Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	
Dr. John T. Renick,	
Petitioner,	DATE: April 22, 1994
- v. -	Docket No. C-93-091 Decision No. CR312
The Inspector General.	

DECISION

On May 12, 1993, the Inspector General (I.G.) notified Petitioner, John T. Renick, M.D., that he was excluded from participating in Medicare and State health care programs for three years.[1] The I.G. told Petitioner that he was being excluded under section 1128(b)(1) of the Social Security Act (Act), based on Petitioner's conviction of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with delivery of health care items or services or with respect to any act or omission in a program operated by or financed in whole or in part by any federal, State, or local government agency.

Petitioner requested a hearing, and the case was assigned to me for a hearing and decision. On December 3, 1993, I held a hearing in Panama City, Florida. The parties submitted post-hearing briefs, reply briefs, and proposed findings of fact and conclusions of law.

I have carefully considered the evidence that I admitted at the hearing, the parties' arguments, and the applicable law and regulations. I conclude that the I.G. had authority to exclude

---

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

Petitioner under section 1128(b)(1) of the Act.[2] I conclude further that regulations require that I sustain the three-year exclusion imposed and directed by the I.G. against Petitioner.

ISSUE

The issue in this case is whether regulations require that I sustain the three-year exclusion which the I.G. imposed and directed against Petitioner.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Petitioner is a psychiatrist. Tr. at 38.[3]

2. Since September 1990, Petitioner has practiced psychiatry in Panama City, Florida. Tr. at 38 - 39; I.G. Ex. 2.

3. Prior to practicing in Panama City, Florida, Petitioner practiced psychiatry in Mobile, Alabama. I.G. Ex. 2 at 1.

4. On July 24, 1992, Petitioner was convicted in United States District Court for the Southern District of Alabama of one count of criminal conspiracy and nine counts of mail fraud. I.G. Ex. 1 at 1.

5. The criminal offenses of which Petitioner was convicted involved fraudulent reimbursement claims made by Petitioner or at his direction to health insurance carriers. I.G. Ex. 1 at 1; I.G. Ex. 2 at 1 - 13.

6. Petitioner was convicted of criminal offenses relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of

---

[2] Petitioner has admitted that he was convicted of a criminal offense within the meaning of section 1128(b)(1) of the Act. Transcript at 8. There is no dispute as to the I.G.'s authority to exclude Petitioner under section 1128(b)(1).

[3] The following citations are used in this Decision:

Petitioner's Brief	P. Br. at (page)
I.G.'s Brief.	I.G. Br. at (page)
Petitioner's Reply Brief. . .	P. R. Br. at (page)
I.G.'s Reply Brief	I.G. R. Br. at (page)
I.G.'s Exhibit	I.G. Ex. (number) at (page)
Transcript	Tr. at (page)
My Findings of Fact and Conclusions of Law . . .	Finding(s) (number)

a health care item or service or with respect to acts or omissions in programs operated by or financed in whole or in part by any federal, State, or local government agency. Findings 4 - 5; Act, section 1128(b)(1); see Tr. at 8.

7. Petitioner concedes that he was convicted of criminal offenses relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care item or service or with respect to acts or omissions in programs operated by or financed in whole or in part by any federal, State, or local government agency. P. Br. at 2 and 3; Petitioner's request for hearing.

8. Petitioner concedes that his conviction is program-related, within the meaning of section 1128(b)(1). P. Br. at 2 and 3; Finding 7.

9. The Secretary of the United States Department of Health and Human Services (Secretary) delegated to the I.G. the authority to determine, impose, and direct exclusions pursuant to section 1128 of the Act. 48 Fed. Reg. 21,662 (1983).

10. The I.G. had authority to impose and direct an exclusion against Petitioner pursuant to section 1128(b)(1) of the Act. Findings 4 - 9.

11. On May 12, 1993, the I.G. excluded Petitioner from participating in Medicare and Medicaid for a period of three years. I.G.'s May 12, 1993 letter to Petitioner.

12. Regulations published on January 29, 1992 establish criteria to be employed by the I.G. in determining to impose and direct exclusions pursuant to sections 1128(a) and (b) of the Act. 42 C.F.R. Part 1001 (1992).

13. The regulations published on January 29, 1992 include criteria to be employed by the I.G. in determining to impose and direct exclusions pursuant to section 1128(b)(1) of the Act. 42 C.F.R. § 1001.201.

14. On January 22, 1993, the Secretary published a regulation which directs that the criteria to be employed by the I.G. in determining to impose and direct exclusions pursuant to sections 1128(a) and (b) of the Act are binding also upon administrative law judges, appellate panels of the Departmental Appeals Board, and federal courts in reviewing the imposition of exclusions by the I.G. 42 C.F.R. § 1001.1(b) (1993).

15. My adjudication of the length of the exclusion in this case is governed by the criteria contained in 42 C.F.R. § 1001.201.

16. An exclusion imposed pursuant to section 1128(b)(1) of the Act must be for a period of three years, unless aggravating or mitigating factors form a basis for lengthening or shortening the period of exclusion. 42 C.F.R. § 1001.201(b).

