Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	DATE: August 12, 1992
The Inspector General	Docket No. C-422
- v. -	Decision No. CR224
Andrew J. Portoghese, O.D.	
Respondent.	

DECISION

Respondent requested a hearing before an Administrative Law Judge (ALJ) to contest the Inspector General's (I.G.) proposed imposition against Respondent of civil monetary penalties of $60,000.00 and assessments of $4,365.00. The I.G.'s Notice was based upon a determination that Respondent presented or caused to be presented to an officer, employee, or agent of Group Health Incorporated (GHI), the Medicare carrier, claims for 32 items or services that were provided during a period in which Respondent was suspended from the Medicare program pursuant to former section 1862(e)(1) of the Act.[1] The I.G. alleged that Respondent violated section 1128A of the Social Security Act (Act) and its implementing regulations at 42 C.F.R. § 1003.100 et seq.

I conducted an evidentiary hearing in New York City, New York, from February 24 through February 27, 1992. Based on the entire record before me, I conclude that

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[1] By Order dated February 18, 1992, I permitted the I.G. leave to amend the original notice letter (Notice) dated July 12, 1991. The amended Notice (dated January 31, 1992) deleted Counts 1, 14, and 17 from the schedule of claims and reduced the amounts sought in penalties from $65,000.00 to $60,000.00. The amounts requested in assessments was reduced from $4,625.00 to $4,365.00.

Respondent unlawfully presented or caused to be presented 28 claims for items or services while excluded.[2] I impose penalties of $56,000.00 and assessments of $3,885.00 against Respondent.

THE APPLICABLE STATUTE

This proceeding was brought pursuant to the Civil Monetary Penalties Law (CMPL), section 1128A of the Act (42 U.S.C. § 1320a-7a)(1988)). Specifically, section 1128A(a)(1)(D) authorizes the Secretary to impose civil money penalties and assessments against any person who presents or causes to be presented to the Medicare program a claim for medical or other items or services furnished during a period in which the person was excluded, or "suspended" under prior law, from the Medicare program.[3]

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[2] During the hearing and also in pleadings and motions filed both before and after the hearing, Respondent objected to specific testimony and exhibits proffered by the I.G. Respondent's objections have included arguments regarding hearsay, authenticity and reliability of documents, veracity and memory of witnesses, investigative techniques of the I.G. and GHI investigators, and the failure of the I.G. to call all his proposed witnesses to the stand. The Federal Rules of Evidence are not binding on these proceedings, and hearsay statements and statements in lieu of testimony are admissible. Parties must list every witness they might call on direct, but they are not required to call any witness.

Also, Respondent declined my offer to hold open the hearing to attempt to get his subpoenaed witnesses to attend. As I stated at the hearing, with the exception of the testimony which I specifically struck from the record at the hearing and the exhibits which I did not admit, it is my practice to use broad discretion in admitting testimony and exhibits, but to consider relevant objections when weighing the probative and evidentiary value of the exhibits and testimony. This I have done. Thus, I deny each and every one of Respondent's new objections and motions and affirm all my prior rulings in this matter.

[3] See discussion infra at part B.1 of this decision regarding "suspensions" under prior law and "exclusions" under current law.

BACKGROUND

Respondent is an optometrist with offices in New York City. In 1983, he hired Dr. Debra Crane, an optometrist and then recent graduate of optometry, who worked with Respondent until his retirement in 1990. Based upon responses from Medicare beneficiaries, who claimed they had received services or items from Respondent rather than Dr. Crane, GHI, and eventually the I.G., began a series of investigations that lasted several years. The I.G. has alleged here that in 32 instances between 1986 and 1989, Dr. Crane signed and submitted Medicare claims under her provider number for items and services that were actually provided by Respondent. The I.G. has further alleged that Respondent submitted or caused the claims to be submitted at a time when Respondent was excluded from the Medicare program. The I.G., therefore, argues that the claims were made in violation of section 1128A(a)(1)(D) of the Act. Respondent denies the allegations.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Having considered the entire record, the arguments, and the submissions of the parties, and being advised fully, I make the following Findings of Fact and Conclusions of Law (FFCLs):[4] [5]

1. I reaffirm each and every prehearing and hearing ruling regarding the admission of testimony and exhibits

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[4] The documentary record of this case will be cited as follows:

I.G.'s Exhibits	I.G. Ex. (number at page)
Joint Exhibits	J. Ex. (number at page)
Respondent's Exhibits	R. Ex. (number at page)
Transcript	Tr. (page)
I.G.'s Post Hearing Brief	I.G. Br. (page)
Respondent's Post Hearing Brief	R. Br. (page)
I.G.'s Reply Brief	I.G. R.Br. (page)
Respondent's Reply Brief	R. R.Br.
Stipulations	Stip. (number)

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

and deny Respondent's post hearing motions and objections on these same and new issues. See note 2, supra.

2. This proceeding is governed by the CMPL, section 1128A of the Act, and the regulations at 42 C.F.R. Part 1003 (1991) and 42 C.F.R. Part 1005 (1992).

3. The regulations concerning CMPL proceedings, pursuant to section 1128A(a)(1)(d) of the Act, to be codified at 42 C.F.R. Part 1003, promulgated at 57 Fed. Reg. 3298, 3345-49 (January 29, 1992) were not intended to apply retroactively to proceedings which began before the regulations were promulgated.

4. Section 1128A(a)(1)(D) of the Act authorizes the Secretary to impose a civil monetary penalty and assessment against any person who presents or causes to be presented to an officer, employee, or agent of the United States, a claim for items or services, under title XVIII (Medicare) of the Act, that the Secretary determines was made during a time the person was excluded from that program.

5. At all times relevant to this case, Respondent Andrew J. Portoghese, O.D., was an optometrist licensed by the State of New York and operating a practice at 29-30 and 29-05 Union Street in Flushing, in the borough of Queens, City of New York. Tr. 612.

6. The designated Medicare Part B Carrier for the borough of Queens is Group Health Incorporated (GHI). Tr. 48.

7. Respondent was convicted in 1978 for perjury based on false testimony in connection with whether Respondent had offered to pay kickbacks for referrals of Medicaid patients to his Medicaid facility. Stip. 7; I.G. Ex. 150 at 13-15, 163.

8. Based on the State perjury conviction and a finding of professional misconduct, Respondent's optometrist's license was suspended for a third time by the New York State Department of Education, Board of Regents, for a one year period beginning in April 1983. Tr. 624, 656-657; I.G. Ex. 150 at 2-15.[6]

9. Based upon the State perjury conviction, Respondent was suspended, under former section 1862(e)(1) of the

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[6] See discussion infra at part 3.c of this decision regarding the prior State suspensions.

Act, from participation in the Medicare and Medicaid programs, effective in February of 1979. Stip. 4; I.G. Ex. 65; Tr. 625.

10. Respondent's suspension notice stated that the suspension was based on his conviction of a criminal offense related to his participation in Medicaid. Stip. 4; I.G. Ex. 65.

11. Respondent's 1988 application for readmission was denied, and his suspension has been in effect continuously since 1979. Stip. 4, 6; I.G. Exs. 66, 169; Tr. 279-81.

12. "Suspensions" under former section 1862(e)(1) of the Act are synonymous with "exclusions" under the current section 1128(a)(1).

13. Beginning in 1987, the Medicare carrier, GHI, began receiving information from beneficiaries, who were patients of Respondent, that claims were being submitted on their behalf. See Tr. 62-63.

