Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Sunil R. Lahiri, M.D.,	)	DATE: December 12, 1994
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-92-088
	)	Decision No. CR348
The Inspector General.	)	
	)	

DECISION

By letter dated February 10, 1992, the Inspector General (I.G.) notified Petitioner that, effective March 1, 1992, Petitioner was excluded, pursuant to section 1128(b)(6)(B) of the Social Security Act (Act), from participation in Medicare and any State health care program as defined by section 1128(h) of the Act.[1] The I.G. further informed Petitioner that his exclusion was for a 10-year period. The I.G. stated that the basis for Petitioner's exclusion was that Petitioner, in seven separate cases, furnished items or services to patients which were substantially in excess of their needs and of a quality which failed to meet professionally recognized standards.[2]

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[1] The term "State health care program" as defined at 1128(h) of the Act encompasses Medicaid and other federally funded health care programs. All references to State health care programs throughout this Decision are to that term as it appears in section 1128(h) of the Act.

[2] For purposes of this Decision, unless explicitly stated otherwise, the term "professionally recognized standard(s)" refers to professionally recognized standards of health care as that term appears in section 1128(b)(6)(B). Additionally, all references to professionally recognized standards as applied to a particular patient pertain to the periods of time that Petitioner was treating that patient. Other references

(continued...)

For the reasons contained below, I find that the I.G. had the authority to exclude Petitioner pursuant to section 1128(b)(6)(B) of the Act. I further find that, pursuant to 42 C.F.R. § 1005.4 and 42 C.F.R. § 1005.20(b), I have the authority to increase the period of exclusion beyond the 10 years advocated by the I.G. Moreover, the record of this case demonstrates that an exclusion of greater than 10 years is justified.

I find that, by his conduct, Petitioner has shown an extreme disregard of his responsibilities as an oncologist and has shown a shockingly callous indifference to the well-being of the seven patients at issue here. Petitioner furnished items and services to these patients that were substantially in excess of their needs and of a quality which failed to meet professionally recognized standards. In doing so, Petitioner jeopardized the patients' health and well-being by failing to adequately diagnose, document, and treat their conditions. He deprived many of these patients of the opportunity to receive treatment that could abate or cure their cancer, or at least minimize the suffering associated with advanced stages of cancer. By having these patients endure numerous, prolonged infusions of subtherapeutic dosages of chemotherapy, and repeated blood tests and vitamin injections of marginal efficacy, Petitioner severely inconvenienced these patients and caused a significant deterioration of their quality of life at a time when their life expectancy was very short. This record of unnecessary and excessive treatment, when combined with Petitioner's refusal and inability to follow Medicare billing practices, leads me to conclude that Petitioner's eagerness to generate the maximum amount of Medicare billings was a principal factor in his choice of treatment for these patients. Moreover, I find that Petitioner's treatment of these patients demonstrates that he lacks the basic knowledge and understanding of the medical practices and procedures necessary to properly treat and diagnose cancer patients. For these reasons and the reasons I will detail in the following pages, I find that Petitioner's conduct justifies that he be permanently excluded from Medicare and federally funded State health care programs.

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[2](...continued)
to professionally recognized standards pertain to Petitioner's treatment of any patient who was subjected to the medical practices at issue in this case.

BACKGROUND

On March 31, 1992, Petitioner filed a request for hearing to contest the I.G.'s determination to exclude him for 10 years. The case was assigned to me. On July 28, 1992, after several continuances of the initial prehearing conference, I conducted a prehearing conference at which I established a schedule through which this case would proceed to hearing on January 25, 1993, in San Francisco, California. On December 1, 1992, Petitioner moved for a continuance of the January 25 hearing based on a motion he had filed in federal court to enjoin these proceedings. On December 10, 1992, I issued a Ruling in which I refused to speculate as to the outcome of Petitioner's motion in federal court and accordingly denied Petitioner's motion for continuance. On January 7, 1993, Petitioner moved to consolidate this case with another exclusion case that the I.G. had brought against him (Docket No. C-93-036) and he once again moved for a continuance of the January 25 hearing. I continued the January 25 hearing to enable the parties to submit pleadings to argue Petitioner's motions for continuance and consolidation.[3] After receiving all of the parties' submissions, I conducted another prehearing conference on February 19, 1993. At the conference, I denied Petitioner's motions.[4]

The parties completed their final exchanges in preparation for the hearing scheduled for April 26, 1993, when, on April 9, my office received a notice from Petitioner's former counsel indicating that he was no longer representing Petitioner. I conducted another prehearing conference on April 12, at which time Petitioner informed me that he had terminated the services of his attorney and requested a stay of the

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[3] Also pending was the I.G.'s motion to dismiss Docket No. C-93-036, based on Petitioner's failure to timely request a hearing. I held in abeyance my ruling on this motion. Docket No. C-93-036 was an exclusion case brought by the I.G. against Petitioner based on an entirely separate set of facts and statutory authority (section 1156 of the Act). Docket No. C-93-036 received a separate hearing and decision which was entirely independent of the instant case. Accordingly, I will not go into the details of that case, as it is not relevant to the issues presented here. My decision in Docket No. C-93-036 was issued as Sunil R. Lahiri, M.D., DAB CR296 (1993).