17. Aggravating factors which may form a basis for lengthening, beyond three years, the term of an exclusion imposed and directed by the I.G. pursuant to section 1128(b)(1) of the Act may consist of any of the following:

a. the acts that resulted in the conviction of an offense, within the meaning of section 1128(b)(1) or similar acts, resulted in loss of $1500 or more to a government program or to one or more other entities, or had a significant financial impact on program beneficiaries or other individuals;

b. the acts that resulted in the conviction of an offense, within the meaning of section 1128(b)(1), or similar acts were committed over a period of one year or more;

c. the acts that resulted in the conviction of an offense within the meaning of section 1128(b)(1) or similar acts had a significant adverse physical or mental impact on program beneficiaries or other individuals;

d. the sentence imposed by the court for the offense upon which the exclusion is based included incarceration; or

e. the excluded party has a prior criminal, civil, or administrative sanction record.

42 C.F.R. § 1001.201(b)(2)(i) - (v) (paraphrase).

18. Mitigating factors which may be a basis for decreasing, to less than three years, the term of an exclusion imposed and directed by the I.G. against an individual or entity pursuant to section 1128(b)(1) of the Act are limited to the following:

a. The excluded party was convicted of three or fewer misdemeanor offenses, and the entire amount of financial loss to a government program or to other individuals or entities due to the acts that resulted in the conviction and similar acts is less than $1500;

b. The record in the criminal proceeding involving the excluded party, including sentencing documents, demonstrates that the court determined that the excluded party had a mental, emotional, or physical condition, before or during the commission of the offense for which that party was convicted that reduced the party's culpability;

c. The excluded party's cooperation with federal or State officials resulted in others being convicted or excluded from Medicare or Medicaid, or the imposition of a civil money penalty against others; or

d. Alternative sources of the type of health care items or services furnished by the excluded party are not available.

42 C.F.R. § 1001.201(b)(3)(i) - (iv) (paraphrase).

19. The I.G. has the burden of proving that aggravating factors exist which justify increasing an exclusion imposed pursuant to section 1128(b)(1) of the Act beyond the three-year standard imposed by regulation. 42 C.F.R. § 1001.201(b)(2)(i) - (v); 42 C.F.R. § 1005.15(c).

20. The I.G. did not allege that any aggravating factors were present in this case.

21. Petitioner has the burden of proving that mitigating factors exist which justify decreasing, below the three-year standard established by regulation, an exclusion imposed pursuant to section 1128(b)(1) of the Act. 42 C.F.R. § 1001.201(b)(3)(i) - (iv); 42 C.F.R. § 1005.15(c).

22. Petitioner alleged that, as a result of his exclusion, alternative sources of the type of health care items or services that he furnishes are not available. P. Br. at 3.

23. Petitioner did not allege or prove that he treats any individuals who are Medicaid recipients. Tr. at 12 - 58.

24. Petitioner's areas of specialization include treatment of posttraumatic stress disorders, eating disorders, multiple personality disorders, and chronic pain conditions. Tr. at 41 - 43.

25. Petitioner did not allege nor did he prove that he treats any Medicare beneficiaries who suffer from eating disorders. Tr. at 12 - 58.

26. Petitioner did not allege nor did he prove that he treats any Medicare beneficiaries who suffer from multiple personality disorders. Tr. at 12 - 58.

27. Petitioner did not establish the number of Medicare beneficiaries he treats who suffer from posttraumatic stress disorders or chronic pain conditions. Tr. at 12 - 58.

28. One way for a petitioner to prove that alternative sources of health care are not available is to establish the residences of the Medicare beneficiaries and Medicaid recipients receiving

treatment from the petitioner, and then to show that the burden to these beneficiaries and recipients of travelling to another provider to receive analogous care would be so onerous as to deprive the beneficiaries and recipients of reasonable access to alternative sources of care. 42 C.F.R. § 1001.201(b)(3)(iv).

29. Petitioner did not establish the residences of those Medicare beneficiaries he treats who suffer from posttraumatic stress disorders or chronic pain conditions. Tr. at 12 - 58.

30. Petitioner is authorized to prescribe the drug Clozaril (described also in the record as "Clozapine"), which is used in treating the primary manifestations of schizophrenia. Tr. at 44 - 45.

31. Petitioner did not establish the number of Medicare beneficiaries to whom he prescribes Clozaril. Tr. at 12 - 58.

32. Petitioner did not establish the residences of those Medicare beneficiaries to whom he prescribes Clozaril. Tr. at 12 - 58.

33. Petitioner did not prove that, as a consequence of his exclusion, Medicare beneficiaries who need treatment for posttraumatic stress disorders, chronic pain, or who receive Clozaril for schizophrenia would be deprived of reasonable access to alternative sources of care for their conditions.

34. Petitioner did not establish that, as a consequence of his exclusion, Medicare beneficiaries or Medicaid recipients would be deprived of access to hospital care for mental conditions requiring hospitalization. Tr. at 12 - 58.

35. Petitioner did not prove that Medicare beneficiaries who he treats for the conditions which he specializes in treating do not have reasonable access to other psychiatrists who are qualified to treat such conditions. Tr. at 12 - 58.

36. Petitioner did not establish that, as a consequence of his exclusion, Medicare beneficiaries or Medicaid recipients would be deprived of reasonable access to the type of medical care which is provided by Petitioner. Findings 23 - 33.

37. Petitioner did not prove that, as a consequence of his exclusion, alternative sources of the type of health care items or services furnished by Petitioner are not available. Findings 34 - 36.

38. Petitioner did not prove the presence of any mitigating factors under 42 C.F.R. § 1001.201(b)(3)(i) - (iv). Finding 37.