14. The 32 claims set forth in the Notice as Counts 2-13, 14-16, and 17-35, were presented to GHI for payment. See I.G. Exs. 3-64.

15. Respondent presented or caused to be presented to GHI claims for 28 of the 32 items or services at issue in this proceeding.

16. Respondent furnished to Medicare beneficiaries 28 of the 32 items or services at issue in this proceeding.

17. When Respondent presented or caused to be presented the 28 claims for the items or services at issue, he knew that he was excluded from participation in the Medicare program.

18. When Respondent presented or caused to be presented the 28 claims for the items or services at issue, he knew that he was not entitled to payment because of his exclusion.

19. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 3, during a period when he was suspended from participating in Medicare, in violation of section 1128A(1)(d) of the Act.

20. Respondent provided the items or services, and presented or caused to be presented the Medicare claims

contained in Count 4, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

21. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 6, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

22. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 7, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

23. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 8, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

24. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 9, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

25. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 10, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

26. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 12, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

27. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 13, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

28. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 15, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

29. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 16, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

30. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 18, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

31. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 19, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

32. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 21, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

33. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 22, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

34. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 23, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

35. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 24, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

36. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 25, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

37. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 26, during a period when he was

suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

38. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 27, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

39. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 28, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

40. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 29, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

41. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 30, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

42. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 31, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

43. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 32, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

44. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 33, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

45. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 34, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

46. Respondent provided the items or services, and presented or caused to be presented the Medicare claims contained in Count 35, during a period when he was suspended from participating in Medicare, in violation of section 1128A(a)(1)(d) of the Act.

47. The I.G. did not prove by a preponderance of the evidence that Respondent provided the items or services at issue in Count 2.

48. The I.G. did not prove by a preponderance of the evidence that Respondent provided the items or services at issue in Count 5.

49. The I.G. did not prove by a preponderance of the evidence that Respondent provided the items or services at issue in Count 11.

50. The I.G. did not prove by a preponderance of the evidence that Respondent provided the items or services at issue in Count 20.

51. Respondent is liable for presenting or causing to be presented claims for 28 items or services that he furnished during a period of suspension.

52. The CMPL statute imposes an affirmative obligation upon Respondent to inform beneficiaries and those responsible for his billing about his suspension and its effect.

53. The statutory phrase "caused to be presented" means that the person furnishing the item or service either directed or permitted another person to submit a claim to Medicare for reimbursement.

54. Pursuant to section 1128A(a)(1)(D), an excluded provider "causes to be presented" a claim for items or services to Medicare beneficiaries by failing to take the reasonable and necessary steps to prevent any party from billing Medicare for items or services furnished by that provider.

55. By enacting section 1128A(a)(1)(D) with a strict liability standard, Congress imposed an affirmative obligation upon excluded parties to ensure that no claims would be submitted to Medicare for services or items furnished by them. See H.R. Rep. No. 85, 100th Cong., 1st Sess. 25-26 (1987).

56. Respondent assured the beneficiary in Count 29 that Medicare would reimburse for an exam he had given her. I.G. Ex. 123.

57. During an interview with an I.G. agent in 1988, Respondent reviewed the medical records of certain beneficiaries and confirmed that he had treated them on the dates of service in question. I.G. Ex. 172; Tr. 308.

58. Respondent furnished items or services to Medicare beneficiaries while suspended and saw several beneficiaries daily. Tr. 631.

59. Respondent knew or had reason to know that Dr. Debra Crane would present claims to Medicare for items or services furnished by Respondent. Tr. 661.

60. Respondent's notation: "Do not bill Medicare for tint," on a medical record entry, indicates that Respondent knew that a claim for this service or item furnished by him would be presented to the Medicare carrier. See I.G. Ex. 177 at 3; Tr. 441-42, 514.

61. Respondent knew or had reason to know that the effect of his suspension was that Medicare would not pay for any items or services he provided. I.G. Ex. 65; Tr. 654.

62. Dr. Crane billed Medicare for items and services which Respondent had provided to Medicare beneficiaries. Tr. 527.

63. Respondent was aware that Dr. Crane billed Medicare for items or services which he provided. Tr. 578.

64. About 10 percent of the time when Dr. Crane completed the Medicare claim forms, she asked Respondent about notations he had made on medical record entries for his Medicare patients. Tr. 542.

65. Dr. Crane came to Respondent's existing optometrist practice when Respondent hired her in 1983. See Tr. 477, 479, 653.

66. From approximately April 1984 until August 1990, Respondent and Dr. Crane were the sole partners in a partnership to practice optometry at the Union Street office. Tr. 354, 447-48, 484, 612-13.

67. The Respondent's and Dr. Crane's partnership used one bank account, which was held in the names of both

parties. Both parties had check writing authority. Tr. 521; I.G. Ex. 181.

68. All of the partnership's bills were paid from the partnership bank account, and all receipts were deposited there. Tr. 522-23; see I.G. Exs. 139-149.

69. Respondent did not tell his partner, Dr. Crane, that he had been excluded from participation in the Medicare program. Tr. 523, 631, 660-61.

70. Respondent did not tell Dr. Crane that payment could not be made by Medicare for items or services which were furnished by Respondent. Tr. 654, 660.

71. The optometrists in the practice, including Respondent and Dr. Crane, provided services to Medicare patients. Tr. 505.

72. Respondent made Dr. Crane responsible for the Medicare billing without training her in its rules and procedures. Tr. 576.

73. There was no established system in the office whereby Medicare patients or bills for Medicare patients were screened or otherwise treated as different from other patients and bills. See Tr. 449.

74. When a patient called for an appointment, requests for specific doctors would be accommodated, if possible. Tr. 505. If a request could not be accommodated, the patient was scheduled to see another doctor. I.G. Ex. 138 at 2; Tr. 505.

75. Dr. Crane was acting as Respondent's agent by presenting claims to GHI for items and services furnished by Respondent. Section 1128A(1) of the Act.

76. Respondent was aware of the acts of Dr. Crane.

77. Respondent is liable for violating the terms of the CMPL statute.

78. The CMPL provides for the imposition of a penalty of up to $2,000.00 for each item or service which is falsely claimed, and assessments, in lieu of damages, of up to twice the amount for each item or service which is falsely claimed. Section 1128A(a) of the Act.

79. In determining the appropriate amounts of penalties and assessments to be imposed against Respondent, both Section 1128A of the Act and the 42 C.F.R. § 1003.106

suggest that both aggravating and mitigating factors be considered.

80. A respondent has the burden of producing evidence proving the existence of any mitigating factors. 42 C.F.R. § 1003.114(d).

81. If there are substantial or several aggravating circumstances, the aggregate amount of the penalties and assessments should be set at an amount sufficiently close to, or at, the maximum permitted by law. 42 C.F.R. § 1003.106(c).

82. It is an aggravating factor that the claims in this case were presented over a lengthy period of time, from May 1986 through August 1989. See 42 C.F.R. § 1003.106(b)1); I.G. Exs. 3-63.

83. It is an aggravating factor that the total amount claimed by Respondent was "substantial" within the meaning of the regulations, i.e., more than $1,000.00. 42 C.F.R. § 1003.106(b)(1); General V. Thuong Vo, M.D., DAB CR45 at 24 (1989).

