Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	
Henry T. Pimentel, M.D.,	DATE: October 16, 1992
Petitioner,	Docket No. C-435
- v. -	Decision No. CR235
The Inspector General.	

DECISION

This case is governed by section 1128 of the Social Security Act (Act). By letter dated June 7, 1991 (Notice), the Inspector General (I.G.) notified Petitioner that he was being excluded from participation in Medicare and all federally funded State health care programs for a period of seven years.1/ The I.G. informed Petitioner 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 (42 U.S.C. § 1320a-7).

Petitioner timely requested a hearing before an Administrative Law Judge (ALJ), and the case was assigned to ALJ Joseph K. Riotto. The case was reassigned to me on November 26, 1991. On May 13, 1992, I held an in-person evidentiary hearing in Chicago, Illinois.2/ The parties submitted posthearing briefs.

1/ "State health care program" is defined by section 1128(h) of the Act to include three types of federally assisted programs, including State plans approved under Title XIX of the Act (Medicaid). I use the term "Medicaid" in this decision to represent all State health care programs from which Petitioner was excluded.

2/ By letter dated June 18, 1992, the I.G. noted several errors and omissions in the hearing transcript. As Petitioner has not objected, I shall consider the transcript record with the I.G.'s proposed amendments.

I have considered the evidence of record, the parties' arguments, and the applicable law. I conclude that the I.G. had authority to exclude Petitioner, and that the seven-year exclusion imposed and directed by the I.G. is appropriate and reasonable under the circumstances. Therefore, I sustain the exclusion.

BACKGROUND

At the time of the criminal actions in question, Petitioner was a physician licensed in the State of Illinois and was a corporate officer of, and working at, the Reymar Clinic Health Care, Inc. (Reymar Clinic) in Chicago. Based upon an investigation by the Medicaid Fraud Control Unit for the State of Illinois, it was determined that from June 1985 until April 1988, Petitioner permitted Oscar Hosenilla to work as a "physician" at the Reymar Clinic seeing and treating patients, ordering tests, and prescribing medications. Petitioner was aware that, during this period, Mr. Hosenilla was not licensed by the State of Illinois to practice medicine.3/ Petitioner submitted claims, under his own Medicaid provider number, to the Illinois Department of Public Aid (IDPA) for the medical services and items provided by Mr. Hosenilla. An audit identified approximately $40,000 in "false bills." The investigation led to Petitioner's indictment, and he subsequently pled guilty to the class one felony of vendor fraud. After the conviction, Petitioner's license to practice medicine in Illinois was suspended for a period of years, and the I.G. determined to exclude Petitioner for seven years.4/

3/ The parties have argued extensively over whether to address Oscar Hosenilla as "Dr." Petitioner argues that he should be addressed as such because he holds a degree in medicine from the Philippines. As Petitioner has introduced no evidence to support this claim, I have no basis to make a determination on Mr. Hosenilla's status as a medical practitioner.

4/ On April 15, 1991, the Illinois Department of Professional Regulations suspended Petitioner's medical license for a period of years. Stip. 8; Tr. 63. The I.G.'s Brief at 7 states that the suspension period is two years, but Stipulation 8 refers only to "a period of years."

ADMISSIONS

Petitioner admits that he was "convicted" of a crime "related to" the delivery of an item or service under the Medicaid program, within the meaning of section 1128(a). Petitioner argues, however, that he should be excluded for only the minimum five -- not seven -- years. Tr. 4-6.

ISSUES

The remaining issues are:

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

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

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):5/ 6/

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

5/ The documentary record of this case will be cited as follows:

I.G.'s Exhibits	I.G. Ex. (number/page)
Petitioner's Exhibits	P. Ex. (number/page)
I.G.'s Posthearing Brief	I.G. Br. at (page)
Petitioner's Posthearing Brief	P. Br. at (page)
Transcript	Tr. (page)
Stipulations	Stip.

6/ 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.

2. This proceeding is governed by section 1128(a)(1) of the Act.

3. The regulations concerning mandatory exclusion proceedings brought under section 1128(a)(1) of the Act (to be codified at 42 C.F.R. Part 1001, promulgated at 57 Fed. Reg. 3298 et seq. (January 29, 1992)) were not intended to apply retroactively to proceedings which began before the regulations were promulgated.

4. Section 1128(c)(3)(B) of the Act authorizes the Secretary to impose a mandatory five-year exclusion against any person who is "convicted" of a criminal offense "related to the delivery of a health care item or service" within the meaning of section 1128(a)(1).