[4] My Order of March 4, 1993 details these events.

hearing to enable him to obtain new counsel. I granted Petitioner's request.[5]

On April 22, 1993, Indra Lahiri, Esq., entered his appearance on behalf of Petitioner. On April 23, 1993, I conducted another prehearing conference and gave Petitioner until April 30, 1993 to either file additional submissions or notify me of his intent to go forward on the documents and exhibits that had been submitted by Petitioner's previous counsel. At the conference, Petitioner's new counsel stated that he would go forward with this case on the record as submitted by the previous counsel and agreed to a schedule culminating in a two-week hearing to begin on August 2, 1993 in San Francisco, California.[6]

On April 29, 1993, Petitioner moved for a continuance or bifurcation of the August 2 hearing. The stated reason for Petitioner's motion was Petitioner's desire to attend a medical continuing education seminar beginning on August 7, 1993. In my Order of May 25, 1993, I denied Petitioner's motion, for the reasons stated therein.

On July 26, 1993, Petitioner again moved for a continuance of the August 2 hearing. Petitioner's counsel stated that Petitioner had suffered a heart attack of such severity that he would be unable to attend the August 2 hearing and further stated that it would be three to six months before Petitioner could withstand the rigors of a hearing. In an Order dated July 27, 1993, I directed Petitioner to provide me with documentation supporting his oral representation that he was unable to attend the August 2 hearing for medical reasons. In a letter dated July 27, 1993, Petitioner supplied me with documentation to support his position. Counsel for the I.G. objected to Petitioner's request for a continuance, stating that the documentation was inadequate to support his contentions regarding the nature and severity of his medical condition.

I subsequently denied Petitioner's request for continuance because I found the documentation submitted by Petitioner to be insufficient to support his request

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[5] These events are described in more detail in my Order of April 15, 1993.

[6] My April 30, 1993 Order and Notice of Hearing describes the events of the April 23 prehearing conference in detail.

for continuance.[7] Because of the delays necessitated by my ruling on this matter, I delayed the start of the hearing to August 4, 1993. On August 3, 1993, Petitioner's attorney informed me that Petitioner had instructed him not to appear at the August 4 hearing.

I conducted a telephone conference on August 4, 1993, for the purpose of clarifying the parties' positions regarding the statement made by Petitioner's counsel that Petitioner had instructed him not to appear at the scheduled hearing. At the August 4 telephone conference, it was agreed by all parties that Petitioner's counsel would appear on August 11, 1993 to litigate a motion to dismiss in Docket No. C-93-036, as Petitioner's counsel had agreed that Petitioner's presence and testimony were not required to fully and fairly litigate that case.[8] It was further agreed by the parties that the hearing in this case would be continued to November 15, on the condition that Petitioner make a good faith showing by documenting his current physical condition, the nature of his treatment, and a prognosis that would show that he would be medically able to attend the November 15 hearing.

On August 23, in accordance with the instructions contained in my August 11 Ruling, Petitioner submitted additional documentation of his medical condition. However, in my Ruling of September 29, 1993, I noted that the additional documentation submitted by Petitioner was inadequate to support his previous representations regarding his medical condition and therefore insufficient to support his request for continuance of the hearing to November 15. Also in my September 29 Ruling, I gave Petitioner until October 8, 1993 to submit documentation sufficient to support his request for continuance.

Petitioner failed to submit sufficient documentation in accordance with my September 29 Ruling. Accordingly, in my Order of October 15, 1993, I required Petitioner, by October 25, to provide additional specific information to support his request for continuance of the hearing to November 15, 1993. In a letter dated October 22, 1993,

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[7] In my Ruling of August 2, 1993, I detail my analysis and the basis for denying Petitioner's request for continuance.

[8] The events and the oral Ruling I made at the August 4 conference appear in written form in my Ruling dated August 11, 1993.

Petitioner submitted documentation that indicated that he had received medical clearance to attend the November 15 hearing.

Accordingly, I conducted a hearing in this case on November 15 - 23, 1993 in San Francisco, California. From November 15 - 19, the I.G. presented its case-in-chief against Petitioner. On November 22, 1993, Petitioner began to testify on his own behalf. Toward the close of the day, it became apparent that Petitioner could not complete his testimony by the end of the day and would have to return on November 23 to do so. Petitioner's counsel requested a recess for the purpose of allowing him to contact his other witness and instruct him not to travel to San Francisco to testify on November 23 because Petitioner would be testifying that entire day.