84. It is an aggravating factor that Respondent violated his affirmative obligation to inform beneficiaries that Medicare could not be billed for his services.

85. It is an aggravating factor that Respondent misrepresented Medicare billing information to his Medicare patients. Tr. 631-32.

86. It is an aggravating factor that Respondent engaged in other wrongful conduct in connection with a program for reimbursement of medical services. 42 C.F.R. § 1003.106(b)(3).

87. It is an aggravating factor that Respondent was convicted of perjury related to Medicaid fraud. I.G. Ex. 150 at 13-15, 46-47; R. Exs. 58-61.

88. It is an aggravating factor that Respondent practiced optometry while his license was suspended. I.G. Ex. 150 at 8, 2-15; Tr. 654, 656-57.

89. Respondent's actions seriously damaged the reputation for probity and the integrity of the Medicare program.

90. Respondent has not proven that payment of the penalties and assessments would impair his ability to provide medical services. 42 C.F.R. § 1003.106(b)(4).

91. Unsupported assertions of financial inability to pay, especially when made by a witness of questionable credibility, do not justify the reduction of proposed penalties and assessments. See Berney R. Keszler, M.D., DAB CR107 at 37 (1990); Tommy G. Frazier DAB CR79 at 27-28 (1990) aff'd 940 F.2d 659 (6th Cir. 1991).

92. The federal government has the right to be compensated for the damages caused by medical practitioners who have wrongly submitted claims for medical items or services to the government.

93. Because of the substantial number of aggravating circumstances and the lack of mitigating circumstances, the penalties and assessments should be set at or near the maximum amount. See 42 C.F.R. § 1003.106(c)(2).

94. Penalties totalling $56,000.00 and assessments of $3,885.00 are appropriate in this case.

ISSUES

1. Whether new regulations promulgated on January 29, 1992, are applicable to this case;

2. Whether Respondent presented or caused to be presented claims for items or services in violation of section 1128A of the Act; and

3. Whether assessments and penalties should be imposed against Respondent and, if so, in what amounts.

DISCUSSION

A. The substantive parts of the regulations published on January 29, 1992, do not govern my decision in this case.

On January 29, 1992, the Secretary promulgated new federal regulations which effect both procedural and substantive changes with respect to CMPL and exclusion cases. 42 C.F.R. Parts 1001-1007; 57 Fed. Reg. 3298 et seq. (new regulations). During the hearing, I ruled that Part 1005 of the new regulations, which governs the procedural aspects of the appeal, were applicable. Tr. 8-9. However, I offered the parties the opportunity to brief the issue of whether the substantive portions of Part 1003 of the new regulations would apply. Id.

In his Post Hearing Brief, the I.G. argues that, as the new regulations were effective when published, they are now binding on this proceeding. He also asserts that any differences between the language of the former Part 1003

and new regulations are not substantive. Respondent argues that due process requires that the prior regulations apply.

The publication of the new regulations in the Federal Register stated an effective date of January 29, 1992, but contained no guidance as to whether they were to apply to pending cases. There is a presumption that administrative rules should not be applied retroactively unless their language specifically requires that application. See Bowen v. Georgetown Univ. Hosp., 488 U.S. 204, 208 (1988). An appellate panel has recently found that to apply the substantive provisions of the new regulations to an exclusion case in midstream, absent specific and uncontroverted guidance to do so, would constitute a violation of a petitioner's due process rights. Behrooz Bassim, M.D., DAB 1333 at 8-9 (1992). The appellate panel also concluded that those portions of the new regulations which changed substantive law may permissibly be applied only to cases in which the I.G.'s Notice of Intent to Exclude, Notice of Exclusion, or Notice of Proposal to Exclude is dated on or after January 29, 1992. Id. at 9.[7]

I find that this analysis is equally applicable to CMPL cases. Part 1003 of the new regulations is similar -- but not exactly the same as the prior regulations. For example, the prior regulations offer nonbinding guidelines with respect to aggravating or mitigating circumstances which I may consider in determining the appropriateness of the proposed penalties and assessments. Section 1003.106(d)(1) of the new regulations, as interpreted by the I.G., would make application of these "guidelines" binding unless either the penalty or the assessment -- or both -- exceed constitutional limits. Also, the new regulations add a provision at 42 C.F.R. § 1003.106(b)(4) which outlines specific conduct to be considered as an aggravating circumstance. Thus, application of these and other new or modified substantive portions of the new regulations to this proceeding, which began prior to their enactment, would be a violation of Respondent's due process rights.[8]

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[7] See also, my discussion of the new regulations and their applicability to pending cases in Sukumar Roy, M.D., CR205 at 6-10 (1992).

[8] As noted supra, this proceeding began on July 12, 1991, when the I.G. notified Respondent of the proposal to impose penalties and assessments pursuant to section 1128A of the Act (Notice).

I find, therefore, that Part 1003 of the new regulations is inapplicable to this proceeding. I will rely on the prior regulations found at 42 C.F.R. Part 1003 (1991).[9]

B. Respondent violated section 1128A of the Act by presenting claims or causing claims to be presented to Medicare while he was excluded.

To prove liability under section 1128A of the Act, the I.G. must show, by a preponderance of the evidence: a) that Respondent was excluded; b) that he provided items or services to Medicare beneficiaries while excluded and that claims for reimbursement were submitted for those items or services; and c) that Respondent submitted or caused the claims to be submitted. See Berney R. Keszler M.D., DAB CR107 at 28 (1990).

1. Respondent was excluded from Medicare and Medicaid programs pursuant to Section 1128(a)(1) of the Act.

It is undisputed that Respondent has been excluded from Medicare and Medicaid continuously since February 6, 1979. Stips. 4, 6. Respondent was suspended from the programs originally for a one-year period, pursuant to former section 1862(e)(1) (revised and recodified as 1128(a)(1) of the Act). His suspension was based on a New York State conviction for perjury in the first degree.[10] I.G. Exs. 65, 163; Tr. 623. Respondent did not request a hearing on the original suspension. Respondent's application for reinstatement was denied in 1989. Respondent then withdrew his application. I.G. Exs. 67-69; Tr. 281.[11]

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[9] All further references to Part 1003 in this decision shall be to the regulations found in the 1991 edition of the C.F.R., unless specifically identified otherwise.

[10] The "suspensions" of former section 1862(e)(1) are synonymous with "exclusions" under the current section 1128(a)(1). See Keszler, at 29. Therefore, Respondent's "suspension" is sometimes referred to here as an "exclusion," especially when used in reference to section 1128A of the Act and its regulations.

[11] The I.G. states that the reinstatement request was rejected because Respondent was suspected of billing the Medicare program while excluded. I.G. Ex. 67; Tr. 281-82.

2. Respondent provided items and services to Medicare beneficiaries while excluded, and claims for reimbursement were submitted for those items and services.

The I.G. has presented evidence regarding 32 claims for items and services (eye examinations and optical items) allegedly rendered by Respondent to Medicare beneficiaries between May 15, 1986, and August 3, 1989. The fact that these claims were submitted to and paid by Medicare is not in dispute. I admitted, without objection, the 32 actual claim forms. Each of the claims was signed by Dr. Debra Crane and bore her provider number. The claims were received, processed, and paid by Medicare through its carrier GHI.[12] See I.G. Exs. 3-64; Tr. 189, 192-194. Respondent generally argues either that there is no proof that any of the items or services were provided by Respondent or that he was not responsible for their being presented as claims. As I have observed (note 2, supra), he has attacked the veracity of witnesses, the authenticity of exhibits, and the investigative abilities of the GHI and I.G. agents. Also, Respondent alleges that because Dr. Crane was responsible for preparing the billings, signed the claims, and used her provider number, either she provided the services or they were performed by other optometrists in the office under her auspices. In the alternative, he asserts that she presented the claims without Respondent's knowledge or approval. This latter issue is considered later in this decision (part 2.c.).