5. Petitioner, Henry T. Pimentel, M.D., was licensed by the State of Illinois to practice medicine between March 29, 1968, and April 15, 1991; between June 1985 and April 1988, Petitioner practiced medicine at Reymar Clinic. Stips. 1 and 7.

6. On May 11, 1990, Petitioner pled guilty in the Circuit Court of Cook County, Illinois, to the offense of vendor fraud, a class one felony, for willfully and fraudulently obtaining Medicaid benefits for the delivery of medical items and services purportedly delivered or ordered by a licensed physician when, in fact, those items and services had not been ordered or delivered by a licensed physician. Stips. 5 and 6; Tr. 31; I.G. Exs. 1 and 2/5-6.

7. Petitioner was sentenced to 24 months' probation and ordered to pay $40,000 restitution to IDPA and to forfeit $20,000 to the Medicaid Fraud and Abuse Prevention Fund. Petitioner still owes approximately $15,000 of the $40,000. Stip. 6; Tr. 32-33; I.G. Exs. 4 and 5.

8. Petitioner admitted that he was convicted of a criminal offense within the meaning of section 1128(a)(1) of the Act. Tr. 4-6.

9. 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 provision of sections 1128(a)(1) and 1128(c)(3)(B) of the Act.

10. 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.

11. The serious nature of Petitioner's conviction is reflected in the fact that the conviction was for a class one felony which involved the defrauding of the Medicaid program for a period of several years and for many thousands of dollars.

12. Petitioner endangered the health and safety of his patients at the Reymar Clinic by allowing an unlicensed individual to treat them.

13. Petitioner has not demonstrated that he understands the seriousness of his crime as it relates to the health and safety of his patients and the integrity of the Medicaid program.

14. Petitioner's fraudulent acts are harmful to the Medicaid program and show a high degree of culpability.

15. Petitioner has not presented any mitigating circumstances which would establish his trustworthiness or temper the necessity for a seven-year exclusion.

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

17. The seven-year exclusion imposed and directed by the I.G. is reasonable.

DISCUSSION

I. The I.G. Had The Authority To Exclude Petitioner Pursuant To Sections 1128(a)(1) And 1128(c)(3)(B) Of The Act.

A. Petitioner Was "Convicted" Of A Criminal Offense "Related To" The Medicaid Program.

Section 1128(a)(1) of the Act mandates the exclusion of individuals who have been "convicted" of a criminal offense "related to the delivery of an item or service" under the Medicare or Medicaid programs. Petitioner does not contest that he was convicted of a criminal offense within the meaning of section 1128(a)(1). Tr. 5-6. He was indicted by a grand jury in Cook County, Illinois for the criminal offenses of vendor theft and fraud. Stip. 3; I.G. Ex. 1. On May 11, 1990, Petitioner pled guilty to vendor fraud, a class one felony. Stip. 4.

Petitioner's crime involved the willful and fraudulent obtaining of Medicaid benefits and the taking of payments from the IDPA, between June 1985 and April 1988, for the delivery of items or services purportedly delivered or ordered by Petitioner, a licensed physician when, in fact, those items and services had been ordered or delivered by Mr. Hosenilla, an unlicensed individual.7/

The Court sentenced Petitioner to 24 months' probation and ordered him to pay $40,000 restitution to the IDPA and to forfeit $20,000 to the Medicaid Fraud and Abuse Prevention Fund. Tr. 32-33; I.G. Exs. 4-6. As of May 13, 1992 (the date of the hearing), Petitioner still owed to IDAPA approximately $15,000 of the $40,000 restitution. Tr. 33.

Therefore, based on the evidence and Petitioner's admissions, I find that this was a program-related conviction under section 1128(a)(1) of the Act.

B. The I.G. Was Required To Exclude Petitioner For A Minimum Period Of Five Years.

I have found that 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. Thus, the I.G. has authority to impose and direct an exclusion against Petitioner pursuant to sections 1128(a)(1) and 1128(c)(3)(B) of the Act. Under these circumstances, the statute mandates that the I.G. exclude Petitioner for a minimum period of five years.

7/ Petitioner, as corporate officer or registered agent, pled guilty on behalf of several corporations that also were indicted on the charge of vendor fraud: Reymar Clinic; Reymar Clinic Pharmacy, Inc.; Reymar Clinic X-Ray, Inc.; and Englewood Clinical Laboratory, Inc. The corporations were convicted and sentenced to a period of conditional discharge for 24 months. Tr. 29; I.G. Exs. 2/5-6, 8, 9, and 10. Mr. Hosenilla was indicted for practicing medicine without a license and holding himself out as a physician. I.G. Ex. 1/4-7. Based on Mr. Hosenilla's cooperation in the investigation, he was permitted to plead to the class four felony of holding himself out as a physician, and the court sentenced him to two years' probation. I.G. Ex. 7.