At the conclusion of the recess, Petitioner informed me that he would be unable to testify on November 23 because he had contemplated that he would need only one day to testify. Also, Petitioner stated that his brother had passed away 10 days prior and that he would be unable to testify for the remainder of the week because he had to attend a religious service related to his brother's death. Petitioner's counsel stated that he knew Petitioner's brother had passed away, but was unaware until that moment that Petitioner's presence would be required at a religious service such that it would preclude Petitioner from completing his testimony. Unfortunately, Petitioner's counsel, unaware of Petitioner's situation, had instructed the witness not to attend the hearing the following day.

To resolve the situation, I offered to allow Petitioner to continue his testimony until late that evening, but counsel for the I.G. did not wish to do so. Counsel for Petitioner offered to try to correct the situation by contacting his witness and instructing him to be present to testify on November 23. On November 23, Petitioner's counsel informed me that he had been unsuccessful in contacting his witness. With the agreement of all parties, I continued the hearing to January 24 - 28, 1994 in San Francisco. The parties agreed to complete all remaining testimony in this case during that time.[9]

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[9] The events which caused the hearing to be resumed the week of January 24, 1994 can be found in the transcript at pages 1959 - 1977, 2012 - 2030, 2035 - 2044.

On December 15, 1993, the I.G. moved to truncate the hearing to allow her to present rebuttal testimony 30 days after the January 24 - 28 completion of the case-in-chief. The I.G. moved also to exclude several of Petitioner's exhibits, asserting that these exhibits were not offered in accordance with my order governing the final prehearing exchange of documents. The I.G. moved also to compel Petitioner to document the reason why he failed to continue his testimony on November 23.

In a letter dated December 29, 1993, Petitioner requested a continuance of the hearing. In his motion, Petitioner contended that a hearing was neither economical nor feasible, in view of the adverse decision Petitioner had received in Sunil R. Lahiri, M.D., DAB CR296 (1993).

In my Ruling of January 10, 1994, I denied the motions for truncation and continuance and gave detailed reasons for doing so. I ruled also that the I.G.'s motion to exclude several of Petitioner's exhibits was not ripe. The parties completed their presentation of testimony on January 24 - 26, 1994. Upon review of the parties' posthearing briefs, on June 17, 1994, I requested supplemental briefing from the parties on: 1) whether I have authority to increase the term of exclusion proposed by the I.G. and 2) whether, assuming I have the authority, such an increase is justified based on the record of this case.[10]

ISSUES

The issues in this case are whether:

1. The I.G. had the authority to exclude Petitioner pursuant to section 1128(b)(6)(B) of the Act; that is, whether Petitioner furnished or caused to be furnished items or services to these patients substantially in excess of the needs of these patients or of a quality which failed to meet professionally recognized standards.

2. The term of exclusion of imposed and directed against Petitioner by the I.G. is reasonable.

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[10] As part of his posthearing activity, Petitioner moved for a rehearing and for me to recuse myself. In a Ruling of October 7, 1994, I denied Petitioner's motion. In that Ruling, I identified and rejected an I.G. exhibit as I.G. Ex. 18. This exhibit should have been referred to as I.G. Ex. 20, and it has now been marked as such.

3. Pursuant to the remedial purposes of the Act and the regulations at 42 C.F.R. § 1001.701 and 42 C.F.R. § 1005.20(b), I have the authority to increase the term of exclusion to a period greater than the 10-year period referenced in the Notice.

4. Assuming I have the authority to increase the term of Petitioner's exclusion beyond the 10-year period referenced in the Notice, whether an increase is justified based on the record before me and, if so, for what period of time should Petitioner be excluded.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. At all times relevant to this case, Petitioner was a physician licensed to practice medicine in the State of California. Tr. at 1668, 1675.[11]

2. At all relevant times, Petitioner was practicing oncology in Bakersfield, California. Tr. at 1668 - 1686.

3. Oncology is the study of the treatment of cancer and tumors. See Tr. at 56 - 60.

4. An oncologist is a medical doctor who specializes in the treatment of cancer and tumors. See Tr. at 56 - 60.

5. Medical oncology is the use of drugs to treat cancer. Tr. at 59.

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[11] I refer to the parties' exhibits, briefs, and the transcript as follows:

I.G.'s Exhibit	I.G. Ex. (number at page)
Petitioner's Exhibit	P. Ex. (number at page)
Transcript	Tr. at (page)
Petitioner's 1st posthearing brief . .	P. Br. at (page)
I.G.'s 1st posthearing brief	I.G. Br. at (page)
Petitioner's reply brief	P. R. Br. at (page)
I.G.'s response brief	I.G. R. Br. at (page)
Petitioner's supplemental brief . . .	P. Supp. Br. at (page)
I.G.'s supplemental brief	I.G. Supp. Br. at (page)

6. Surgical oncology is the use of surgery to treat cancer. Tr. at 59.

7. Radiation oncology is the use of radiation therapy to treat cancer. Tr. at 59.

8. As of April 10, 1993, Petitioner's license to practice medicine in California was revoked, the revocation was stayed, and Petitioner was placed on probation for seven years on the condition that he a) voluntarily cease to practice oncology, b) complete a course in ethics, and c) practice only while being monitored by another physician, with that physician obligated to periodically report to the California Medical Board. I.G. Ex. 10; Tr. at 1726 - 1732.