I find that the I.G. has met his burden of proof that Respondent provided the items and services at issue with respect to Counts 3, 7, 10, 13, 15, 16, 18, 21, 22, 29, 31, and 32. In each of these instances, the evidence, as

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[12] With respect to payment, Respondent argues that the I.G. has provided evidence of payment in a summary chart, I.G. Ex. 182, in, at most, 13 of the 32 counts. However, Respondent's counsel stipulated "that the government paid each of the 32 claims that are at issue here and paid them by checks which went through an account bearing the Portoghese/Crane name on the dates indicated on those various documents . . . ." Tr. 194. Liability under section 1128A of the Act attaches not when a claim is paid, but when it is "presented or caused to be presented." In any event, this chart is only a summary of the evidence submitted and contains other errors such as wrong amounts for certain of the claims and a wrong total amount. Because of the many errors, I have disregarded it in my analysis.

a whole, demonstrates persuasively that the beneficiaries either wrote to GHI in response to Medicare statements listing Dr. Crane as the provider or responded to a GHI inquiry by stating that they had seen Respondent on the dates at issue, and that he -- not Dr. Crane -- had provided the services or items claimed.[13] Most of these counts are evidenced by one or more statements written and signed by the beneficiary who received the service or item. In several cases, the original statements are also supported by telephone or personal interviews with GHI or I.G. investigators. In Count 22, for example, the beneficiary stated that he had seen Respondent for five years and had not seen Dr. Crane until Respondent retired in 1990. In others, such as in Count 21, a GHI telephone inquiry is more fully supported by testimony identifying Respondent's handwriting on the beneficiary's medical records on the date in question. In another, Count 29, the beneficiary recalled that Respondent told her that she would not have to pay for the eye exam because Medicare paid for them. The beneficiary in Count 18 called Respondent's receptionist, who confirmed that Respondent had seen her on the date in question. See note 12, supra.

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[13] The numbers in parentheses are the amounts shown on the claim forms.

Count 3 ($50.00): I.G. Exs. 3, 72 at 2; Tr. 329.
Count 7 ($50.00): I.G. Exs. 13, 82-84; Tr. 353.
Count 10 ($50.00): I.G. Exs. 18, 88-90; Tr. 303-04.
Count 13 ($40.00): I.G. Exs. 23, 92; Tr. 179, 183.
Count 15 ($50.00): I.G. Exs. 27, 58, 95, 98, 99; Tr. 64-65, 295-6.
Count 16 ($50.00): I.G. Exs. 100, 101; Tr. 333-35.
Count 18 ($50.00): I.G. Exs. 33, 103-105, 107, 109; Tr. 285-86, 288-91.
Count 21 ($50.00): I.G. Exs. 39, 112, 176 at 1; Tr. 440, 516.
Count 22 ($50.00): I.G. Exs. 41, 114, 115; Tr. 169, 317-18.
Count 29 ($50.00): I.G. Exs. 52, 122, 123, 125; Tr. 116-17, 121-22., 296-98.
Count 31 ($50.00): I.G. Exs. 56, 130, 131; Tr. 167-68, 337. (The amount stated in the I.G.'s Br. was incorrect.)
Count 32 ($50.00): I.G. Exs. 58, 95, 99; Tr. 64-65, 73, 291, 295-96. See also Count 15.

With respect to the following counts, I find also that the I.G. met his burden of proof and that Respondent provided the items and services at issue. However, because of certain arguments raised by Respondent, I will address them individually. The numbers in parentheses are the amounts shown on the claim forms.

Count 4 ($50.00): This beneficiary stated during a telephone contact by GHI, and in a later interview with I.G. agents, that he had seen only Respondent, never any other doctor at that office. I.G. Exs. 76, 77; Tr. 167, 344. Respondent's argument that the beneficiary only had his glasses adjusted and that Dr. Crane was responsible for the claim billing for an eye examination is misplaced. Both Dr. Crane and Dr. Sagalow, another optometrist working at the office, testified that it was Respondent's handwriting on the medical records for the examination. Tr. 442-43, 509-11. See also I.G. Ex. 7.

Count 6 ($150.00): In both telephone and in person interviews, this beneficiary identified Respondent as having provided the services in question. I.G. Exs. 80, 81; Tr. 166-67. Respondent's argument, that the beneficiary had only a prescription for eyeglasses filled and was not examined, is not pertinent. The statute is violated if any reimbursable service or item is furnished. Section 1128A(i)(3). See also I.G. Ex. 11.

Counts 8-9 ($60.00, $95.00): By telephone and in person interview, this beneficiary stated that Respondent had treated her on both visits. I.G. Exs. 86, 87; Tr. 172, 320-21. Respondent's arguments regarding the lack of medical records are unpersuasive. There is a record for the filling of a prescription for one of the dates. Considering the paucity of Respondent's records generally, and the strength of this beneficiary's statements, I find Respondent liable.[14]

Count 12 ($150.00): Although there is no date for the claim noted in the telephone contact sheet for this beneficiary, I.G. Ex. 91; Tr. 168, Drs. Crane and Sagalow testified that Respondent's handwriting was on the medical records for this beneficiary, and the records were dated the same day as the claim and for the same items and services. Additionally, Respondent wrote on the medical record "do not bill Medicare for tint." I.G.

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[14] Of the 26 beneficiaries named in the original Notice, patient records were made available during discovery for only 10. See Tr. 583; R. Exs. 35-37, 39-40, 43-44, 46; I.G. Ex. 194.

Ex. 177 at 3; Tr. 441-42, 514-515. This strongly supports a finding, that not only had Respondent seen this beneficiary, but that he was aware that Medicare would be billed for part of the services.

Count 19 ($50.00): This beneficiary responded to a written inquiry by stating that he had been seen by Respondent on the date at issue. I.G. Ex. 110; Tr. 180, 184. Respondent has introduced no evidence to support his questioning of the authenticity of this beneficiary's signature or the lack of medical records. As noted above, there were few medical records available. Further, Respondent has produced no medical records showing Dr. Crane provided any of the items or services here. Therefore, I cannot give any great weight to the lack of records. Respondent cannot rely on his own office's lack of medical records, especially in light of his poor record keeping and "chaotic" billing practices. See, e.g., R. Br. 32-34; Tr. 578-79.

Count 23 ($50.00): This beneficiary sent a letter to GHI in response to a Medicare statement she received listing Dr. Crane as the provider. Her letter stated "I don't know any Dr. Crane." I.G. Ex. 119 at 2. She followed this up in a telephone contact to GHI and in a written statement to an I.G. agent, also stating that she had been Respondent's patient for over 20 years. I.G. Exs. 116, 117; Tr. 305-06, 315-16. Once again, I am unpersuaded by Respondent's argument regarding the lack of medical records, especially in light of the strong evidence presented that Respondent did see this beneficiary on the date in question, and for many years previously.

