 Fed. Reg. 3298, 3330 - 3341 (January 29, 1992).

32. The Secretary did not intend that regulations contained in 42 C.F.R. Part 1001, and, in particular, 42 C.F.R. §§ 1001.101 and 1001.102, govern my decision in this case.

33. An exclusion of eight years is needed in this case to protect federally-funded health care programs and their beneficiaries from the commission of future harm by Petitioner.

ANALYSIS

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

Petitioner admits that he was convicted of a criminal offense related to the delivery of an item or service, within the meaning of sections 1128(i) and 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.

Since Petitioner was "convicted" of a criminal offense and it was "related to the delivery of an item or service" under Medicare, 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. Regulations published by the Secretary on January 29, 1992 are not applicable to this case.

On January 29, 1992, the Secretary published new regulations (Parts 1001 - 1007) pertaining to his authority under the Medicare and Medicaid Patient and Program Protection Act (MMPPPA), Public Law 100-93, to exclude individuals and entities from reimbursement for services rendered in connection with the Medicare and Medicaid programs.[4] These regulations also included amendments to the civil money penalty authority of the Secretary under MMPPPA. For purposes of this proceeding, the specific regulatory provisions relating to mandatory exclusions under section 1128(a)(1) of the Act (section 1001.102) and appeals of such exclusions (Part 1005) must be considered in terms of their applicability to this case.

The I.G. argues that the new regulations became effective upon publication on January 29, 1992. I.G. Supp. Br. 1. The I.G. further contends that whether the new or the old regulations are applied to this case, the result will be the same. I.G. Supp. Br. 1. However, during the oral argument held on March 26, 1992, the I.G. forcefully argued that the new regulations apply and that the new regulations are not a retroactive application of the law. Petitioner contended during the oral argument that the I.G. excluded him prior to the new regulations being published and that the new regulations should not apply in this case because it would be an unlawful retroactive application of the law.

I conclude that my review of the reasonableness of the exclusion imposed and directed against Petitioner is not

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[4] These regulations can be found at 42 C.F.R. § 1001 et seq., 57 Fed. Reg. 3298 et seq.

governed by the new regulations' criteria for determining exclusions under section 1128(a)(1). The regulations contained in Part 1001 of the new regulations, and 42 C.F.R. § 1001.102 in particular, were not intended by the Secretary to govern hearings as to the reasonableness of exclusion determinations. Charles J. Barranco, M.D., DAB CR187 (1992) (Barranco); Syed Hussaini, DAB CR193 (1992); Steven Herlich, DAB CR197 (1992) (Herlich); Stephen J. Willig, M.D., DAB CR192 (1992). And, even if the Part 1001 regulations do govern such hearings, they do not apply in cases involving exclusion determinations made prior to the regulations' publication date. Id.

I further conclude that it was not the Secretary's intent to retroactively apply the new regulations to unlawfully strip parties, including Petitioner, of previously vested rights. Therefore, the new Part 1001 regulations were not intended to apply to cases pending as of the date of their publication (assuming they establish criteria for administrative review of exclusions). I have previously addressed this issue in depth in my decision in Barranco at 16 - 27. ALJ Steven T. Kessel has addressed this issue in depth in his decision in Herlich at 8 - 16. For purposes of this case, I incorporate the rationale in Barranco and Herlich that Petitioner's hearing rights would be substantially adversely affected and it would be manifestly unjust to apply the new regulations. Moreover, the Court of Appeals held in Varandani v. Bowen, 824 F.2d 307, 312 - 313 (4th Cir. 1987), that regulations implementing section 1156 of the Act would not apply retroactively even where the new regulations arguably placed the excluded party in a better position to defend against the I.G.'s exclusion. As here, the new Peer Review Organization regulations specified an effective date and were silent on the issue of retroactivity. In such circumstances, the court applied the "usual rule that laws are not retroactive unless they expressly so provide." Id. at 312.