9. For purposes of this case, the term chemotherapy refers to the administration of chemicals, either singly or in combination, to patients for the purpose of treating cancer. Tr. at 72 - 73.

10. Chemotherapy drugs are generally administered via intravenous injection, called the "bolus method." P. Ex. 17 at 5; Tr. at 528 - 530.

11. The bolus method is a method of administering chemotherapy drugs to a patient in which the drugs are either injected directly into the patient's vein, or injected into a bag of saline solution (called a "slow IV (intravenous) push") that then flows into the patient's vein, thus causing the chemotherapy to enter the patient's bloodstream over a period of several minutes. Tr. at 187 - 188, 529 - 530.

12. The bolus method of injecting chemotherapy drugs has been the standard procedure for administering chemotherapy drugs for the last 30 years. Tr. at 187 - 188, 529 - 530; P. Ex. 17 at 5.

13. Infusion of chemotherapy drugs is generally performed via a central venous line. P. Ex. 17 at 26 - 27.

14. A central venous line is an intravenous tube in a large central vein, usually located in the chest area, through which chemotherapy drugs are administered to the patient, usually over a 24 to 72 hour period. Tr. at 2776 - 2777; see P. Ex. 17 at 26.

15. Under certain specific conditions, infusion of some chemotherapy drugs over a 24 to 72 hour period can reduce the toxicity of the chemotherapy drugs to the patient and

can increase the rate at which the cancer cells are killed. Tr. at 189, 1391; P. Ex. 17, 18, 19.

16. Some chemotherapeutic agents that are administered by bolus injection can cause local toxicity (to the tissue surrounding the area of the injection) if the drug leaks from the vein into the surrounding tissue. Tr. at 76, 2769.

17. In instances where a patient has problems with local toxicity resulting from leakage of the chemotherapeutic agent into the surrounding tissue, the chemotherapeutic agent can be infused over a period of up to one hour to eliminate such problems. Tr. at 76, 569 - 574, 1829 - 1830, 2769.

18. Petitioner failed to document that any of the seven patients at issue were, at any time during which Petitioner administered chemotherapy to them, ever suffering from local toxicity effects such that they required one hour infusions for the purpose of eliminating local toxicity. Tr. at 1812 - 2737; I.G. Ex. 3E, 3N, 3O, 3P, 3Q, 3R, 3S, 3T.[12]

19. Infusing chemotherapy drugs over a one to eight hour period does not reduce or minimize toxicity to the patient (other than local toxicity) or increase the rate at which the cancer cells are killed. Tr. at 184 - 190, 241 - 242, 529, 1337 - 1338, 1390 - 1391, 1829 - 1830, 2769; see P. Ex. 17, 19.

20. There is no evidence of record that would allow me to conclude that any of these seven patients had experienced local toxicity such that one hour infusions were medically indicated to eliminate local toxicity effects. I.G. Ex. 3N, 3O, 3P, 3Q, 3R, 3S, 3T; Tr. at 1812 - 2737.

21. The dosages and administration of chemotherapy drugs, even when administered in accordance with professionally recognized standards and not substantially in excess of the patient's needs, must be carefully controlled, as the chemicals used in chemotherapy treatments are always toxic to the person to whom they are administered. Tr. at 73 - 75, 769 - 772, 1345 - 1346.

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[12] Some of the I.G.'s exhibits are marked with numbers and letters.

22. The toxicity from chemotherapy drugs involves nausea, vomiting, destruction of bone marrow cells, anemia, low white blood cell counts, low platelet counts, and damage and impairment of function to organs such as the heart, liver, and lungs. Tr. at 771 - 772; P. Ex. 17, 19.

23. Anemia, low white blood cell counts, and low platelet counts lead to weakness, bleeding, infection, and possible death. Tr. at 771 - 772.

24. Professionally recognized standards mandate that an oncologist treating a patient create a document called a flow sheet for the purpose of precisely documenting the types and amounts of chemotherapy drugs he administers to the patient, the response the patient's cancer is having to the treatment, and any adverse effects or toxicity the patient may be encountering, as well as to ensure continuity of care in the event the patient should have to be treated by another physician or oncologist. Tr. at 102, 771 - 774, 1399 - 1400; see Tr. at 764 - 787, 966 - 1008, 1069 - 1071, 1083 - 1089.