Counts 24-26 ($95.00, $32.50, $40.00[15]): This beneficiary told GHI that he always saw Respondent. I.G. Ex. 120; Tr. 172. Respondent's handwriting was identified by Drs. Crane and Sagalow on a medical entry for one of the dates at issue. I.G. Ex. 175 at 4; Tr. 438, 518. Thus, Respondent's argument that the I.G. has made no case for these claims flies in the face of reality. He is mistaken in arguing that Counts 24 and 25 are duplicative. Each item or service improperly claimed is a violation of section 1128A of the Act. Section 1128A(i)(3). Here, while Counts 24 and 25 were claimed on the same form, they are for different listed and priced items, "1 pair of single vision lens frame ready" and "lens distance." See I.G. Ex. 45.

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[15] This amount is based on I.G. Ex. 47, the claim form, not the amount given in the I.G.'s Brief.

Counts 27-28 ($95.00, $95.00): Here, GHI contacted the beneficiary who stated that Respondent had examined her on the dates in question. I.G. Ex. 121; Tr. 169. Again, Respondent's arguments regarding the lack of medical records for this patient and unsupported allegations regarding the authenticity of the telephone contact are unpersuasive.

Count 30 ($50.00): In a telephone contact, this beneficiary stated that she had seen Respondent in connection with the claim in question. I.G. Ex. 128; Tr. 167. Here, while there is a medical record, R. Ex. 35, and Dr. Crane testified that Respondent's handwriting was not on it, Tr. 560-61, Respondent has made no attempt to show who did make the record. Thus, he has not refuted the eyewitness evidence provided by the beneficiary's statement.

Counts 33-34 ($40.00, $150.00[16]): This beneficiary stated in a telephone contact that she had seen Respondent. I.G. Ex. 132; Tr. 167. Later, in an interview and sworn statement, she said that Respondent always treated her and that Dr. Crane had helped her try on a pair of glasses on only one occasion. I.G. Ex. 164. Further, Dr. Crane testified that Respondent's handwriting was on the medical record for the claim in question and that she used that information to fill out the claim form. Tr. 574. Again, Respondent's argument is that these counts are duplicative, while they are actually separate items claimed on the same form. See I.G. Ex. 60.

Count 35 (150.00): In this beneficiary's original complaint to GHI, she denied knowing Dr. Crane. I.G. Ex. 137; Tr. 147-48. In a follow up telephone contact, she stated that she had received items and services from Respondent on the day in question and denied seeing a woman doctor. I.G. Ex. 135; Tr. 173. Finally, in a sworn statement, she reiterated that she was not treated by a woman. I.G. Ex. 133; Tr. 319-320. While Respondent has made much of this beneficiary's not specifically naming Respondent in her initial complaint and later sworn statement, she did identify him in the telephone contact made shortly after the initial complaint. Her initial complaint was in response to a letter she received from GHI listing Dr. Crane as having providing the service. The subsequent sworn statement was made over two years after the date in question, and while the

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[16] This amount is based on I.G. Ex. 60, the claim form, not the amount given in the I.G.'s Brief.

beneficiary may not have remembered Respondent's name by then, she did recall that the person was male. I find it more persuasive that she recalled Respondent's name in the earlier telephone contact.

In contrast to the above counts, I find that the I.G. has not met his burden of proof with respect to Counts 2, 5, 11, and 20. In the following instances, although I find it highly likely that Respondent did provide the items and services at issue in these counts, I cannot so find by a preponderance of the evidence. The evidence supporting these counts is either insubstantial or contradictory.

Count 2 ($40.00): In May of 1989, a statement signed by this beneficiary's daughter was returned to GHI. The daughter had circled Respondent's name as having provided the services on the date in question. I.G. Ex. 72. When the beneficiary was interviewed in 1991 by I.G. agents, he stated that he had seen both Respondent and Dr. Crane and didn't recall the date in question or who he had seen. I.G. Ex. 73. As there is no other probative evidence to support this count, I cannot find that Respondent performed the services in question.

Count 5 ($50.00): The evidence of record here consists of an unsigned statement dated February 1988 indicating that the beneficiary had received treatment from Respondent on the date in question. I.G. Ex. 78. During an interview in October 1991, however, the beneficiary appeared confused, stating that she saw Respondent for her eyes about two years ago but that it might have been Dr. Crane. I.G. Ex. 79. Thus, there is no direct evidence linking Respondent with the claim at issue.

Count 11 ($110.00): The I.G. filed two counts for this beneficiary. See Count 12, supra. The evidence connecting Respondent to Count 11 is limited and somewhat contradictory. While there is a telephone contact in evidence which states that the beneficiary said she saw Respondent, subsequent testimony by one of the I.G.'s agents indicates that the beneficiary did not recall who she saw. Tr. 384-385. There is no other evidence linking Respondent to this claim as was present in Count 12. The medical records contain only a copy of the third party prescription made a few days before the date of service on the claim. Thus, there is insufficient evidence to support a finding that Respondent performed the items or services in question.

Count 20 ($40.00): The original GHI telephone inquiry was answered by the beneficiary's daughter who said that

her mother had seen Respondent or Dr. Sagalow -- not Dr. Crane. I.G. Ex. 112. However, by the time an investigator interviewed the beneficiary a few years later, she appeared no longer competent to answer questions and stated that she did not know Respondent. Tr. 380. Thus, there is insufficient evidence linking Respondent and the claim at issue.

In summary, I find that it is undisputed that the 32 claims were submitted for payment during a time period that Respondent was excluded from the programs and that the I.G. has proven by a preponderance of the evidence that Respondent provided the items or services in 28 of the 32 counts.[17]

3. Respondent presented or caused to be presented 28 of the claims in issue.

Section 1128A(a)(1)(D) of the Act makes it unlawful for a party to present or cause to be presented a claim for a medical or other item or service while excluded. The "present or cause to be presented" language, which is in several subsections of this statute, was intended by Congress to include both claims presented by an excluded provider and those which the provider causes to be presented by others, such as agents, employees, or beneficiaries. Section 1128A(l) of the Act; see Keszler at 20 (provider caused employees who were nurses to file claims); cf. Tommy G. Frazier, DAB CR79 at 18 (1990) aff'd 940 F.2d 659 (6th Cir. 1991) (provider caused false claims to be presented by billing service).

This section of the Act does not require proof of intent as an element. Rather it imposes a standard of strict liability, which the I.G. satisfies by proving that the excluded provider presented or caused to be presented the claims at issue. Keszler at 28.

The I.G. asserts that Respondent is liable for the claims at issue because he concealed his status as an excluded provider, because he permitted improper claims to be submitted, and because he was liable, as Dr. Crane's partner, for her acts in submitting the claims. Respondent contends, again, that there is no evidence of improper billing, but asserts that, if there were, as Dr.

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[17] While I have not cited to every relevant piece of evidence provided by the parties with respect to this issue, I have considered all the testimony, the exhibits, and the parties arguments, and weighed them accordingly in reaching these specific findings.

Crane was responsible for the office's billings and her name and provider number are on the claims, she alone is responsible.[18] Respondent argues also that Dr. Crane may have believed she was able to bill under her number for services or items provided by optometrists under her supervision, including Respondent. Thus, apparently, Respondent argues that even if there were improper billings, there was no intent to avoid the effects of the statute.

