Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	
Bhupandra Patel, M.D.,	DATE: August 19, 1992
Petitioner,	Docket No. C-92-067 Decision No. CR227
- v. -	
The Inspector General.	

DECISION

In this case, governed by section 1128 of the Social Security Act (Act), the Inspector General (I.G.) of the United States Department of Health and Human Services (DHHS) notified Petitioner by letter dated December 10, 1991, that he was being excluded from participating in the Medicare and Medicaid programs for a period of eight years.[1] Petitioner was advised that his exclusion resulted from his conviction of a criminal offense related to the delivery of an item or service under Medicaid, within the meaning of section 1128(a)(1) of the Act.

Petitioner timely requested a hearing before an Administrative Law Judge (ALJ), and the case was assigned to me for a hearing and decision. During the prehearing conference I conducted on March 10, 1992, Petitioner admitted that he was convicted of a criminal offense related to the delivery of an item or service under Medicaid. Petitioner indicated that he was not contesting the mandatory five-year exclusion, he was merely contesting the I.G.'s imposition of an additional three-year period. Petitioner contended that there were

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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.

mitigating circumstances that made a five-year period of exclusion appropriate, not eight years. Petitioner and the I.G. agreed to proceed by way of summary disposition, in lieu of an in-person hearing, whereby the I.G. would submit a motion for summary disposition and Petitioner would submit a response to the I.G.'s motion.

I admit all of the parties' exhibits into evidence and I have considered the parties' briefs and exhibits.[2] I conclude that the I.G. had authority to exclude Petitioner and that the eight-year exclusion directed against Petitioner is appropriate and reasonable under the circumstances.

APPLICABLE STATUTES AND REGULATIONS

I. The Federal Statute.

Section 1128 of the Act is codified at 42 U.S.C. § 1320a-7 (1988). Section 1128(a)(1) of the Act permits the I.G. to exclude from Medicare, Medicaid and related health care programs:

> . . . any individual or entity that has been convicted, under Federal or State law, of a criminal offense related to the delivery of a health care item or service under Medicare

II. The Federal Regulations.

The federal regulations governing this proceeding are codified in 42 C.F.R. Parts 498, 1001, and 1002 (1990).

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[2] The parties' exhibits, briefs, and my findings of fact and conclusions of law will be referred to as follows:

I.G.'s Exhibits	I.G. Ex. (number/page)
Petitioner's Exhibits	P. Ex. (number/page)
I.G.'s Post Hearing Brief	I.G. Br. at (page)
Petitioner's Post Hearing Brief	P. Br. at (page)
I.G.'s Post Hearing Reply Brief	I.G. R. Br. at (page)
My Findings of Fact and Conclusions of Law	FFCL (number)

Part 498 governs the procedural aspects of this exclusion case; Parts 1001 and 1002 govern the substantive aspects.

ADMISSIONS

Petitioner admits that (1) he was convicted of a criminal offense, (2) his criminal conviction is related to the delivery of an item or service under the Medicaid program, and (3) he is subject to a five year minimum mandatory exclusion. Petitioner contends that an exclusion of eight years is unreasonable.

ISSUES

1. Whether the regulations published on January 29, 1992, at 57 Fed. Reg. 3298 et seq. are applicable to this case.

2. Whether the eight year exclusion imposed and directed against Petitioner by the I.G. is appropriate and reasonable.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Petitioner is a medical doctor engaged in the practice of internal medicine and licensed in New York State and New Jersey. I.G. Ex. 3; P. Br. 1-3.

2. Petitioner is not licensed as a psychiatrist or psychotherapist, nor does he have the required training to qualify as a psychiatrist or psychotherapist. P. Br. 1; I.G. Ex. 1/5; I.G. Ex. 2.

3. Petitioner was indicted in a New York State court on two counts of grand larceny and 31 counts of offering a false instrument for filing, all 33 counts involving Medicaid fraud. I.G. Ex. 2.

4. On June 7, 1992, Petitioner pled guilty to one count of grand larceny in the third degree and two counts of offering a false instrument for filing. (Counts one, 16 and 17 of indictment #9337/89). Petitioner was sentenced to five years probation and to pay restitution in the amount of $123,500. I.G. Exs. 3; 5; 6.

5. Petitioner pled guilty to third degree grand larceny as a result of his submitting fraudulent claims to the New York State Medicaid agency for reimbursement for

psychiatric and psychotherapy services that he was not qualified or licensed to provide. I.G. Ex. 3.