25. Precise documentation in the patient's flow sheet is essential to ensure that the patient avoids serious and potentially dangerous risks from failure to adequately monitor and treat the patient's cancer, from excessive toxicity from chemotherapy drugs, or from failure to ensure continuity of care. Tr. at 102, 771 - 774, 1400; I.G. Ex. 3E, (especially at 3 - 4); see Tr. at 764 - 787, 966 - 1008, 1069 - 1071, 1083 - 1089.

26. Professionally recognized standards mandate that an oncologist treating a patient with chemotherapy list on the flow sheet the doses of drugs that the patient actually receives. Tr. at 771 - 772, 2766; see Tr. at 764 - 787, 966 - 1008, 1069 - 1071, 1083 - 1089; Findings 24 - 25.

27. Petitioner is cognizant of the purposes and crucial importance of keeping accurate medical records and accurately documenting in the patient's flow sheet the amount and type of medication the patient actually receives. Tr. at 1865 - 1866.

28. It is potentially hazardous to the health, life, and well-being of the patient if an oncologist does not enter on the patient's flow sheet the dosages of chemotherapy drugs that the patient actually receives. Tr. at 764 - 787, 966 - 1008, 1069 - 1071, 1083 - 1089; Findings 24 - 26.

29. It is below professionally recognized standards for an oncologist to fail to enter on a patient's flow sheet the doses of chemotherapy the patient actually receives. Findings 24 - 28; Tr. at 771 - 787, 2766.

30. Adriamycin is a drug used in chemotherapy that is toxic both to the bone marrow and to the heart muscle. Tr. at 74.

31. Adriamycin causes cumulative damage to the heart muscle. Each time it is used, more damage occurs from which the heart does not recover. Tr. at 74.

32. The maximum safe dosage of Adriamycin is approximately 350 - 550 milligrams per square meter of the patient's body surface area. Tr. at 74, 1334 - 1335.

33. Adriamycin is contraindicated in patients with heart problems. Tr. at 1416.

34. Adriamycin can cause local toxicity if, during the injection, it leaks out of the vein. Tr. at 74 - 76.

35. The local toxicity effects of Adriamycin are tissue necrosis, ulcers, and abscesses. Tr. at 74.

36. Adriamycin must be administered carefully to minimize these local toxicity effects, but these effects cannot be avoided completely. See Tr. at 74.

37. Cytoxan is a drug used in chemotherapy that is toxic to the bone marrow, the lining of the bladder, and the heart, and potentially damaging to the lungs. Tr. at 75, 1340, 1490.

38. Cytoxan administered in combination with Adriamycin causes additional toxicity to the heart muscle. Tr. at 1335.

39. Cytoxan received in doses that are customarily given to patients receiving chemotherapy causes hair loss. Tr. at 75.

40. The combination of Cytoxan administered with 5FU (fluorouracil) causes hair loss, nausea, vomiting, diarrhea, suppression of bone marrow, and oral lacerations. Tr. at 348, 352.

41. Cytoxan administered at the rate of 500 milligrams per week will cause death in an average patient within 6 weeks. Tr. at 96.

42. Vincristine is a drug that, when used in dosages that are required for treating cancer patients via chemotherapy, is extremely toxic to the nervous system, producing constipation, numbness and tingling, and loss of reflexes, and, if administered in high doses, paralysis. Tr. at 75.

43. Bleomycin is a drug that, when used in the dosages that are required for treating cancer patients via chemotherapy, causes irreversible lung damage. Tr. at 240, 1434, 2859.

44. BCNU is a drug that, when used in the dosages that are required for treating cancer patients via chemotherapy, causes suppression of bone marrow. Tr. at 1533.

45. Complete blood counts (CBCs) are tests that reveal the number of the different blood cells in a patient's blood. See Tr. at 123 - 125.

46. Platelets are substances in the blood which allow the blood to clot. See Tr. at 123 - 124.

47. Platelet counts are laboratory tests that reveal the number of platelets in a patient's blood. See Tr. at 123 - 124.

48. CEA stands for "carcinogenic embryonic antigen." Tr. at 239 - 240, 294 - 295.

49. CEA is a substance that is produced when the body has certain types of cancer and that, in certain instances, is useful in monitoring the progression of the cancer. Tr. at 294 - 295.

50. A CEA test is a laboratory test that measures the amount of CEA in a patient's blood. Findings 48, 49; Tr. at 294 - 295.

51. PAP stands for "prostatic acid phosphatase." Tr. at 337, 346.

52. A PAP test is a laboratory test that measures the level of prostatic phosphatase in a patient's blood, and that, in certain instances, can be used to monitor the progression of prostate cancer. Tr. at 345 - 346.