39. Neither aggravating nor mitigating factors are present in this case.

40. The three-year exclusion which the I.G. imposed and directed against Petitioner is mandated by regulation.

RATIONALE

The only issue of material fact in this case is whether there exist mitigating factors which might establish that the three-year exclusion imposed and directed against Petitioner by the I.G. is unreasonable. I find that Petitioner failed to prove by a preponderance of the evidence that mitigating factors exist. Therefore, I am required to sustain the three-year exclusion.

This is a case in which the I.G. excluded Petitioner pursuant to section 1128(b)(1) of the Act. This section permits the Secretary to exclude parties who are convicted of criminal offenses relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct committed in connection with the delivery of a health care item or service or with respect to any act or omission in a program operated by or financed in whole or in part by any federal, State, or local government agency.

The undisputed evidence in this case is that Petitioner was convicted in United States District Court for the Southern District of Alabama of one count of conspiracy and nine counts of mail fraud based on fraudulent reimbursement claims for health care items or services which Petitioner presented or caused to be presented to health care insurers. Findings 4, 5. Petitioner concedes that he was convicted of offenses within the meaning of section 1128(b)(1). He does not question that the I.G. was authorized to exclude him. Findings 6 - 8. He asserts, however, that the length of the exclusion which the I.G. imposed and directed against him is unreasonable.

Departmental Appeals Board appellate panels and administrative law judges delegated to hear cases under section 1128 of the Act have held consistently that section 1128 is a remedial statute. Exclusions imposed pursuant to section 1128 have been found reasonable only insofar as they are consistent with the Act's remedial purpose, which is to protect program beneficiaries and recipients from providers who are not trustworthy to provide care. Robert M. Matesic, R.Ph., d/b/a Northway Pharmacy, DAB 1327, at 7 - 8 (1992). Prior to the publication of regulations which were made expressly applicable to adjudications of the length of exclusions, the trustworthiness standard was held to permit excluded parties to offer a full explication of evidence pertaining to their trustworthiness to provide care. That evidence included evidence which related to:

> 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.

Matesic, DAB 1327, at 12.

However, regulations published in 1992 and 1993 impose on adjudicators a standard for evaluating the length of exclusions which departs from the standard identified in Matesic. 42 C.F.R. Part 1001; Jose Ramon Castro, M.D., DAB CR259 (1993). In the case of most exclusions imposed under section 1128(b) of the Act, the regulations establish benchmark exclusion periods which may be increased only in the presence of aggravating factors or decreased only in the presence of mitigating factors. Only those factors which are identified by the regulations as aggravating or mitigating may be considered as a basis for increasing or decreasing the length of an exclusion imposed pursuant to one of the subsections of section 1128. A factor identified under Matesic as being relevant to the Act's remedial purpose is not germane under these regulations, unless it is a mitigating or an aggravating factor identified in the regulations. Castro, DAB CR259, at 15; Joseph Weintraub, M.D., DAB CR303, at 17 - 18 (1994).

This case involves an exclusion imposed pursuant to section 1128(b)(1) of the Act. The section of the regulations governing exclusions imposed pursuant to section 1128(b)(1) is 42 C.F.R. § 1001.201.

1. Petitioner alleges the mitigating factor of no alternative sources of health care.

The I.G. imposed an exclusion of three years, which is the benchmark exclusion under 42 C.F.R. § 1001.201 for exclusions imposed pursuant to section 1128(b)(1) of the Act. The I.G. did not identify any aggravating factors which would justify imposing an exclusion in excess of three years.

Petitioner alleges the presence of a mitigating factor. He asserts that alternative sources of the type of health care which he provides are not available. This is a mitigating factor under 42 C.F.R. § 1001.201(b)(3)(iv). If proven by Petitioner, it could be a basis for reducing the length of the exclusion imposed

and directed against him by the I.G.[4] Petitioner has not alleged the presence of other mitigating factors.

2. Petitioner has the burden of proving the existence of a mitigating factor by a preponderance of the evidence.

The regulations do not assign the burden of proving the presence or absence of a mitigating factor. I held in Castro that the petitioner in that case bore the burden of proving, by a preponderance of the evidence, the mitigating factor alleged by him, which was that alternative sources of the type of health care he provided were not available. Castro, DAB CR259, at 16 - 17. Similarly, Administrative Law Judge Steinman held in Weintraub that the petitioner in that case bore the burden of proving, by a preponderance of the evidence, that alternative sources of the type of health care he provided were not available. Weintraub, DAB CR303, at 19 - 20.

Although the regulations do not assign the burden of proving the presence or absence of a mitigating factor, the regulations plainly describe mitigating factors as affirmative defenses to the imposition of exclusions. This suggests strongly that the burden of proving the presence of mitigating factors should fall on the excluded provider. Furthermore, it makes no sense to require the I.G. to prove a negative proposition, i.e., the absence of a mitigating factor. Finally, administrative law judges have the authority under the regulations to assign burdens of proof in cases involving exclusions imposed pursuant to section 1128 of the Act. 42 C.F.R. § 1005.15(c). The regulations provide further that, in all cases, the evidentiary standard to be applied to decide whether a party has met a burden of proof is preponderance of the evidence. 42 C.F.R. § 1005.15(d).