The I.G. also argues that Respondent had an affirmative duty to inform his employees and Dr. Crane of his exclusion and to prevent her billing Medicare for his services. The history of the Act indicates that it places an affirmative obligation on Respondent "to notify all patients eligible for Medicare or State health care programs of the exclusion and the fact that the programs will not make payment" for his services to ensure that no claims were made.[19] Respondent failed in this duty by deliberately treating Medicare patients without telling them of his status. He testified that he filled out Medicare claim forms for his patients who "would insist on them." Tr. 632. He testified further that afterwards he then "threw" the forms away. Id.

Respondent also had an affirmative duty to see that his partner and employees did not bill Medicare for his services and to ensure that those responsible for billing did not bill Medicare for any services and items provided by Respondent. The issue here is whether Respondent breached this duty and submitted or caused to be submitted the 28 claims at issue. I find that he did cause them to be submitted.

The evidence shows that Dr. Crane joined Respondent's practice in 1983. Tr. 477, 612-13. One year later, she

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[18] Respondent has attempted to implicate Dr. Crane in these billings. Respondent also asserts, and the I.G. denies, that Dr. Crane has been granted immunity in return for her testimony. I do not need to, nor do I, decide Dr. Crane's culpability or whether she was granted immunity. She is not an excluded provider, and, therefore, cannot be liable under section 1128A(a)(1)(D) of the Act. I have taken notice of the correspondence between GHI and Dr. Crane, dated November 8, 1991, and have considered it in weighing her testimony. See R. Ex. 48.

[19] H.R. Rep. No. 85, 100th Cong., 1st Sess. 25-26 (1987) (legislative history of section 1128A).

became his partner (Tr. 478-79, 613), and by 1984, or 1985, at Respondent's request, she had taken over the responsibility for handling the office billings and the preparing and submitting of Medicare claims. Tr. 449, 452, 466, 506, 521; 526-27. She testified that she believed that Respondent was aware that she billed Medicare for his services, and that "about 10 percent of the time" questioned him on his medical record entries in preparation for billing. Tr. 542, 578. Respondent urged Dr. Crane to obtain a medical provider number so she could begin billing for Medicaid and Medicare items and services. Tr. 526. The parties agree that Dr. Crane knew that Respondent did not have a provider number, and, therefore, he could not bill on his own. There has, however, been much argument and testimony regarding whether Dr. Crane knew of Respondent's exclusion. She testified that he never told her, she never asked the reason for his not having a number, and did not learn of his exclusion until March 1990. Tr. 523, 588. She also testified that he never told her not to bill for his Medicare work. Tr. 523. Respondent, in turn, testified that he did not originally tell her because he was embarrassed and afraid she would not come to work for him. Tr. 630-31, 660-61. He said also, in hindsight, he "would not have told her the first few years." Tr. 661.

Respondent asserts that he encouraged Dr. Crane to do all the billing and that, once she took over, he never interfered. Also, he claims that he was uninterested in the billings and was uninterested generally in money. However, Dr. Crane testified that she consulted Respondent on billing matters. Tr. 542. Regardless, Respondent's alleged lack of interest in his practice's billing habits are not an excuse for fraudulent behavior. Respondent was well aware that he was not able to bill on his own and had a duty to see that no bills were submitted for services or items provided by him. The claims at issue cover several years and include a period when Dr. Crane and Respondent had conversations with GHI regarding his office's billing practices for Medicare. Tr. 578, 660.

I am persuaded by additional evidence to find that Respondent caused to be presented the claims at issue. Respondent frequently saw Medicare beneficiaries during his exclusion, as did the other optometrists in his office. See Tr. 435, 441, 505, 631-32; R. Br. at 63. There is no evidence that any attempt was made by Respondent or his employees to tell these Medicare patients about the exclusion or to book them with other

optometrists working at the office.[20] See I.G. Ex. 170; Tr. 273, 394, 429, 435. As noted previously, Respondent testified that he often threw out Medicare claims rather than bill for them. Tr. 632; see R. Ex. 112. However, while Respondent was free to treat patients without billing them, he had a duty to tell them that he could not bill for Medicare and why.[21] Also, even if Respondent did not bill all his Medicare patients, this does not prove that he did not bill for the 28 counts at issue. He conceded also that it was possible that a patient may have paid Respondent for an item or service and his office also may have billed Medicare. Tr. 654-55.

There is also evidence that Respondent knew his services would be billed to Medicare. For example, the beneficiary in Count 29 was told by Respondent that Medicare now paid for eye exams. I.G. Ex. 123. Also, in Count 12, Respondent wrote on the patient's medical record for glasses, "do not bill Medicare for tint." I.G. Ex. 177 at 3; Tr. 441-42, 514.

Respondent notes that Dr. Crane testified that she believed it proper to bill for patients under her number as long as the treatment was done under her supervision. Tr. 568-70. While admitting that in filing the claims she certified that she supervised him, Dr. Crane denied that she was Respondent's "boss." Tr. 575. Respondent also argues that Dr. Crane spoke to a GHI employee who told her it was not illegal to file claims under her provider number while another optometrist provided the services. Tr. 586-87. However, it does not appear that the employee was aware of Respondent's excluded status, and, if Dr. Crane did not know, she could not mention it. See I.G. Ex. 173. While Medicare does permit a first

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[20] Respondent asserts that he frequently provided free service to Medicare patients, service people, and clergy. However, Dr. Sagalow testified that it was not the general practice to treat indigents. Tr. 461.

[21] There is a statement in evidence from Dr. Worth, an optometrist employed by Respondent and Dr. Crane, which stated that he believed patients who wanted to be seen under Medicare were told that they would have to be seen by Dr. Crane -- not Respondent. R. Ex. 111. However, this doctor did not join the practice until July 1988, after Respondent knew that he was under investigation by GHI. Dr. Worth also recalled that he had heard rumors that Respondent was in trouble with Medicare. Id.

billing by an excluded party to be paid, so as not to punish an individual beneficiary, and a provider may bill for services performed by an employee under his or her supervision, provided the employee has not been excluded, excluded parties cannot hide behind their associates and partners. An excluded party may not work as an "employee" for another and have his or her services billed under the "employer's" provider number. Dr. Crane was told by GHI personnel that the doctor who was rendering the services should be billing and that Respondent "should be billing on his own provider number, not hers." See I.G. Ex. 173; Tr. 125, 501. Respondent was told also, in a personal interview in June of 1988, that he could not bill for his services and was warned that criminal and civil liabilities were possible. I.G. Ex. 172; Tr. 308. He told the investigator at that time that he did not know that Dr. Crane was billing for his examinations. However, it does not appear from the record that he attempted to fully correct the situation. See Tr. 640.

Although intent is not a required finding for liability, I conclude that Respondent's testimony that he was unaware of the billing practices in his office is not credible. Respondent was an experienced optometrist who had operated his own offices for many years before hiring Dr. Crane. He had been excluded for several years prior to her joining him and taking over the billing. Also, at one time, Respondent owned a 75% interest in a Medicaid clinic. I.G. Ex. 150 at 214. Thus, he was experienced in running medical offices and, having been in the Medicare program, should have been familiar with its requirements. While it is possible that, as a new employee untrained in billing or Medicare matters, Dr. Crane could have made a few billing errors, I find it improbable that Respondent knew nothing at all throughout the three year period she was filing his Medicare claims for him. This is especially unlikely as the parties have admitted that they talked about the issue at least once after Dr. Crane had talked to a GHI investigator, and the billing continued even after Respondent was told about the problems by an investigator in 1988.