II. The Substantive Portions Of The Regulations Published On January 29, 1992, Are Not Applicable To This Case And Do Not Establish Criteria Which Govern My Decision On The Reasonableness Of The Length Of The Exclusion.

On January 29, 1992, the Secretary published new regulations which effect both procedural and substantive changes with respect to exclusion cases. 42 C.F.R. Parts 1001-1007; 57 Fed. Reg. 3298 et seq. (new regulations). Before the hearing, I permitted the parties to brief the issue of whether the new regulations should apply to this proceeding. The I.G. argued that the new regulations should apply because they were effective upon publication. Petitioner argued that the relevant regulations on the length of the exclusion do not limit an ALJ's authority to review cases, and it would be unfair to apply the new regulations as the Notice was filed before they were published.

At a prehearing conference on May 1, 1992, I ruled that the procedural aspects of the new regulations and the substantive aspects of the former regulations, 42 C.F.R. Part 1001 (1991), would apply to this case. The I.G. has renewed his objection to this ruling. I reaffirm the above ruling. Also, I conclude that my review of the reasonableness of the length of the exclusion is not governed by the new regulations' criteria for the I.G.'s determination of that matter. I find that 42 C.F.R. § 1001.102 of the new regulations was not intended by the Secretary to govern de novo hearings as to the reasonableness of the I.G.'s exclusion determinations. See Anthony W. Underhill, DAB CR231 at 12-13 (1992).

Even if the Part 1001 regulations were to govern these hearings, an appellate panel of the Departmental Appeals Board (DAB) recently found that they do not apply retroactively in cases such as this one where the exclusion determination was made prior to the regulations' publication date. Behrooz Bassim, M.D., DAB 1333 at 5-9 (1992) (retroactive application would deprive petitioner of due process). The I.G. relied on the former regulations at 42 C.F.R. § 1001.125(b) (1991) to determine the length of Petitioner's exclusion. I find that the application of the new regulations, and, in particular, the application of 42 C.F.R. § 1001.102, to this proceeding would materially alter Petitioner's substantive rights.

III. A Seven-Year Exclusion Is Appropriate And Reasonable.

A. Several Factors Are Relevant To Determining Trustworthiness.

Since the parties agree that 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 seven years -- rather than the minimum five years. Since this is a de novo hearing, I may consider whether the I.G.'s exclusion period, which is in excess of the five years' minimum, is reasonable and either increase it or decrease if I find it to be unreasonable. See Section 205(b)(11) of the Act.

The exclusion laws are civil statutes and designed to protect government financed health care programs from fraud and abuse by providers. Thus, resolution of the reasonableness of Petitioner's seven-year exclusion depends on an analysis of the evidence of record in light of the remedial purposes of the Act. Arthur V. Brown, M.D., DAB CR252 at 9 (1992). 8/

Also, the regulations at 42 C.F.R. § 1001.125(b) (1991), set forth criteria which the I.G. was required to consider in setting the length of Petitioner's exclusion. As discussed in part II of this decision, I may refer to these criteria -- but am not required to do so -- in determining the reasonableness of the length of the exclusion. These factors include: 1) the number and nature of the program violations and other related offenses; 2) the nature and extent of any adverse impact the violations have had on beneficiaries; 3) the amount of the damages incurred by the Medicaid program; 4) whether there are any mitigating circumstances; 5) the length of the sentence imposed by the court; 6) any other facts bearing on the nature and seriousness of the program violations; and 7) the previous sanction record of the excluded party under the Medicare or Medicaid

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8/ 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 the programs or that they can not be entrusted with the well-being and safety of beneficiaries and recipients. See S. Rep. No. 109, 100th Cong., 1st Sess., reprinted in 1987 U.S.C.C.A.N. 682.

program. The I.G. must consider any mitigating circumstances and balance them against other factors bearing on the nature and seriousness of the program violations. John Crawford, Jr., M.D., DAB 1324 at 8 (1992). These factors may be used by me as general guidance as to the type of evidence that may be relevant to determining a person's trustworthiness to be a health care provider. See, e.g., Eric Kranz, M.D., DAB 1286 at 11 (1991); Chandor Kachoria, R.Ph., DAB CR220 at 13 (1992). Also, an appellate panel of the DAB, in adopting criteria previously outlined by ALJs in section 1128 cases, has provided a listing of some of the factors which should be considered:

> the nature of the offense committed by the provider, the circumstances surrounding the offense, whether and when the provider sought help to correct the behavior which led to the offense, how far the provider has come toward rehabilitation, and any other factors relating to the provider's character and trustworthiness.