6. Petitioner pled guilty to count 16 of the indictment, which charges him with submitting fraudulent claims for reimbursement to the New York State Medicaid Agency. In pleading guilty to count 16, Petitioner admitted that he claimed to have provided psychiatric and psychotherapy services to Medicaid patients when he was not qualified or licensed to do so. I.G. Ex. 3.

7. Petitioner pled guilty to count 17 of the indictment, which charges him with submitting fraudulent claims for reimbursement to the New York State Medicaid Agency. In pleading guilty to count 17, Petitioner admitted that he claimed to have provided medical tests to Medicaid patients, when in fact no such tests were performed. I.G. Ex. 3.

8. Petitioner was convicted of a criminal offense, within the meaning of section 1128(a)(1) and 1128(i) of the Act. FFCL's 3 -7.

9. Petitioner was convicted of a criminal offense "related to" the delivery of an item or service under the Medicaid program, within the meaning of section 1128(a)(1) of the Act. FFCL 8.

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

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

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

13. Petitioner has demonstrated a pattern of defrauding the Medicaid program by claiming to provide services that he did not provide and by billing Medicaid for psychotherapist and psychiatric services that he was not qualified to provide. FFCL's 4 - 7.

14. The financial loss to the Medicaid program resulting from Petitioner's criminal misconduct amounted to at least $123,500, and significant amount of money. FFCL 4.

15. Petitioner's criminal activities occurred over the period between February 1, 1984, and June 23, 1986, more than two years, a lengthy period of time. I.G. Exs. 2/2; 3/16; P. Br. 3.

16. Petitioner has demonstrated a pattern of initiating and submitting false, fraudulent and inaccurate claims. Such actions are harmful to the Medicaid program and show a high degree of culpability. FFCL 15.

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

18. The eight year exclusion imposed and directed by the I.G. is reasonable.

DISCUSSION

I. The regulations published on January 29, 1992, are not applicable to this case.

On January 29, 1992, new federal regulations applicable to exclusion cases were published at 57 Fed. Reg. 3298 et seq. The I.G. argues that the new regulations have merely codified the existing statutory and case law as applicable to a mandatory minimum five year exclusion under section 1128(a)(1). I.G. Br. at 18. While the new regulations do not seem to change the factors for me to consider in an 1128(a)(1) exclusion -- i.e., whether Petitioner's conviction was program related and whether an eight year exclusion is reasonable -- I nonetheless find that the new regulations are not applicable to this case.

For me to apply the new regulations to this case in midstream, absent specific and uncontroverted guidance to do so, would constitute a violation of Petitioner's due process rights. Also, because application of the new regulations to this case would result in derogation of section 205(b) of the Act, which guarantees Petitioner a de novo hearing, and would conflict with relevant DAB precedent, I find that the January 29, 1992, regulations do not apply to my review of the reasonableness of the exclusion imposed and directed against Petitioner. 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. Bruce G.

Livingston, D.O., DAB CR202 (1992); Charles J. Barranco, M.D., DAB CR187 (1992); Syed Hussaini, DAB CR193 (1992); Steven Herlich, DAB CR197 (1992); Stephen J. Willig, DAB CR192 (1992); Sukumar Roy, M.D., DAB CR205 (1992); Aloysius Murcko, M.D., DAB CR189 (1992); Narinder Saini, M.D., DAB CR217 (1992). Even if the Part 1001 regulations do govern such hearings, an appellate panel of the DAB recently held they do not apply in cases involving exclusion determinations made prior to the regulations' publication date. Behrooz Bassim, M.D., DAB 1333 at 5 - 9 (1992).

II. Petitioner is subjected to a minimum five year exclusion because he was convicted of a criminal offense related to the delivery of a item or service under Medicare, within the meaning of section 1128(a)(1) of the Act.