Lastly, the I.G. alleges that Respondent is liable as a partner for the acts of Dr. Crane. It is uncontroverted that, by 1984, and certainly by the time these claims began in 1986, Respondent and Dr. Crane had become partners. Tr. 478-491. By 1986, they were filing partnership forms with the Internal Revenue Service and had opened a joint bank account. See I.G. Exs. 183-192; J. Ex. 1; Tr. 497. According to Dr. Crane's undisputed

testimony, they also drew up and signed a partnership agreement. Tr. 478.

The I.G. asserts that, under the general partnership law of New York State, the partners are agents of each other and each is responsible for the acts of the other.[22] It is unnecessary for me to rule on New York State law because Section 1128A(1) of the Act also provides that a principal is liable for penalties and assessments imposed as a result of the actions of the principal's agents acting within the scope of the agency. Respondent argues that Dr. Crane's actions in billing for Respondent under her provider number was not within the scope of the agency. However, he authorized Dr. Crane to do all the billing. Further, one of his arguments is that they thought it proper for her to bill for him under her number as long as she was his "supervisor," and that, on the advice of a GHI employee, "believed she was doing the right thing." R. R.Br. 41, 62; Tr. 526-27. That Dr. Crane was acting within the scope of the agency is further supported by the fact that Respondent was apprised of the problems in 1988 and billings occurred until 1989. Also, Respondent is incorrect in his argument that he is not liable for Dr. Crane's acts because "the liability of one partner for the acts of the other does not extend to punitive penalties." R. R.Br. 50. Respondent has not raised the issue of whether the proposed penalties and assessments are punitive. Also, it is well settled that the CMPL is remedial -- not punitive. See discussion infra at part C of this decision. I find Respondent liable: he was excluded and could not bill for his services, but he concealed that exclusion and then provided items and services to Medicare beneficiaries and delegated the billing for these items and services to his partner, Dr. Crane. Therefore, Respondent violated section 1128A(a)(1)(D) of the Act by causing to be presented the 28 items and services he provided while excluded.

C. Penalties and assessments are appropriate in this case.

Once I have found liability under the CMPL, it is my duty to review the penalties and assessments proposed by the I.G. and determine if they comport with the Act. The CMPL is a civil statute and is designed to protect

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[22] The New York partnership statute provides that each partner acts as an agent of the partnership. N.Y. PARTNERSHIP LAW § 20(1) (McKinney 1988); Besen v. Kelley, 373 N.Y.S.2d 765, 767 (1975).

government financed health care programs from fraud and abuse by providers. Mayers v. U.S. Dept. of Health and Human Services, 806 F.2d 995, 997 (11th Cir. 1986), aff'g William J. Mayers, D.C., DAB CR1 (1985), cert. denied, 484 U.S. 822 (1987); Anesthesiologists Affiliated, DAB CR45 at 58 (1990) aff'd 941 F.2d 678 (8th Cir. 1991). The assessments and penalties are designed to implement the Act's remedial purpose in two ways. One is to enable the government to recoup the cost of bringing a respondent to justice and the financial loss to the government resulting from the false claims presented by a respondent. Bernstein v. Sullivan, 914 F.2d 1395, 1397 (10th Cir. 1990), aff'g Donald O. Bernstein, D.C., DAB CR16 (1989). The other is to deter other providers from engaging in these activities. Anesthesiologists Affiliated, at 58.

The Act and implementing regulations provide that a penalty of up to $2,000.00 and an assessment of not more than twice the amount claimed may be imposed on a respondent for each item or service which is presented in violation of the Act. Section 1128A(a) of the Act; 42 C.F.R. §§ 1003.103 and 1003.104. Based on the 32 counts in the Notice, the I. G. has requested that I impose penalties of $60,000.00 and assessments of $4,365.00. However, because I have found that the I.G. proved his case in only 28 counts, the maximum penalties which I may impose against Respondent are $56,000.00, and the maximum assessments are $3,885.00.

The regulations set forth guidelines which I may consider in determining the amount of penalties and assessments. These factors may be either mitigating or aggravating and include: 1) the nature of the claims or requests for payment and the circumstances under which they were presented; 2) the degree of culpability of the person submitting the claim or request for payment; 3) the history of prior offenses of the person submitting the claim or request for payment; 4) the financial condition of the person presenting the claim or request for payment; and 5) such other matters as justice may require. 42 C.F.R. § 1003.106(a); see § 1003.106(b), (c), and (d).

A respondent has the burden of proving by a preponderance of the evidence the presence of mitigating factors which would justify reducing the proposed penalties and assessments. 42 C.F.R. § 1003.114(d). The regulations provide that, in cases where there are substantial mitigating factors, the penalties and assessments should be set correspondingly below the maximum permitted by law. 42 C.F.R. §1003.106(c)(1). Conversely, the I.G.

has the burden of proving the existence of aggravating factors.

The regulations provide that, where aggravating factors preponderate, I have the authority to impose penalties and assessments which exceed the amount actually reimbursed to an respondent for items or services which were unlawfully claimed. Mayers, 806 F.2d at 999.

1. Nature of claim and circumstances

Respondent has argued that the 32 counts are a small number of claims, perpetrated over a short period of time, and involve only a small sum. This is not a mitigating circumstance. Respondent claimed $1942.50 for the 28 counts. The regulations state that any amount over $1000.00 is substantial. 42 C.F R. §1003.106(b)(1); see General V. Thuong Vo M.D., DAB CR38 at 24 (1989) (provider claimed $1,945.00). Further, the 28 counts occurred over three years between May 1986 and August 1989; this is not a short period of time. Also, considering that the date of service for the claim in Count 35 was August 3, 1989 (I.G. Ex. 65), Respondent's argument that there were no claims that year is incorrect. See R. R.Br. 55. Other than the statement by Dr. Worth, who did not begin to work for Respondent until mid-1988, there is no evidence that Respondent tried to stop or correct the billings. Lastly, the claims appear to be only a small sample of a longstanding pattern of unlawful conduct by Respondent. These are all aggravating factors.

2. Degree of culpability

My decision regarding the assessments and penalties considers the presence of serious aggravating factors regarding Respondent's culpability and trustworthiness. These factors include the deliberate fraud committed by Respondent, his apparent contempt for federally funded health care programs, and that this was Respondent's second act of fraud against a government health care program. Also, I have considered his failure to inform the beneficiaries or his employees of his exclusion status, so as to ensure proper billing, and his failure to correct the billing practices. See 42 C.F.R. § 1003.106(b)(2)(ii).

3. Prior offenses

It is a substantial aggravating factor that Respondent has had a history of criminal and administrative sanctions in connection with reimbursement programs for

medical services. See 42 C.F.R. § 1003.106(b)(3).[23] As discussed previously, Respondent was convicted in 1977 in State court of five perjury counts for denying knowledge of making kickbacks in connection with his ownership of a Medicaid clinic. I.G. Exs. 65, 150 at 13-15 and 46-47, 213-28; R. Exs. 58-61. Respondent argues that neither the city code under which he was prosecuted nor his conviction were related to "providing billable services to Medicaid." R. Br. 43. However, the regulation refers only to sanctions "in connection with a program covered by this part." Respondent's actions were "in connection" with his Medicaid clinic.[24] The language of the regulations -- not the language of the city code -- is conntrolling with respect to the determination of aggravating factors. Further, the Findings of Fact in his State suspension specifically state "respondent knowingly and intentionally testified falsely in response to questioning which sought to determine whether respondent had offered to pay cash kickbacks in return for referrals of Medicaid patients to respondent's Medicaid facility." I.G. Ex. 150 at 13-14 FF No. 5.