---

[4] The presence of an aggravating factor in a case does not mean that an exclusion in excess of the benchmark must be imposed or that an exclusion in excess of the benchmark will be adjudicated to be reasonable. Similarly, the presence of a mitigating factor in a case does not mean that an exclusion of less than the benchmark must be imposed or that an exclusion of less than the benchmark will be adjudicated to be reasonable. The presence of aggravating or mitigating factors in a particular case allows the adjudicator to consider whether an exclusion of more or less than the benchmark is reasonable. The presence of such factors does not direct a finding that an exclusion of more or less than the benchmark must be reasonable. The adjudicator must still decide whether an exclusion of a particular length comports with the remedial purpose of the Act, and with the regulations. Weintraub, DAB CR303, at 39.

The issue to be resolved here is whether Petitioner has proved that alternative sources of health care will be unavailable as substitutes for the items or services he would have provided but for his exclusion. The burden of proving this issue rests entirely on Petitioner. Absent a credible showing by Petitioner that alternative sources of health care will be unavailable, the I.G. has no burden to rebut Petitioner's evidence by proving that alternative sources actually are available.

3. Petitioner must prove several predicate elements in order to meet his burden of proof.

In proving that alternative sources of health care are not available, Petitioner must prove certain predicate elements. Ultimately, he must prove that alternative sources of care of the type and quality which he provides are not reasonably available to Medicare beneficiaries and Medicaid recipients.

The regulations do not define what is meant by the terms "alternative sources" and "not available." Judge Steinman addressed the meaning of these terms in Weintraub and in James H. Holmes, M.D., DAB CR270 (1993). I find his analysis in these two decisions to be persuasive.[5]

In Holmes and Weintraub, Judge Steinman found that, in the absence of a definition, the terms "alternative sources" and "not available" should be given their common and ordinary meaning. He concluded that the term "alternative" meant "affording a choice of two or more things, propositions, or courses of action," citing the Random House Dictionary of the English Language (2d Ed. 1987). Holmes, DAB CR270, at 13; Weintraub, DAB CR303, at 20. Using this same source, Judge Steinman found that the term "available" meant "suitable, or ready for use or service; at hand." Id. Thus, in order to prove that alternative sources of health care are not available, a petitioner must prove that alternative sources (sources that can be chosen instead) of the type of health care furnished by an excluded provider are not available (suitable or ready for use or service). Id.

In order to qualify as an alternative source of health care, a source of care must provide items or services that are equivalent in quality to the type of items or services provided by the

---

[5] In Holmes and Weintraub, Judge Steinman analyzed the mitigating factor as it appears in 42 C.F.R. § 1001.401(c)(3)(ii), the section of the regulations which identifies that factor in connection with exclusions imposed pursuant to section 1128(b)(3) of the Act. However, the language regarding the mitigating factor in that section is identical to the regulatory language which is at issue here, appearing in 42 C.F.R. § 1001.201(b)(3)(iv).

excluded provider. The alternative source also must be able to substitute for the items or services furnished by the excluded provider without jeopardizing the health of the beneficiaries or recipients of those items or services. Weintraub, DAB CR303, at 21; Holmes, DAB CR270, at 13. Furthermore, the alternative source of health care also must be "available." This means, consistent with the regulation and the comments that accompanied its publication, that alternative sources of health care must be reasonably available. Id.; 57 Fed. Reg. 3315 - 3316 (1992).

Therefore, to qualify as an alternative source of health care, a source of care must be available in circumstances where Medicare beneficiaries and Medicaid recipients are able reasonably to make use of it. Thus, a source of health care will not qualify as an alternative source under the regulations if it does not consist of care of the type and quality which was furnished by the excluded provider. Nor will it qualify if it is located in a setting so remote from affected beneficiaries and recipients that they are deprived of reasonable access to it.

However, it is of critical importance to understand that the I.G. does not have the burden of proving that alternative sources of care are reasonably available. In every instance where a petitioner alleges that alternative sources of care are not available, it is the petitioner who bears the burden of proof. That means that the petitioner must show that there are not sources of care which substitute for the care which he or she provides which are reasonably available to Medicare beneficiaries and Medicaid recipients. If a petitioner fails to make that showing by a preponderance of the evidence, then the petitioner has not established the presence of a mitigating circumstance within the meaning of the regulations.

A petitioner bears the burden of establishing precisely what items or services he or she provides that will be affected by the exclusion. Furthermore, he or she must show what the impact of the exclusion will be on Medicare beneficiaries and Medicaid recipients. In this case, Petitioner could have met his burden of proof by defining the patient population which has reasonable access to the items or services he provides, and by proving that other providers or practitioners are not available to provide the items or services to this patient population.

A petitioner will fail to establish his or her burden if he or she proves only that services of the type and quality that he or she provides will be less available to Medicare beneficiaries and Medicaid recipients by virtue of the petitioner's exclusion. By definition, an exclusion of a provider or practitioner will reduce the availability to beneficiaries and recipients of the items or services that the petitioner provides. However, the issue is not whether availability has been reduced, but whether, by virtue of that reduction of availability, beneficiaries and

recipients have been denied reasonable access to care.

Furthermore, a petitioner will fail to establish his or her burden if he or she proves only that beneficiaries and recipients may be inconvenienced somewhat by virtue of his or her exclusion. The test under the regulation is not whether beneficiaries and recipients have been inconvenienced, but whether, by virtue of the exclusion of a provider or practitioner, they may no longer obtain care in a reasonably practicable manner.