A. Petitioner was "convicted" of an offense within the meaning of section 1128(i).

An individual or entity is considered to have been "convicted" of a criminal offense when a plea of guilty or nolo contendere by the individual or entity has been accepted by a Federal, State, or local court. Section 1128(i)(3). Petitioner has admitted, and the evidence verifies, that he pled guilty to three separate offenses. FFCL 4. Petitioner pled guilty to grand larceny in the third degree and to two separate counts of offering a false instrument for filing. The court accepted Petitioner's guilty plea and judgment was entered. Petitioner was therefore "convicted" of a criminal offense within the meaning of section 1128(i).[3]

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[3] There is a discrepancy in the documents submitted by the I.G. I.G. Ex. 3/13 - 21 indicates that Petitioner pled guilty to count one of the indictment (grand larceny in the third degree in the amount of $118,600) and also pled guilty to counts 16 and 17. At the plea proceedings, the court specifically stated that Petitioner was to make $123,500 in restitution based on the sum total of his wrongful billings from counts one and two of the indictment -- the two grand larceny counts of $118,600 and $4,900, respectively. I.G. Ex. 3/5, 17. (The court misspoke when it indicated at I.G. Ex. 3/17 that the amount for count one was $118,000, because the indictment says $118,600, and the restitution amounts would not add up correctly otherwise. I.G. Ex. 2/2.) The sentencing document is at odds with I.G. Ex. 3,

(continued...)

B. Petitioner's conviction is "related to" the Medicaid program within the meaning of section 1128(a)(1) of the Act.

Petitioner has admitted, and evidence verifies, that he was convicted of a criminal offense "related to" the delivery of an item or service under the Medicaid program within the meaning of section 1128(a)(1) of the Act. Under section 1128(a)(1), it makes no difference that the criminal offenses for which Petitioner was convicted were against Medicaid rather than Medicare. Section 1128(a)(1) applies equally to criminal offenses related to the delivery of an item or service under either program. David D. DeFries, DAB CR156 (1991).[4]

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[3](...continued)
because it states that Petitioner pled guilty to count two of the indictment (grand larceny in the third degree in the amount of $4,900) and to counts 16 and 17. I.G. Ex. 6/1.

However, the discrepancy does not affect my analysis of this case, because while the exhibits are unclear as to which grand larceny count Petitioner actually pled guilty to, it is apparent that Petitioner did plead guilty to one count of grand larceny in the third degree. While Petitioner was convicted on only one of the grand larceny counts, it is apparent that the court ordered restitution based on the amount of the wrongful billings submitted by Petitioner to the Medicaid program. The court found that amount to be $123,500, which is the sum of both of the grand larceny counts. I.G. Exs. 3/19; 5; 6.

[4] Specifically, Petitioner pled guilty to counts 1, 16, and 17 of the Indictment. Count one was the third degree larceny count, in which Petitioner was charged with submitting New York State Medical Assistance (Title XIX) Program Practitioner Claim forms to the State of New York, when Petitioner knew these forms contained false representations that psychiatric treatment had been rendered to Medicaid recipients by him as a specialist in psychiatry. In submitting these forms, Petitioner intentionally caused the State of New York to pay him approximately $118,600 to which he was not entitled. Count 16 (offering a false instrument for filing) alleges that Petitioner submitted a New York State Medical Assistance (Title XIX) Program form, knowing that form contained false representations that psychiatric treatment had been rendered to a Medicaid recipient by him as a specialist in psychiatry. Count 17 (offering a
(continued...)

C. Petitioner is subject to the provisions of section 1128(c)(3)(B) of the Act.

Petitioner's conviction falls within the provisions of section 1128(a)(1) of the Act. Section 1128(c)(3)(B) of the Act provides that, in the case of individuals against whom a mandatory exclusion is imposed, the minimum length of such an exclusion shall be five years. Petitioner was properly excluded by the I.G. for the minimum mandatory five year period. Neither the I.G. nor the ALJ has discretion to reduce the mandatory minimum five year period of exclusion. Charles W. Wheeler and Joan K. Todd, DAB 1123 (1990); John Strausbaugh, DAB CR186 (1992).

III. Eight years is a reasonable period of exclusion to be imposed and directed against Petitioner.

There is no dispute that Petitioner is subject to the mandatory minimum exclusion of five years. Petitioner pled guilty to three separate criminal counts. Count one was third degree larceny, as to which Petitioner admitted that, from February 1984 through June of 1986, he submitted bills in excess of $118,600 to the New York State Medicaid program for psychiatric and psychotherapy services he claimed to have provided, and did so with the knowledge that he was not eligible to be reimbursed as a psychiatrist or psychologist. I.G. Ex. 3/15-17. In pleading guilty to count 16, Petitioner admitted that he submitted a claim for reimbursement to the Medicaid program in which he claimed to have provided psychotherapy to a Medicaid recipient when he provided no such services to the recipient. I.G. Ex. 3/14-18. In pleading guilty to count 17, Petitioner admitted to submitting a claim for reimbursement to Medicaid for a breathing test and examination in the amount of $4,900 when, in fact, he performed no such test or exam. I.G. Ex. 3/17-18.