Robert Matesic, R.Ph., d/b/a Northway Pharmacy, DAB 1327 at 12 (1992).

B. The Evidence Of Untrustworthiness In This Case Supports The Seven-Year Exclusion.

I find Petitioner's violations to be serious. His fraudulent behavior lasted almost three years, from June 1985 until April 1988. Tr. 41, 44-45, 51; I.G. Ex. 1/2. Mr. Hosenilla identified approximately $40,000 in Medicaid monies which were paid as a result of his practicing medicine in place of Petitioner.9/ Tr. 28-29; I.G. Ex. 1/2. As a result of these actions, Petitioner was convicted of a class one felony which requires a showing of "willful" misconduct. Tr. 31; I.G. Exs. 1/2, 2/5-6. Petitioner could have received a sentence for this crime of four to fifteen years incarceration and a $10,000 fine. His sentence of 24 months' probation and payment of a total of $60,000.00 was substantial. The evidence also establishes that

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9/ Mr. Donald G. Schweihs, special assistant attorney general for the Illinois State Police Medicaid Fraud Control Unit, testified that, based on handwriting on the records, he believed that Mr. Hosenilla did not identify every service date and patient that he, Mr. Hosenilla, saw. Therefore, Mr. Schweihs thought that the actual amount of false billings was greater. Tr. 42, 50.

Petitioner's conduct was motivated by considerations of unlawful and personal gain.10/

I also find that Petitioner's violations had an adverse impact on program beneficiaries and recipients. Petitioner knowingly permitted Mr. Hosenilla, an unlicensed individual, to evaluate and treat patients without supervision. In addition, he permitted Mr. Hosenilla to order x-ray, blood, and urine tests for patients. Tr. 21-22; I.G. Exs. 13/2-3 and 15-16. Petitioner not only gave Mr. Hosenilla presigned blank lab request and prescription forms but later instructed him on how to sign Petitioner's initials on prescriptions, patient charts, and medical forms.11/

Petitioner argues that, based on his proffered mitigating circumstances, I should reduce the exclusion from seven to five years. He states that there was no intent to defraud the Illinois Medicaid program, and that although Mr. Hosenilla is not licensed in Illinois, he is a real doctor. He asserts that Mr. Hosenilla was initially hired only as a technician for another clinic, and Medicaid was not billed for those services. Tr. 39-41, 96. It is Petitioner's position that he allowed Mr. Hosenilla only later to see patients because the latter told him he wanted patient contact and clinical experience. Tr. 40, 98. Petitioner further argues that Mr. Hosenilla was permitted only to treat minor ailments such as headaches and colds, and Mr. Hosenilla only saw one to six patients a day, for which Medicaid paid about $20.50 per patient visit.12/ Tr. 41, 46, 98, 102, 114.

I find Petitioner's argument that there was no attempt to defraud Medicaid to be specious and to undercut his

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10/ In contrast to Petitioner receiving approximately $40,000.00 from Medicaid for items and services provided by Mr. Hosenilla, Mr. Hosenilla stated that he worked about 34 hours a week and was paid a net amount of $397.00 every two weeks. I.G. Ex. 13/2-3.

11/ The evidence indicates that Petitioner permitted Mr. Hosenilla to use Petitioner's DEA number (a number assigned to physicians for their individual use in prescribing controlled substances). Tr. 60-61.

12/ Mr. Hosenilla told investigators that he treated 10-20 Medicaid patients per day. I.G. Ex. 13/2-3. The I.G. witness noted that Medicaid paid about $12.65 per patient visit during the period at issue. Tr. 54.

assertions that he is trustworthy. This argument demonstrates only Petitioner's poor judgment. In an analogous case, James D. Payne, D.O., DAB CR142 at 9 (1991), a ten-year exclusion was found reasonable, in part, because petitioner allowed untrained individuals to treat patients. Petitioner was well aware that he could not bill for the unsupervised services of an unlicensed physician. Whether Mr. Hosenilla is licensed in the Philippines or anywhere else is not the question. He is not licensed in Illinois. Tr. 20. Moreover, the only evidence of Mr. Hosenilla's medical background is Petitioner's testimony that he was told that Mr. Hosenilla was a doctor in the Philippines, had been a ship doctor, and had passed the FLEX test.13/ Tr. 96.