Petitioners subject to exclusions imposed by the I.G. under section 1128 of the Act have the right to a de novo hearing under section 205(b) of the Act. Generally, such hearings involve consideration of whether: (1) the I.G. had authority under the Act to impose the exclusion and (2) the exclusion comports with the remedial purposes of the Act. Bernardo G. Bilang, M.D., DAB 1295 (1992) at 9 (Bilang); Eric Kranz, M.D., DAB 1286 (1991) at 7 - 8; Hanlester Network, et al., DAB CR181 (1992) at 39 - 43. In reaching a determination as to whether an exclusion meets the remedial purpose of the Act, the ALJ may consider all evidence regarding the reasonableness of an exclusion, including that which may not have been

available to the I.G. when the decision to exclude was made. Joel Davids, DAB 1283 (1991) at 7; Vincent Baratta, M.D., DAB 1172 (1990) at 11 (Baratta). Also, evidence of a petitioner's culpability, based on review of the derivative actions upon which the I.G. has authority to exclude, can properly be considered by the ALJ in determining the length of an exclusion. Bilang at 9.

The regulation at issue here, 42 C.F.R. § 1001.102, would, if held to establish a standard for reviewing the reasonableness of exclusions in excess of five years imposed pursuant to section 1128(a)(1), severely limit excluded parties from presenting evidence at hearings as to their trustworthiness. For example, the new regulations provide that only certain specified circumstances may be considered as mitigating factors. This is in contrast with the old regulations at 42 C.F.R. § 1001.125(b), which allowed petitioners to present any mitigating factors. Application of the new regulations to the proceeding would deny excluded parties with a full opportunity to demonstrate that exclusions imposed against them are inconsistent with the Act's remedial purpose. It would serve to insulate punitive exclusions from meaningful administrative review.

3. An eight-year exclusion is appropriate and reasonable in this case.

The I.G. excluded Petitioner from participating in the Medicare and Medicaid programs for eight 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 Medicare 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 eight 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).

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. Baratta. 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).

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.

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.

As an osteopathic physician in the State of Illinois, Petitioner treated elderly patients and also operated weight loss clinics. FFCL 1 - 3. Petitioner was indicted on 69 counts of devising and participating in a scheme to defraud and to obtain money by false and fraudulent pretenses, representations, and promises, knowing that the pretenses, representations, and promises were false when made. FFCL 4. The government alleged in the indictment that, as part of the scheme, Petitioner submitted over 60 separate false Medicare or private insurance claims for payment, totaling over $100,000 for services never rendered. FFCL 7. Petitioner's fraudulent activity was conducted over a lengthy period of time -- from at least January 1983 through November 1986. FFCL 19.

Petitioner submitted Medicare insurance payment claims for medical and laboratory tests which were never performed or which were not medically necessary. He also submitted diagnoses which were false and for which he did not tender treatment in order to induce Medicare to pay for such medical and laboratory tests. FFCL 8. Petitioner also submitted Medicare insurance payment claims for medical and laboratory tests which had been performed but the results of which were never reviewed or discussed with his patients. FFCL 9. Petitioner directed his employees to bill Medicare for a complete physical, including a battery of tests, whether or not the patient received a complete physical or battery of tests. FFCL 10.

Petitioner's fraudulent scheme also involved Dr. Chris Casten, an older doctor who had a serious head injury a few years earlier and who was trying to resume the practice of medicine. I.G. Ex. 59/3. Petitioner induced Dr. Casten to allow him to use Dr. Casten's name on billings and to negotiate checks issued by Medicare in Dr. Casten's name, while paying Dr. Casten less than $5,000 over three years for part-time work. FFCL 11. Petitioner allowed Dr. Casten to do very little, and Dr. Casten spent most of his time sitting around the office reading magazines and talking with employees. I.G. Ex. 59/3. Although Dr. Casten did not order the large sets of specialized cardiovascular tests for patients, Petitioner directed his employees to submit the majority of claim forms for these tests listing Dr. Casten, rather than Petitioner, as the treating physician. I.G. Ex. 59/3. Furthermore, Petitioner directed Medicare to send checks to a post office box which he controlled and he caused the checks to be endorsed with a stamped endorsement in the name of Chris Casten, while Petitioner deposited the checks in his own account. FFCL 13. From January 1, 1985 to the close of Petitioner's practice in 1987, he sent bills to Medicare in his own name totalling $35,995, while he submitted bills in Dr. Casten's name totalling $102,745.50.[5] I.G. Ex. 59/3.