As a result of the conviction, Respondent was excluded from Medicare (I.G. Ex. 65), and the New York State Board suspended his optometry license for one year, effective April 1983 to April 1984. See I.G. Ex. 150 at 2-15; Tr. 624, 656-57. Thus, it appears also that Respondent was practicing optometry without a license when he hired Dr. Crane in 1983. I am persuaded that these are aggravating factors, and I am not dissuaded from this concludsion either by Respondent's arguments that these events happened a long time ago or that he might not have been practicing at the time he hired Dr. Crane. The events are not that distant in time from the early counts in this proceeding. In fact, the license suspension ended

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[23] Respondent's 1967 conviction for mail fraud (R. Ex. 105 at 2), and the subsequent 1969 and 1970 suspensions of his optometry license by New York State (I.G. Ex. 150; R. Exs. 101-103), indicate a certain disregard for the law, but they are not related to any public or private program of reimbursement for medical services and thus are not considered aggravating factors under this subsection of the regulation.

[24] Several dates for this conviction are in evidence. The parties stipulated to 1978. Stip. 8. However, the evidence shows that Respondent was indicted in 1976 (I.G. Exs. 163, 150 at 212), found guilty in 1977 (I.G. Ex. 163), and sentenced in 1978 (I.G. Ex. 150 at 144).

only about two years before the conduct at issue in the first count. Also, if, as Respondent has testified, he did not tell Dr. Crane about his exclusion because she would not have come to work for him, certainly he would have had even more cause for concern to tell her that he couldn't practice at all -- or could practice only under her supervision. I note that while Respondent has suggested several scenarios regarding this issue, he has specifically not said that he wasn't practicing during that period. See R. R.Br. 65-67.

4. Respondent's financial condition

Respondent's assertions that he is not financially capable of paying the penalties and assessments is not credible. Section 1003.106(b)(4) of the regulations provides that a Respondent's financial condition is a mitigating factor if payment of the penalties and assessments would jeopardize a respondent's ability to provide medical services. However, Respondent has retired from optometry and has no license to practice. Therefore, payment of the penalties and assessments will not affect his ability to provide medical services. See Dean G. Hume, D.O., DAB CR40 at 26 (1989).

Secondly, section 1003.106(b)(4) of the regulations provides that Respondent's financial resources will be considered in determining the penalties and assessments. However, the burden of proof here is on Respondent. I do not find his undocumented assertions regarding his financial ability to be credible. While the I.G. and Respondent introduced some evidence regarding Respondent's earnings from his practice before his retirement, Respondent has offered no evidence regarding his current financial condition.[25] He offered only anecdotal evidence regarding his financial status and responsibilities. Unsupported assertions do not justify a reduction of penalties and assessments. Barbara K. Johnson, D.D.S., DAB CR78 at 7 (1992). For example, Respondent testified that his health was not good and that he paid for a companion for his mother. Tr. 642-43.

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[25] The I.G. offered evidence of Respondent's financial condition in the form of an "Earnings Summary" for the years 1979-1990. I.G. Ex. 159, 184, 186, 188, 190, 192. The parties jointly introduced several tax earnings statements for the partnership. J. Ex. 1. I also note R. Ex. 54, which shows that the gross office income, deposited into the partnership bank account between September 1987 and December 1989, was in excess of $1,000,000.00.

However, he submitted no further evidence on these matters. In fact, Respondent told an investigator in 1988 that he could live on the small reimbursements from his optometry practice because he was independently wealthy. Tr. 307; I.G. Ex. 172. Also, the financial evidence of record indicates that Respondent may have attempted to dispose of substantial assets during the course of this proceeding.[26] At the hearing, when Respondent was questioned about the recent transfers of two properties to his wife's name, he stated that his attorney had requested that he do so for malpractice and health reasons. Tr. 641-42, 659-60. The transfers, at this time, are more than coincidental, especially in light of Respondent's overall culpability and untrustworthiness on other issues. I note also that it was not until February of 1992 that Dr. Crane began making her $3,000.00 monthly rent checks on the office lease to Respondent's wife, instead of Respondent. Tr. 484; see I.G. Ex. 153 at 1 (lease agreement with Respondent).

5. Other matters which justice requires

Respondent's fraud has damaged the integrity and reputation of the Medicare program. Those damages cannot be quantified in dollars. Respondent's contempt for the programs was amply demonstrated by the evidence showing his scheme to thwart the effects of his exclusion. While some protections are built into the system, providers of health care are generally trusted to act honorably when filing reimbursement claims. Here, the scheme may have continued longer, had not some beneficiaries noticed the substitution of Dr. Crane's name for Respondent's and notified GHI. Respondent most probably would have continued this practice had not the I.G. begun an investigation. Further, had these claims been denied on first presentation, the beneficiaries might have paid Respondent for services or items that they could have obtained from a legitimate Medicare provider.

Respondent argues that no actual damage was suffered as a consequence of the submitted claims. He premises this allegation on his arguments that the I.G. failed to prove

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[26] Respondent transferred ownership of two properties to his wife shortly before the hearing. Tr. 641, 647-53, 659-60; I.G. Ex. 151A-D. He testified that his residence was worth only $180,000.00. Tr. 649. The office property is appraised by the City of New York at $400,000.00, and Dr. Crane's option price to purchase it is $408,000.00. R. Ex. 111; Tr. 488-496, 616..

that any of the items or services were provided by Respondent or that, if they were provided, they were done under the supervision of Dr. Crane. However, Medicare is under no obligation to pay for items or services rendered while Respondent is excluded. Therefore, to the extent I have found that items or services were rendered by Respondent, no Medicare items or services provided by him should have been reimbursed. The government was damaged to the extent it paid for items or services for which it was not required to pay.[27]

The assessments and penalties which I am imposing cannot begin to recoup the cost which the government incurred in connection with this case. In addition to the payment of the improper claims, the government paid for the investigation into Respondent's Medicare claims practices, which lasted for several years.

The regulations suggest that, if there are several substantial aggravating circumstances, the aggregate amount of the penalties and assessments should be set at or near the maximum permitted by law. 42 C.F.R. § 1003.106(c)(2). I have considered Respondent's conduct in light of the totality of the evidence and the Act's remedial purpose and regulatory criteria and have set the penalties and assessments at the maximum that the law permits me to impose. I impose penalties of $56,000.00 and assessments of $3,885 against Respondent.[28] I conclude that these amounts are justified by the Respondent's egregious conduct, the presence of substantial aggravating factors, and the absence of mitigating factors. They will serve also as a deterrent against others engaging in this illegal conduct.

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[27] Respondent improperly claimed a total of $1,942.50, based on the 28 items and services.

[28] Respondent's arguments regarding the calculation of the penalties and assessments is misplaced. While the I.G. may propose the amounts, the regulations plainly give me authority to set them at the maximum permissible amounts. See 42 C.F.R. § 1003.106(b)(2).

CONCLUSION

For the reasons set forth in this Decision, I impose penalties of $56,000.00 and assessments of $3,885.00 against Respondent.

/s/

Charles E. Stratton
Administrative Law Judge