4. Petitioner contends that alternative sources of health care do not exist.

Petitioner contends that he is the only psychiatrist practicing in the vicinity of Panama City, Florida, who specializes in the treatment of posttraumatic stress disorders resulting from abuse occurring during childhood, multiple personality disorders, eating disorders, and chronic pain cases. Finding 24. He argues, furthermore, that he is the only psychiatrist in Panama City who is authorized to prescribe the drug Clozaril, which is used in treating the primary manifestations of schizophrenia. He contends that, by virtue of his exclusion, Medicare beneficiaries who need treatment for the conditions he specializes in treating will have to seek their treatment elsewhere. Moreover, according to Petitioner, other psychiatrists in the Panama City area lack the background and expertise that Petitioner has, or are reluctant, unwilling, or unable to treat patients suffering from the disorders that Petitioner specializes in treating.

Petitioner argues that psychiatrists who practice in other communities besides Panama City are located too far away to provide reasonable access to Medicare beneficiaries for the items or services which Petitioner provides. According to Petitioner, the nearest community of substantial size is Fort Walton Beach, Florida, a town located approximately 60 miles from Panama City. Other large communities which are relatively close to Panama City are Pensacola, Florida, and Mobile, Alabama. There are psychiatrists who practice in these communities. However, they are located several hours from Panama City. Petitioner contends, furthermore, that there is not much public transportation between Panama City and other communities. Petitioner argues additionally that patients suffering from chronic pain conditions would not be able to withstand the rigors of the long drives to Fort Walton Beach, Pensacola, or Mobile.

Thus, according to Petitioner, his exclusion means that beneficiaries and recipients will be deprived of reasonable access to items or services of the nature and quality provided by Petitioner. He argues, therefore, that alternative sources of the type of health care items or services he provides will not be available to beneficiaries and recipients.

The evidence which Petitioner offered to support these contentions consists of Petitioner's testimony and the testimony of John F. Mason, M.D. Dr. Mason is a psychiatrist who has practiced in the Panama City area since 1967. Tr. at 13. He testified that there exist two hospitals in Panama City with psychiatric beds; Rivendale Hospital, with 80 beds, and Bay Medical Center with 22 beds. Tr. at 14. He identified also a community mental health facility in Panama City, Life Management, which functions as a community health center, providing services primarily to the indigent population. Id.

Dr. Mason testified that he was familiar personally with Petitioner. Tr. at 15. He contended that Petitioner had certain areas of expertise that other psychiatrists in the Panama City area lacked. Tr. at 18. These areas included treatment of multiple personality disorders, chronic pain disorders, chronic eating disorders, and posttraumatic stress disorders related to ritualistic abuse. Tr. at 18 - 19. He estimated that from 25 to 50 percent of Petitioner's practice consisted of patients whom other psychiatrists in Panama City either can't or won't treat. Tr. at 19.

Dr. Mason contended that, as a consequence of Petitioner's exclusion, it had become difficult to maintain a rotation of psychiatrists at hospitals in Panama City who are available to admit patients who need acute care. Tr. at 20 - 21. He did not aver that Petitioner's exclusion had resulted in situations where psychiatrists were unavailable to authorize hospitalization of patients needing acute care.

Dr. Mason testified also concerning the treatment specialties of other psychiatrists in the Panama City area and their willingness to accept Medicare beneficiaries as patients. Tr. at 21 - 29. He testified concerning the following psychiatrists: Dr. Daniel Tucker, Dr. Rojani Pattel, Dr. Louis Zumarraga, Dr. Rudolfo Nellas, Dr. Multaiya Darmarajah, Dr. F.E. Hebron, Dr. Ofelia Borlongon, Dr. John Sapoznikoff, Dr. Teodora Reyes, Dr. Vijapura Divan, and Dr. Ben Pimental. Dr. Mason testified also about a Dr. Subareddy, in Cottondale, Florida, two psychiatrists in the Fort Walton Beach area, Drs. Neumeyer and Calnaido, and a psychiatrist in Marianna, Florida, Dr. Ralph Walker. Tr. at 29 - 32.

Dr. Mason asserted that Dr. Tucker's practice is confined "predominately" to children and adolescents and that Dr. Tucker was "really not available to the Medicare group." Tr. at 23. He stated that Dr. Pattel is a child psychiatrist predominately, who "treats a few adults." Tr. at 23 - 24. He testified that Dr. Zumarraga did not have special training in the treatment of posttraumatic stress disorders, nor did he have special training in the area of chronic pain management. Tr. at 25. Furthermore, according to Dr. Mason, it was his understanding that Dr.

Zumarraga planned to retire in the next year or so. Id. Dr. Mason asserted that Dr. Nellas no longer practiced in the Panama City area. Tr. at 26. He testified that Dr. Hebron works for Life Management. He stated that he had no direct knowledge of the types of patients that Dr. Hebron treated. Id. Dr. Mason asserted that he did not know Dr. Borlongon, and that he was unable to find a listing for Dr. Borlongon in the Panama City telephone directory. Tr. at 27. He testified that Dr. Sapoznikoff accepted Medicare beneficiaries as new patients. Tr. at 27. However, he asserted that Dr. Sapoznikoff had a heavy caseload and that his practice did not "specifically" involve the areas of concentration in which Petitioner specialized. Tr. at 27 - 28. Dr. Mason testified that Dr. Divan accepted new patients who are Medicare beneficiaries. Tr. at 28 - 29.