In furtherance of his fraudulent scheme, Petitioner submitted false insurance claims to private insurance carriers in order to obtain reimbursement for expenses supposedly connected to his treatment of patients for problems other than weight loss. FFCL 15. Petitioner submitted false insurance claim forms containing false medical diagnoses to justify the fee for the weight loss program, knowing that the insurance carriers would not

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[5] There appears to be a discrepancy in terms of just how much the Medicare program lost because of Petitioner's fraudulent scheme. The presentencing investigation states that between January 1, 1985 and early 1987, Medicare paid Petitioner $43,580 for claims he submitted. I.G. Ex. 59/7. At least 80 percent of the tests paid for by Medicare were found to be medically unnecessary and those claims totalled $34,864. I.G. Ex. 59/7. However, the restitution memorandum indicates that the Medicare program suffered a loss of $33,164 and that, based on the $100,000 in restitution that Petitioner was ordered to make, Medicare would receive just over 65 percent of its claimed loss, or $21,584.43. I.G. Ex. 60. Regardless of the exact monetary amount, Medicare suffered a pecuniary loss as a result of Petitioner's fraud. FFCL 22.

make reimbursement for expenses associated solely with weight loss. FFCL 17. Representing his fraudulent insurance claim scheme as a legitimate weight loss business, Petitioner sold it to another physician for over $65,000. FFCL 18.

Petitioner was found guilty and convicted of 65 counts (37 counts of mail fraud and 28 counts of making false statements in applications for Medicare payments). FFCL 5. 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 Medicare program. The serious nature of Petitioner's offense is reflected by the sentence imposed on Petitioner by the United States District Court. The court sentenced Petitioner to a suspended sentence, with four years' probation; ordered him to reside in and participate in a work release program for one year, while simultaneously prohibiting him from practicing medicine for remuneration during the term of work release; ordered him to perform 600 hours of community service; fined him $50,000; ordered him to make restitution of $100,000; and prohibited him from practicing medicine for remuneration during the term of probation. FFCL 6. The serious nature of Petitioner's offenses is also reflected in the fact that on November 17, 1987 the Illinois Department of Registration and Education suspended his license for a two-year period beginning on February 3, 1988, followed by an additional one-year period of probation. FFCL 23 - 25.

Petitioner engaged in a systematic fraud of the Medicare program, resulting in the unlawful appropriation of thousands of dollars. Petitioner's fraudulent activity against Medicare and private insurance carriers was conducted over a lengthy period of time. Petitioner contends that he acknowledged those areas of his conduct which were wrong and that he apologized in court, as well as to the government, for that conduct. P. Br. 1. He points to the fact that he was much younger and less educated at the time he committed his fraudulent conduct. P. Br. 1. He avers that his record as a physician was unblemished until he was convicted. He contends that none of the victims of the scheme were physically injured or exposed to physical danger or invasive procedures and that his misconduct primarily involved unnecessary noninvasive testing. P. Br. 2. He alleges that the procedures which he administered and which were found unnecessary have since been declared to be prudent diagnostic preventive procedures and are being approved for such use by some of the carriers who testified

against his use of those procedures. P. Br. 2. He argues that he ceased the practices for which he was convicted on his own, two years prior to having been indicted, and that he has no intention of repeating his criminal behavior. P. Br. 4. He states that he has changed in the last decade; he has completed law school, passed the bar, is raising young children, and sees things differently. P. Br. 1. Since the conviction, Petitioner volunteered at Fort Sheridan for medical duty during Operation Desert Storm. P. Br. 3.