Since the minimum mandatory exclusion of five years is applicable to Petitioner, the issue before me 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 remedial purposes

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[4](...continued)
false instrument for filing) alleges that Petitioner submitted Medicaid claim forms which falsely stated that he provided medical treatment to a certain Medicaid patient, when in truth and in fact, as the Petitioner well knew, no such medical treatment had been provided.

of the Act. Lakshmi N. Murty Achalla, M.D., DAB 1231 (1991); Joel Davids, DAB 1283 (1991); Robert Matesic, R.Ph., d/b/a Northway Pharmacy, DAB 1327 (1992).

Congress enacted the exclusion law to protect the integrity of federally funded health care programs. Among other things, the law is designed to protect program beneficiaries and recipients from individuals who have demonstrated by their behavior that they threaten the integrity of federally funded health care programs or that they could not be entrusted with the well-being and safety of beneficiaries and recipients. S. Rep. No. 109, 100th Cong., 1st Sess., reprinted in 1987 U.S.C.C.A.N. 682.

An exclusion imposed and directed pursuant to section 1128 of the Act advances this remedial purpose. The principal purpose is to protect programs and their beneficiaries and recipients from untrustworthy providers until the providers demonstrate they can be trusted to deal with program funds and to properly serve beneficiaries and recipients. As an ancillary benefit, the exclusion deters other providers of items or services from engaging in conduct which threatens the integrity of the programs or the will-being and safety of beneficiaries and recipients. H. R. Rep. No. 393, Part II, 95th Cong. 1st Sess., reprinted in 1977 U.S.C.C.A.N. 3072.

My purpose in hearing and deciding the issue of whether an exclusion is reasonable is not to second guess the I.G., but to decide whether the length of the exclusion imposed by the I.G. was extreme or excessive. 48 Fed. Reg. 3744 (1983); Abelard A. Pelaez, M.D., DAB CR157 at 14 - 15 (1991); Barranco at 29 - 30.

An appellate panel in The Hanlester Network, et al., DAB 1347 (1992) set forth with approval criteria previously developed by DAB ALJ's in their determinations of evaluating trustworthiness:

> - the circumstances of the misconduct and the seriousness of the offense, in particular the commission of misconduct in the nature of a program-related crime, see [The Hanlester Network, et al,] DAB 1275, at 52 [(1991)];
>
> - "the degree to which a [Petitioner] is willing to place the programs in jeopardy," even if no actual harm is accomplished, id. at 52; [footnote omitted]

- the failure to admit misconduct, or express remorse, or evidence rehabilitations, see e.g., Olufemi Okonuren, M.D., DAB 1319, at 13 (1992); Robert Matesic R.Ph. d/b/a Northway Pharmacy, DAB 1327, at 12 (1992); and

- the "likelihood that the offense or some similar abuse will occur again," see e.g., Matesic, at 8.

Hanlester DAB 1347 at 46 - 47.

In applying these factors to determine 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. I have evaluated and applied the totality of the circumstances with regard to Petitioner and have reached the following conclusions regarding his trustworthiness to be a program provider.

Despite the fact that he was not a licensed psychotherapist or psychiatrist, Petitioner submitted claims for reimbursement in excess of $118,600 in which he claimed to have provided psychotherapy to a Medicaid recipient. Petitioner also submitted a claim for reimbursement in the amount of $4,900 to Medicaid for a breathing test and examination that he did not, in fact, perform. Petitioner's criminal conduct in willfully and knowingly submitting fraudulent claims for services that he did not and could not provide is serious, involved a substantial amount of money, and occurred over a significant period of time.

Petitioner contends that the I.G. has mischaracterized his criminal convictions in stating that the sum of $123,500 is the result of false and fictitious billing. P. Br. 3. Petitioner contends that the billing was improper because he was not properly qualified to render or bill for the treatment administered. P. Br. 3. However, Petitioner's argument misses the point. Petitioner has admitted that he was not qualified to bill for psychotherapy services and that, knowing this, he submitted bills to the Medicaid program for such services. FFCL's 2, 5, 6; I.G. Ex. 3. Petitioner has also admitted that he submitted a claim for reimbursement for a breathing test that he did not administer. FFCL 7; I.G. Ex. 3. Whether Petitioner chooses to call these acts false, fraudulent, or improper is irrelevant. The facts indicate that he deliberately submitted claims to

the Medicaid program for reimbursement, while knowing that he was not entitled to reimbursement for those claims.