53. Laurens Park White, M.D. (Dr. White) is a physician and surgeon who is board certified in medical oncology and internal medicine. Tr. at 55.

54. Dr. White has been board certified in internal medicine since 1961 and has been board certified in medical oncology since 1977. Tr. at 60.

55. Dr. White has had 45 articles published in various medical journals, most of these relating to the practice of medical oncology. Tr. at 60 - 63.

56. Dr. White is a specialist in the treatment of melanoma. Tr. at 476.

57. Dr. White is an experienced practitioner and an expert in both oncology and internal medicine. I.G. Ex. 6; Findings 53 - 56.

58. The standards of practice for medical oncology are the same throughout the country. Tr. at 65, 763.

59. Dr. White is a credible, articulate, and knowledgeable individual who, at all periods of time relevant to this case, is an expert regarding professionally recognized standards for the treatment of cancer patients. Findings 53 - 58; Tr. at 55 - 753, 2751 - 2918.

60. Dr. White's review of Petitioner's treatment of patients B.G., J.W., D.R., H.W, J.L., H.S., and R.N. is accurately summarized in I.G. Ex. 8. Tr. at 68.

61. Klaus D. Hoffman, M.D. (Dr. Hoffman) has been in private practice as an oncologist and hematologist since 1977. I.G. Ex. 4.

62. Dr. Hoffman served a fellowship in the medical oncology program of Tufts University. I.G. Ex. 4.

63. Dr. Hoffman is board certified in both medical oncology and internal medicine and is a member of the American Society of Clinical oncology. I.G. Ex. 4.

64. Dr. Hoffman has been a consultant in medical oncology to several hospitals and has authored six articles relating to oncology studies or procedures. I.G. Ex. 4.

65. Dr. Hoffman is an expert in the areas of medical oncology and internal medicine. Findings 61 - 64.

66. Dr. Hoffman is a credible, knowledgeable, and articulate individual who, at all periods of time relevant to this case, is an expert regarding

professionally recognized standards for the treatment of cancer patients. Findings 61 - 65; Tr. at 760 - 957, 966 - 1081.

67. Dr. Hoffman's review of Petitioner's treatment of patients B.G., J.W., D.R., H.W, J.L, H.S., and R.N. is accurately summarized in I.G. Ex. 3E. Tr. at 763.

68. Nagendranath Bellare, M.D., F.A.C.P. (Dr. Bellare) has served fellowships in both hematology and oncology at the Cook County Hospital in Illinois. I.G. Ex. 5.

69. Dr. Bellare is board certified in internal medicine and oncology and is a member of the American Society of Clinical Oncology. I.G. Ex. 5.

70. Dr. Bellare is serving on the Board of Directors of the American Cancer Society and has served on the Board of Directors of the Central California Cancer Registry and is currently a junior faculty member in the bone marrow transplantation department at the M.D. Anderson Cancer Center in Texas. I.G. Ex. 5; Tr. at 1297.

71. Dr. Bellare is an expert in medical and clinical oncology and internal medicine. Findings 68 - 70.

72. Dr. Bellare is a credible, knowledgeable and articulate individual who, at all periods of time relevant to this case, is an expert regarding professionally recognized standards for the treatment of cancer patients. Findings 68 - 71; Tr. at 1297 - 1654.

73. Dr. Bellare's review of Petitioner's treatment of patients B.G., J.W., D.R., H.W., H.S., and R.N. is accurately summarized in I.G. Ex. 3E. Tr. at 1301 - 1302.[13]

74. Drs. White, Hoffman, and Bellare are all familiar with the professionally recognized standards used by oncologists in the treatment of cancer patients, which standards were at all times relevant to Petitioner's treatment of the seven patients at issue in this case. Findings 53 - 73.

75. At all times relevant to this case, all seven patients at issue in this case were Medicare beneficiaries. I.G. Ex. 3C, 3E, 3N, 3O, 3P, 3Q, 3R, 3S, 3T.

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[13] Dr. Bellare did not review Petitioner's care of patient J.L. Tr. at 1301 - 1302.

Petitioner's treatment of patient B.G.

76. B.G. was a 74-year-old female retired farm worker who spoke only Spanish. I.G. Ex. 3N.

77. B.G. was hospitalized by Petitioner in September 1983 for sudden onset of rectal and vaginal bleeding. I.G. Ex. 3N at 26 - 28.

78. After her admission to the hospital, B.G. was examined under general anesthesia by a Dr. Lin, a gynecologist. P. Ex. 10 at 1.

79. In his September 19, 1983 report, Dr. Lin noted that B.G.'s uterus was normal in size and that he could feel no definite adnexal mass. P. Ex. 10 at 1.[14]

80. On September 21, 1983, B.G. was discharged from the hospital with a diagnosis of cervical cancer. I.G. Ex. 3N at 30.

81. Petitioner stated in the discharge summary that he planned to treat B.G. with radiation therapy plus or minus systemic chemotherapy and indicated he would do further work to determine the stage of B.G.'s cancer. I.G. Ex. 3N at 30.