Dr. Mason testified that Dr. Subareddy no longer practiced in Cottondale, a town which, according to Dr. Mason, is located 50 miles from Panama City. Tr. at 29. He testified that he did not know either Dr. Neumeyer or Dr. Calnaido. Tr. at 30. He asserted, however, that travel time to Fort Walton Beach was about an hour and one-half, due to traffic, and that there was no regular public transportation between Panama City and Fort Walton Beach. Id. He asserted that it would be very difficult for chronically ill or elderly patients to travel from Panama City to Fort Walton Beach. Tr. at 31. Dr. Mason testified that Dr. Walker suffered from metastatic cancer and would soon be unable to treat patients. Tr. at 32.

Dr. Mason testified that travel time from Panama City to Mobile, Alabama, was about three hours. Tr. at 32. He testified that the State hospital in Chattahoochee, Florida, was not available to hospitalize patients. Tr. at 32 - 33. He contended that Harbor Oaks Hospital in Fort Walton Beach did not accept acute care psychiatric patients. Tr. at 33. He testified that the Humana Hospital in Fort Walton Beach provided services in a one hundred mile radius, "just like we do." Tr. at 33. Finally, he contended that a patient from Panama City and his or her family would incur greater inconvenience by virtue of being hospitalized in Fort Walton Beach than if that patient were hospitalized in Panama City. Tr. at 33 - 34.

Petitioner testified that he has practiced psychiatry in the Panama City area since September 1990. Tr. at 39. He asserted that in his practice he sees between 700 and 900 individuals a year. Tr. at 40. According to Petitioner, about 30 percent of his patients are Medicare beneficiaries. Tr. at 41. He averred that from five to seven percent of his patients are recipients of some kind of federal funding other than Medicare. Id. Petitioner did not testify that he sees patients who are Medicaid recipients, nor did Petitioner offer other evidence to establish that he treats Medicaid recipients. See Tr. at 40 - 41.

Petitioner averred that he has extensive experience in treating patients who suffer from posttraumatic stress disorders. Tr. at 41 - 42. He contended that "most of my patients who are post-traumatic stress disorder either from ritual abuse or from childhood sexual and/or sadistic abuse end up being Medicare patients because they're pretty disabled people." Tr. at 42. However, Petitioner did not offer an estimate of the number of patients he treated who suffer from posttraumatic stress disorders and who are Medicare beneficiaries. See Tr. at 42.

Petitioner averred also that he has a large number of chronic pain patients. Tr. at 43. According to Petitioner: "These usually begin as Workman's Compensation patients, and then end up usually after a very short period of time as Medicare patients." Id. However, Petitioner offered no estimate of the number of Medicare beneficiaries he treats who are chronic pain patients. See Tr. at 43.

Petitioner testified that his specialties include the treatment of eating disorders. Tr. at 43 - 44. He did not aver that any patients of his who are Medicare beneficiaries suffer from eating disorders. See Tr. at 43 - 44. He testified additionally that he specialized in the treatment of multiple personality disorders. Tr. at 44. However, he did not testify that he treated patients who are Medicare beneficiaries who suffer from multiple personality disorders. See Tr. at 44.

Petitioner testified that he is the only physician in the Panama City area who is authorized to prescribe the drug Clozaril (also referred to in Petitioner's testimony as "clozapine"). Tr. at 45. He asserted that Clozaril is the only "cure" for schizophrenia. Id. Petitioner contended that, in order to be authorized to prescribe Clozaril, a physician must be on a registry of physicians who are authorized to prescribe the drug. Tr. at 46. He testified that most people receiving Clozaril are chronic schizophrenics who are receiving Medicare benefits or who are Medicaid recipients. Tr. at 47. Petitioner did not testify as to the number of his patients who received Clozaril who are Medicare beneficiaries. See Tr. at 46 - 47.[6]

Petitioner testified concerning his knowledge of other psychiatrists' areas of specialization and the patients they treated. Tr. at 48 - 55. He testified that Dr. Tucker devotes most of his time to his duties as medical director of Rivendale Hospital. Tr. at 48. He contended that Dr. Tucker takes on few new patients and that his area of specialization consisted of child and adolescent psychiatry. Id. He asserted that Dr. Pattel specializes also in child and adolescent psychiatry. Id.

---

[6] As I noted above, Petitioner offered no evidence to show that he treats Medicaid recipients.

Petitioner testified that, since his exclusion, Medicare beneficiaries who were his patients who needed to be hospitalized had been hospitalized under the authority of Dr. Mason, Dr. Tucker, or Dr. Pattel. Tr. at 49.

Petitioner testified that he continued to maintain a relationship with these patients as a primary therapist and that he would see them without charging them a fee. Id. He testified that his sentence mandated that he devote 750 hours to community service and that, as a result, he had been providing free services. Tr. at 49 - 50. Petitioner offered no estimate of the percentage of the hours of non-compensated medical care he is providing that are being provided on behalf of his patients who are Medicare beneficiaries. See Tr. at 50. Petitioner did not testify as to the number of Medicare beneficiaries who were patients of his who had been hospitalized under the authority of Dr. Mason, Dr. Tucker, or Dr. Pattel. See Tr. at 48 - 49.

Petitioner contended that he had attempted unsuccessfully to refer his patients to other psychiatrists. Tr. at 49. According to Petitioner: "Most of my patients the other psychiatrists don't want." Id. Petitioner asserted that he did not know whether his relationship with Drs. Tucker and Pattel would continue on its present basis once he completed the community service aspect of his sentence. Tr. at 50 - 51. Petitioner did not indicate whether, upon completion of his community service, his relationship with Dr. Mason would continue. See Tr. at 50 - 51.