Equally specious is Petitioner's argument regarding the extent of Mr. Hosenilla's services. Again, were it relevant, there is no evidence, other than Petitioner's testimony, to support this. Further, there is no way to determine whether a patient's ailment is minor before examining him or her. As the I.G. notes, "colds" and "headaches" may be symptoms of far more serious problems. The evidence shows that Mr. Hosenilla treated a special investigator once for an ear ache and once for pain in the right hand. Also, Mr. Hosenilla told investigators that when he wanted to hospitalize a patient, Petitioner would arrange it without examining the patient. I.G. Ex. 13/3. Finally, regardless of the amount paid by Medicaid for each patient ($20.50 as claimed by Petitioner or $12.65 as noted by an I.G. witness), Petitioner's documented "false" billings totalled approximately $40,000. Tr. 28; I.G. Ex. 1/2.

Also, Petitioner offered as mitigating circumstances his acknowledgement of his mistake, the benefit to the community of an early reinstatement, and his knowledge and reputation as a physician. Petitioner argues that he did not have the motivation to defraud and feels remorse for his actions. He contends that his clinic provides medical services in an area in which the availability of other medical services is extremely limited. He states that the clinic is in a poor area with a high crime rate and that approximately 90 percent of the clients there are public aid patients. P. Br. at 8; Tr. 67, 94-95, 114. Petitioner maintains that the need for medical services is much greater than he can provide and that, because of the area, it has been difficult to hire

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13/ "FLEX" is the Federation Licensing Examination which is one of the prerequisites for obtaining a medical license in Illinois. I.G. Br. at 9.

additional doctors. Tr. 101-02, 114, 123. Without the services of Mr. Hosenilla, Petitioner claims that many of the patients of the clinic would have gone without medical services at all.14/ In further support, Petitioner has introduced evidence of his credentials as a surgeon, his attendance at numerous medical workshops and continuing medical education courses, and the testimony of Mr. James E. Malone, an x-ray technologist, who worked at the clinic. (See P. Exs. 1-27 for Petitioner's credentials and training and Tr. 75-91 for the testimony of Mr. Malone.)

Petitioner has introduced some evidence of the limited availability of medical services in the area surrounding his clinic. This is not a mitigating circumstance for fraud. Petitioner may not have been able to hire as many qualified doctors as needed, but this not an excuse for hiring and encouraging an unlicensed individual to treat and medicate Medicaid patients. Nor is it an excuse for billing Medicaid for those services and items. Medicaid patients are entitled to the care for which federally funded health care programs are designed.

I do not find Petitioner's extensive credentials and training to be mitigating factors. Inasmuch as they are neither related to the crime for which Petitioner was convicted nor to the services or items provided by someone else, they are not relevant. If anything, Petitioner's patients and the Medicaid program would have the right to expect more from a physician of Petitioner's training and experience.

The testimony of Petitioner's former x-ray technologist is not mitigating. Mr. Malone's statement that Petitioner ordered fewer x-rays than other doctors at the clinics has no relevance to this case. Further, Mr. Malone's testimony regarding Petitioner's good reputation among his patients is not probative of whether Petitioner is trustworthy.

In summary, I find that the I.G. has demonstrated that Petitioner is culpable and untrustworthy. Petitioner actively participated in, and profited from, his systematic and fraudulent behavior for almost three years. He knowingly and intentionally allowed Mr. Hosenilla to treat and medicate Petitioner's patients; he

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14/ Petitioner introduced some testimony regarding the closing of several hospitals and the limited remaining medical services in the area of the Reymar Clinic. Tr. 68, 78-80, 94, 99, 105.

gave Mr. Hosenilla presigned forms and taught him to sign Petitioner's name; and he filed the Medicaid forms using Petitioner's provider number for services and items provided by Mr. Hosenilla.

I find no probative evidence of remorse. In fact, the evidence shows that, although Petitioner is currently working as a surgeon for a Veteran's Administration hospital in Michigan, as of the hearing he had not paid $15,000 of the $40,000 restitution owed to IDPA. Tr. 32-33, 107, 126-27; P. Ex. 2/1. Petitioner's unlawful acts show that he is capable of engaging in fraudulent schemes for personal gain and that he has a propensity to commit offenses harmful to the financial integrity and operation of federally-funded health care programs. By using an unlicensed individual to act as a physician and billing for those services and items under Petitioner's name, Petitioner has undercut the public's perception of the honesty and integrity of federally financed health care program providers. A lengthy exclusion is needed to provide Petitioner with an opportunity to demonstrate that he can be trusted to be a program provider. In light of the record and the paucity of evidence minimizing the risk to the program, I am unable to conclude that the seven-year exclusion is extreme or excessive and should be reduced. I find the seven-year exclusion to be appropriate and reasonable.

CONCLUSION

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

/s/

Charles E. Stratton
Administrative Law Judge