82. Cancer of the cervix can be divided into four stages. In stage I, the cancer is confined to the cervix of the uterus and is entirely removable by surgery; in stage II, the cancer has grown outside of the uterus into the surrounding tissue, but does not extend to the pelvic wall; stage II is frequently divided into stage II(a) and II(b) depending upon the amount of growth of the cancer; in stage III, the cancer has spread into the pelvis and in stage IV, the cancer has spread throughout the patient's body to involve other body systems (metastasized), such as the lymph nodes, liver, and the lungs. Tr. at 72, 78 - 79; P. Ex. 1 at 12.

83. Chemotherapy is not an appropriate treatment for stage II(a) or II(b) cancer of the cervix, because chemotherapy does not cure cancer of the cervix, and

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[14] This is noted in the chart as "no definite adnexal mass palpable." P. Ex. 10 at 1. The term adnexal refers to a location next to the cervix. In the context of this case, the term "adnexal" is used to describe a cancerous mass located next to the cervix that would be characterized as stage III cancer of the cervix. Tr. at 1375.

cervical cancer at that stage can potentially be cured by radiation treatment. Tr. at 85, 1306 - 1308.

84. The proper identification of the progression of cervical cancer (staging) is vital to enable the oncologist to determine the most effective treatment for the patient. Tr. at 1307 - 1310.

85. Petitioner diagnosed B.G. as having stage III cervical cancer. P. Ex. 1.

86. Petitioner based his diagnosis that B.G. had stage III cervical cancer on a pelvic ultrasound report, dated September 13, 1983. Tr. at 1374, 1820; P. Ex. 1 at 1 - 4.

87. Ultrasound is not an accurate diagnostic tool in staging cervical cancer. Tr. at 1376 - 1381.

88. Professionally recognized standards relevant to the treatment of B.G. during the period of time in which Petitioner treated her dictated that Petitioner determine the stage (progression) of B.G.'s cervical cancer based on a combination of 1) a pelvic examination given under general anesthesia and 2) an examination of B.G. by a radiation oncologist. Tr. at 1378 - 1382; P. Ex. 1 at 12.

89. Staging cervical cancer based on ultrasound is below professionally recognized standards. Tr. at 1376 - 1381; Findings 84 - 88.

90. Petitioner's diagnosis of B.G.'s cervical cancer as stage III based on an ultrasound report was below professionally recognized standards. Findings 84 - 89.

91. On September 19, 1983, Dr. Lin performed a pelvic examination of B.G. and found no evidence of Stage III cancer. P. Ex. 10 at 1.

92. As of September 1983, B.G.'s cancer had spread out of the cervix but had not attached to the pelvic wall. Tr. at 72, 766.

93. In September 1983, B.G.'s cancer was not stage III, but was either stage II(a) or II(b). Tr. at 72, 766; I.G. Ex. 3E, 3N.

94. Petitioner incorrectly staged B.G.'s cervical cancer. Findings 82, 84 - 93.

95. Professionally recognized standards mandate that a patient with stage II(a) or II(b) cervical cancer be treated with radiation therapy or surgery. Tr. at 72, 768, 1307.

96. Dr. Lin believed that B.G. was not a candidate for surgery because of her age. Tr. at 1309; I.G. Ex. 3N.

97. Professionally recognized standards dictated that, given that B.G. was not a candidate for surgery, she be referred by Petitioner to a radiation oncologist for radiation treatment. Tr. at 68 - 235, 764 - 787, 966 - 1008, 1069 - 1071, 1083 - 1089, 1302 - 1407.

98. Even assuming B.G. had stage III cancer, professionally recognized standards dictated that Petitioner use radiation to control the cancer locally, and to use chemotherapy only in conjunction with radiation. Tr. at 1307, 1318 - 1319.

99. Petitioner documented that, from December 2, 1983 through January 22, 1987, he treated B.G. for cervical cancer by administering infusions of Adriamycin, Vincristine, and Cytoxan on an almost weekly basis. I.G. Ex. 3N.

100. Petitioner treated B.G.'s cervical cancer solely with chemotherapy. I.G. Ex. 3N.

101. Treating B.G. with chemotherapy had no chance of curing B.G.'s cancer and had no chance of prolonging her life. Tr. at 72, 85 - 89, 1310, 1405 - 1406.

102. It is within professionally recognized standards to treat cervical cancer with chemotherapy in only two instances: 1) where the patient's cancer has metastasized (spread) to the lungs, liver, and other organs and 2) where it is given in conjunction with radiation therapy. Tr. at 1320 - 1329.

103. B.G. did not have metastatic cancer when she was first seen and diagnosed by Petitioner in September 1983. Tr. at 1320 - 1329; I.G. Ex. 3N at 9 - 10.