Petitioner testified that Dr. Zumarraga planned to return to the Philippines in the near future and to practice medicine there. Tr. at 51. He stated that Dr. Nellas left the Panama City area about a year ago. Id. He contended that Dr. Darmarajah stated that he did not want to treat posttraumatic stress disorder and eating disorder cases. Tr. at 52. Petitioner testified that Dr. Sapoznikoff will actively take geriatric Medicare patients. Tr. at 55. However, according to Petitioner, Dr. Sapoznikoff told him that he did not want to take new Medicare patients because he didn't get compensated for the work. Id.

Petitioner asserted that hospital facilities in Fort Walton Beach did not offer a viable alternative to treatment facilities in Panama City, because Fort Walton Beach was too far for patients to travel. Tr. at 53. He asserted that Medicare patients were either too old to travel there, or could not afford to travel that distance. Tr. at 54. He averred that there presently existed a waiting list at Life Management, the facility in Panama City which treats Medicaid recipients. Id.

5. The I.G. offered exhibits to rebut Petitioner's contentions.

The I.G. called no witnesses. She offered exhibits which

consisted, essentially, of directories of practitioners and providers in Panama City and other locations which accepted Medicare or Medicaid. I.G. Ex. 3; I.G. Ex. 5. The exhibits listed psychiatrists in Panama City, Fort Walton Beach, and Pensacola, who accepted Medicare or Medicaid. The following Panama City psychiatrists were listed as accepting Medicare: Dr. Borlongon, Dr. Darmarajah, Dr. Hebron, Dr. Nellas, Dr. Sapoznikoff, and Dr. Zumarraga. I.G. Ex. 5 at 4. The following Pensacola psychiatrists were listed as accepting Medicare: Dr. Frank Creel, Dr. Theodore Marshall, Dr. Jose Montes, and Dr. Russell Packard. I.G. Ex. 5 at 6. The following Panama City psychiatrists were listed as accepting Medicaid: Dr. Borlongon, Dr. Darmarajah, Dr. Hebron, Dr. Nellas, Dr. Pimental, Dr. Sapoznikoff, Dr. Vijapura, and Dr. Zumarraga. I.G. Ex. 3 at 7 - 8.

6. The evidence offered by Petitioner is unpersuasive, and is insufficient to prove the absence of alternative sources of health care.

I conclude that Petitioner has not met his burden of proving that alternative sources of the type of health care he provides are not reasonably available to Medicare beneficiaries and Medicaid recipients. He has failed in three respects. First, he has not shown the extent to which his unique services are utilized by Medicare beneficiaries and Medicaid recipients. Second, he has not shown that program beneficiaries, including his patients, will be unable reasonably to obtain alternative sources of health care. Finally, the proof which he offered was insubstantial, and I do not accept key elements of it as credible.

There is no evidence to suggest that Medicaid recipients will be affected by Petitioner's exclusion. Petitioner did not aver that he accepted Medicaid recipients as patients. He is not listed in any of the I.G.'s exhibits as a practitioner who is willing to accept reimbursement from the Florida Medicaid program for treating Medicaid recipients. I do not find that Petitioner actually treats Medicaid recipients. Given that, there is no proof that his exclusion will have any impact on Medicaid recipients.[7]

---

[7] Petitioner's claim that from five to seven percent of his practice involve individuals whose health care is financed by federal programs other than Medicare is not sufficient for me to conclude that any of these patients are Medicaid recipients. Other than stating his estimate as to the percentage of his practice which involved such patients, Petitioner offered no testimony whatsoever about them. He made no argument that these were Medicaid patients or that any of these patients would be affected by his exclusion.

The centerpiece of Petitioner's argument is that there are no alternative sources of care reasonably available to Medicare beneficiaries who suffer from the conditions which Petitioner specializes in treating. These include posttraumatic stress disorder patients, chronic pain patients, eating disorder patients, and patients who receive Clozaril for schizophrenia. I accept as true Petitioner's assertion that he treats beneficiaries who suffer from posttraumatic stress disorders, chronic pain, or who receive Clozaril for their schizophrenia. Petitioner did not aver that he treats Medicare beneficiaries who suffer from eating disorders and I do not conclude that he treats beneficiaries who suffer from eating disorders. Nor did Petitioner aver that he treats Medicare beneficiaries who suffer from multiple personality disorders. I do not find that he treats Medicare beneficiaries who suffer from multiple personality disorders.

Petitioner offered no evidence as to the number of Medicare beneficiaries he treats who suffer from the conditions he specializes in treating. The fact that 30 percent of his patients may be Medicare beneficiaries does not, in and of itself, lead to the inference that a substantial number of these patients suffer from posttraumatic stress disorders, chronic pain, or schizophrenia treated by Clozaril. Therefore, it is not possible to infer reasonably from the evidence offered by Petitioner that there are a substantial number of Medicare beneficiaries who might be affected adversely by his exclusion.[8]

Furthermore, Petitioner offered no evidence to establish the location of the residences of the Medicare beneficiaries he treats who suffer from the conditions he specializes in treating. Evidence as to the distribution of the residences of the beneficiaries who Petitioner treats potentially could have been helpful in showing whether Petitioner's exclusion would affect these beneficiaries adversely. Absent such evidence, I do not find these beneficiaries are located so close to Petitioner's office in Panama City as to render impracticable their travel to some other community for psychiatric care. For example, the evidence establishes that Fort Walton Beach is located about 60 miles from Panama City. There is nothing in the record to establish whether the Medicare beneficiaries who might need to obtain alternate care by virtue of Petitioner's exclusion live relatively close to Panama City and relatively far from Fort Walton Beach, live at some point between the two communities, or