In submitting claims for reimbursement to the Medicaid program, Petitioner implicitly represented that he had provided the services for which he sought reimbursement and that he was properly qualified to provide such services. That Petitioner represented that he was a qualified and licensed psychotherapist is a deliberate, willful, and knowing fraud perpetrated upon the Medicaid program. It is of particular significance that Petitioner repeated this type of calculated, willful misrepresentation when he submitted a claim for reimbursement in the amount of $4,900 for a breathing test which he did not provide.

Deliberate misconduct, the ultimate goal of which is to unlawfully take money from the Medicaid program, is indicative of a lack of trustworthiness. Petitioner's convictions show that he perpetrated willful and deliberate fraud and misconduct upon the Medicaid program. Such actions are indicative of a lack of trustworthiness. Petitioner has also shown his lack of trustworthiness by his willingness to place the integrity and efficient operation of the Medicaid program in jeopardy for an extended period of time for his own personal gain. Specifically, Petitioner's deliberate and willful infliction of damage to the Medicaid program occurred over a period of more than two years -- from February 1, 1984, to June 23, 1986 -- and is another indication of a lack of trustworthiness.[5]

The failure to admit misconduct, or express remorse, or evidence rehabilitation, has a bearing on the trustworthiness of a petitioner. Petitioner has admitted that he wrongfully billed his services to the Medicaid program. P. Br. 1. Petitioner has also offered as an exhibit, a certificate of relief from civil disabilities. P. Ex. 1. Petitioner argues that the fact that the State court saw fit to grant such a certificate is evidence of his trustworthiness and rehabilitation.

However, my reading of this certificate is that it is of little probative value in determining the trustworthiness of Petitioner, because the certificate is merely a device

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[5] In determining that Petitioner's unlawful conduct occurred over a period of more than two years, I use the more conservative estimate of the time Petitioner engaged in culpable conduct. P. Br. 4.

used by the State court to allow Petitioner to continue to practice medicine in order to meet the restitution payments imposed by the court. The State court saw fit to grant such a certificate as being consistent with Petitioner's rehabilitation and the public interest. However, it is not probative for my purposes because, in granting the certificate, the State court made no specific findings regarding Petitioner's trustworthiness or rehabilitation.

I have no basis from which I can conclude that Petitioner is not sincerely remorseful for his actions. However, I also have not had the opportunity to view Petitioner in an in-person hearing. Additionally, there is no evidence before me from which I can conclude that Petitioner has rehabilitated himself, or sought the appropriate help to do so. In the absence of such evidence and in the face of evidence showing that Petitioner committed deliberate fraudulent acts against the Medicare program for over a two year period, I conclude that Petitioner is not trustworthy.

The likelihood that the offense or similar abuse will occur again is a factor having a bearing on trustworthiness. On this issue the record is again sparse. Petitioner persisted in his criminal behavior for over two years. Petitioner has not made any proffer that these offenses will not happen again. Petitioner has indicated that he is currently a licensed doctor practicing medicine in New Jersey. P. Br. 2. Petitioner has pointed to no safeguards in his current practice which would protect the program from the type of deliberate fraud perpetrated by him in the past. In view of Petitioner's continued ability to practice medicine, and his past record of persistent and egregious fraud, I conclude there is some potential likelihood that the offense or a similar abuse will recur. I find that this is further evidence that Petitioner is not trustworthy.

Petitioner's unlawful actions show that he is an individual who is capable of engaging in false and fraudulent actions. Petitioner's actions also show his disregard for the financial integrity of the Medicaid program and his willingness to subject the program to financial loss for his personal financial gain. Petitioner has shown a propensity to perpetrate his schemes over a substantial period of time and has not shown that he has been rehabilitated in such a way as to not be a program risk. A lengthy exclusion is necessary in this case to provide Petitioner with the opportunity to prove that he is once again worthy to be trusted as a program provider. Based on Petitioner's past criminal

activities and the dearth of evidence showing that he is no longer a risk to the program, I conclude that the eight year exclusion directed and imposed against Petitioner is neither "extreme nor excessive" and therefore should not be reduced.

CONCLUSION

The I.G. properly excluded Petitioner. In this case, an exclusion of eight years is reasonable to protect the integrity of the Medicare and Medicaid programs.

/s/

Charles E. Stratton
Administrative Law Judge