Contrary to Petitioner's assertion that he was younger and less well educated when he committed these fraudulent acts, his fraudulent activities were rather complex, not typical of a naive person. I am deeply troubled by the fact that Petitioner engaged in such an elaborate scheme to defraud both Medicare and private insurance companies. During the oral argument, Petitioner indicated that he went to law school from 1985 to 1988. I find it particularly disturbing that a medical doctor, who was undergoing training to be an attorney, would at the same time engage in fraudulent activity in the magnitude to which Petitioner participated. He obviously was an extremely sophisticated individual who had to have known the consequences of his criminal activity. Despite this, he was not deterred from implementing this fraudulent scheme. If anything, he appears to have used his legal training to impede the investigation of his criminal activities and to conceal the scope and extent of his fraudulent scheme.

I am also concerned that Petitioner directed this scheme at elderly patients who frequently were not sufficiently sophisticated to realize that Petitioner was ordering unnecessary tests and making false diagnoses to justify his fraudulent billing claims. He took advantage of the vulnerability of a group of people who lacked the sophistication to understand the scope and dimension of his illegal activities. And when he decided to end his personal involvement in such activities, he sold it as a legitimate business to a buyer who was not aware of Petitioner's illegal use of the business.

I am equally appalled that Petitioner would take advantage of another physician, Dr. Casten, who apparently had some limitations after a major accident. Petitioner used Dr. Casten to conceal his own wrongdoing and made it appear that this physician was submitting the excessive and fraudulent billings. The record suggests that Petitioner purposely hired Dr. Casten because Petitioner knew that he would not readily question office practices and, because of his ill health, would more

easily become an unknowing accomplice in the fraudulent billing activities.

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. He even attempted to get elderly patients to alter their statements against him and to have a former employee commit perjury. I.G. Ex. 59. Additionally, he frustrated the investigation into his fraudulent activities by obstructive acts, including failing to produce the medical records of most of his patients when the records were subpoenaed by the grand jury. He claimed that many of the records were destroyed innocently in routine "purges" of his inactive files, and Petitioner secreted the files of many active, current patients as well. I.G. Ex. 59/4.

Furthermore, I conclude that the length of Petitioner's exclusion is not too harsh when compared to other cases. Petitioner's conduct in this case is somewhat similar to that of petitioner in Christino Enriquez, M.D., DAB CR119 (1991) (Enriquez). Dr. Enriquez pled guilty to mail fraud and to having conspired to defraud the United States government. Dr. Enriquez admitted to participating in massive fraud against the Medicare program and he acknowledged that he had conspired to steal more than $100,000 from Medicare over a two-year period. In Enriquez, an eight-year exclusion was sustained. As with this case, the ALJ in Enriquez found that federally-funded health care programs needed to be protected from Dr. Enriquez for a lengthy period of time. In Yvon Nazon, M.D., DAB CR169 (1991), in which I sustained a seven-year exclusion, where the petitioner was convicted of 17 counts of presenting false claims to a State agency and was sentenced to five years' probation with a suspended sentence; ordered to serve a year in a work release program; ordered to perform 1,500 hours of community service; and ordered to pay restitution to Medicaid of $84,110.35. Similarly, a seven-year exclusion was sustained in David G. Harow, D.P.M., et al., DAB CR167 (1991) (Harow), where one petitioner pled guilty to eight counts of Medicare fraud and the other petitioner pled guilty to 14 counts of Medicare fraud. The ALJ in Harow found that the crimes admitted to by petitioners established that they were untrustworthy providers of care and that, given the extent and

seriousness of their crimes, a lengthy exclusion was a reasonable remedy.

I conclude that, the eight-year exclusion imposed and directed by this I.G. in this case is reasonable. Petitioner is an untrustworthy individual. Petitioner has offered me no meaningful assurance that he will not engage in future wrongdoing. The evidence of Petitioner's culpability demonstrates that he is an untrustworthy provider and that a lengthy exclusion is needed to ensure that program beneficiaries and recipients will not be subject to the type of conduct evidenced by the fraudulent medical practices that Petitioner has engaged in the past. The remedial purposes of the Act warrant affirmation of the I.G.'s eight-year exclusion of Petitioner.

CONCLUSION

Based on the law and the evidence, I conclude that the eight-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