---

[8] Petitioner averred that he first began practicing in the Panama City area in September 1990. He offered no evidence to show how Medicare beneficiaries in the community who suffered from the conditions which Petitioner contended he is uniquely qualified to treat obtained treatment for their conditions prior to that date.

live elsewhere.[9]

Indeed, there is evidence in the record to show that the facilities in the communities of Panama City and Fort Walton Beach which hospitalize psychiatric patients are organized to accept patients on a regional, rather than a strictly local basis. Dr. Mason testified that Humana Hospital in Fort Walton Beach services "100 miles in every direction, just like we do." Tr. at 33. From the context of Dr. Mason's testimony, I infer that "we" means Rivendale Hospital in Panama City. That these hospitals accept patients on a regional basis suggests that their patient populations may not be concentrated in the communities of Panama City and Fort Walton Beach, but may, in fact, be dispersed.

Petitioner did not prove that the other psychiatrists in the Panama City area who treat Medicare beneficiaries are incapable of treating the conditions which Petitioner specializes in treating. Essentially, Petitioner's evidence as to his specialization is that he is more qualified than other local psychiatrists to treat these conditions. He did not prove that others could not treat these conditions. In fact, Petitioner's own witness, Dr. Mason, admitted that psychiatrists besides Petitioner were qualified to hospitalize patients who suffered from the conditions Petitioner specialized in treating, who needed hospitalization. Tr. at 35 - 36.

Finally, the evidence which Petitioner offered as to the availability of other practitioners to provide care of the type and quality which Petitioner provides is exceedingly weak, and in my judgment, not credible. It consists exclusively of the anecdotal, uncorroborated and not credible hearsay accounts of Petitioner and Dr. Mason as to the areas of expertise of other psychiatrists, and their willingness to treat patients who suffer from the conditions that Petitioner specializes in treating. Petitioner offered no direct evidence as to the specialization of other psychiatrists or their willingness to treat Petitioner's patients. He obtained no statements from other psychiatrists, and called none of them (except Dr. Mason) as witnesses.

For example, Petitioner asserted that he was the only physician in the Panama City area authorized to prescribe Clozaril who actually prescribed it to patients without presenting any

---

[9] Petitioner's contention that his patients would be affected adversely by his exclusion consisted essentially of his uncorroborated allegations. He did not offer statements from any of his patients which suggested that they would be affected adversely. He offered no patient records or other office records to establish who he treated and who might be affected adversely by his exclusion.

evidence besides his unsubstantiated assertion to establish that some special authorization was necessary as a prerequisite for prescribing the drug. He offered no meaningful evidence as to the criteria for obtaining authorization, or as to whether other psychiatrists might qualify to obtain such authorization if, by virtue of Petitioner's exclusion, they found it necessary to do so. He did not suggest that other psychiatrists lacked the training or expertise to administer Clozaril. And, as I find above, he offered no evidence to show how many of his patients were Medicare beneficiaries who actually received Clozaril.

The fact that I admit hearsay evidence in a hearing does not mean that I find it to be persuasive. The reason that most rules of evidence exclude hearsay is that the credibility of such evidence is inherently suspect. See generally, Fed. R. Evid. 801 advisory committee's note; Fed. R. Evid. 802 advisory committee's note; McCormick on Evidence, §§ 244 - 45, at 90 - 96 (4th ed. 1992). Frequently, there is no way for the party against whom hearsay is offered to attack the credibility of the evidence, because the declarant is not available to be cross-examined. That was certainly the case with the evidence that Petitioner and Dr. Mason presented about other psychiatrists. I admit hearsay routinely because it is appropriate for me to do so in the somewhat informal context of an administrative hearing, as opposed to the more rigid rules which govern jury trials. 42 C.F.R. § 1005.17. But I evaluate such evidence critically, to determine whether it is probative and reliable.

In this case, the anecdotal hearsay evidence which Petitioner and Dr. Mason offered concerning the availability of other psychiatrists was totally unsubstantiated and I find it to be not credible. Moreover, I find the attributions which Petitioner and Dr. Mason offered about other psychiatrists to be unreliable because they are self-serving and unverifiable. In reaching my conclusion about this testimony, I recognize that it consists of the testimony of two witnesses. However, both witnesses' testimony is similarly anecdotal and unreliable. Therefore, the fact that Petitioner's testimony is supported by Dr. Mason's testimony does not make it anymore credible or reliable.

Petitioner could have obtained statements from other psychiatrists as to their areas of specialization and their willingness to treat Petitioner's patients. Such statements would have comprised direct evidence from these physicians rather than statements attributed to them. And, although such statements would be hearsay (unless the other psychiatrists appeared personally to testify at the hearing) the I.G. would at least have had notice about these statements and would have had the opportunity to subpoena the declarants for cross-examination or to otherwise impeach the statements. The fact that in this case, Petitioner chose not to present the evidence so that it was subject to cross-examination or verification calls into question

the validity of that evidence.

CONCLUSION

I conclude that Petitioner has not established the presence of any factors which would mitigate the exclusion imposed against him by the I.G. Therefore, I find that the three-year exclusion imposed and directed against Petitioner by the I.G. is consistent with the requirements of 42 C.F.R. § 1001.201(b), and I sustain it.

/s/

Steven T. Kessel
Administrative Law Judge