104. B.G. did not have metastatic cancer when she was started on chemotherapy treatment by Petitioner in December 1983. Tr. at 1320 - 1329; I.G. Ex. 3N at 58; see Tr. at 68 - 235, 764 - 787, 966 - 1008, 1069 - 1071, 1083 - 1089.

105. It was below professionally recognized standards for Petitioner to use only chemotherapy to treat B.G.'s cervical cancer. Tr. at 1388; Findings 76 - 104.

106. Petitioner gave B.G. a course of treatment which had no chance of curing her. Findings 76 - 105 (especially at 100 - 101).

107. During the course of Petitioner's treatment of B.G., B.G.'s cervical cancer continued to grow and her condition continued to worsen. Tr. at 770 - 771; I.G. Ex. 3N at 12 - 22.

108. It was below professionally recognized standards for Petitioner, in the face of steady progression of B.G.'s cancer which demonstrated the ineffectiveness of the chemotherapy treatments he was providing to B.G., to simply add to the treatment various drugs without discontinuing the administration of drugs that had proven to be ineffective in treating her cancer. I.G. Ex. 3N at 12 - 22.

109. Petitioner documented in B.G.'s flow sheet that he gave her approximately 4840 milligrams of Adriamycin. I.G. Ex. 3N.

110. On an average-sized patient with a 1.75 square meter body surface area, 4840 milligrams of Adriamycin is approximately 2765 milligrams per square meter. Tr. at 1334 - 1335.

111. The maximum dosage of Adriamycin that can be withstood by a normal-sized patient is 550 milligrams per square meter. Tr. at 1334 - 1341.

112. The dosage of Adriamycin that Petitioner documented that he gave to B.G. would have killed B.G. Tr. at 1334 - 1341; Findings 109 - 111.

113. B.G.'s death was not related to or caused by the toxic side effects and heart damage from Adriamycin. I.G. Ex. 3E, 3N; see Tr. at 68 - 235, 764 - 787, 966 - 1008, 1069 - 1071, 1083 - 1089, 1302 - 1407.

114. Petitioner did not administer Adriamycin to B.G. in the dosages that were documented on her flow sheet. I.G. Ex. 3E, 3N; Tr. at 1340 - 1341, 2753, 2767; Findings 109 - 113.

115. Petitioner's failure to enter into B.G.'s flow sheet the amount of Adriamycin that she actually received jeopardized B.G.'s health and safety by failing to

adequately ensure continuity of care and failing to protect her from excess toxicity. I.G. Ex. 3E, 3N; Findings 24 - 29, 114.

116. Petitioner's failure to document in B.G.'s flow sheet the actual amount of Adriamycin he administered to B.G. is below professionally recognized standards. I.G. Ex. 3E, 3N; Findings 24 - 29, 114 - 115.

117. Petitioner documented that he administered the drug Vincristine to B.G. in the amount of 5 milligrams per week from July 1985 through January 1987. I.G. Ex. 3N at 69 - 72.

118. The amount of Vincristine that Petitioner documented that he gave to B.G. would have caused complete paralysis of her arms and legs within several months' time. Tr. at 96, 2770.

119. B.G. did not experience complete paralysis of her arms and limbs. I.G. Ex. 3E, 3N.

120. B.G. did not receive Vincristine in the amounts Petitioner documented in her flow sheet. I.G. Ex. 3E, 3N; Findings 42, 117 - 119.

121. Petitioner's failure to enter into B.G.'s flow sheet the amount of Vincristine that she actually received jeopardized B.G.'s health and safety. Findings 24 - 29, 42, 117 - 120.

122. Petitioner's failure to enter into B.G.'s flow sheet the amount of Vincristine that she actually received is below professionally recognized standards. Findings 24 - 29, 117 - 121.

123. Vincristine is not a drug that is useful in the treatment of cancer of the cervix. Tr. at 96, 2770 - 2775.

124. Petitioner offered no evidence that he administered Vincristine to B.G. for any purpose other than to treat her cervical cancer.

125. Petitioner's attempt to treat B.G.'s cervical cancer by using the drug Vincristine was below professionally recognized standards and substantially in excess of B.G.'s needs. Findings 85, 117 - 124.

126. Petitioner documented that, in the first six weeks of treating B.G., he administered Cytoxan to B.G. in an amount sufficient to kill her. I.G. Ex. 3E, 3N; Tr. at 96 - 97, 1340 - 1341; see Finding 41.

127. B.G. did not die within the first six weeks of receiving Cytoxan from Petitioner. I.G. Ex. 3E, 3N.

128. B.G. did not receive Cytoxan in nearly the amount Petitioner documented that he administered to B.G. Tr. at 1340 - 1341; Findings 126 - 127.

129. It was below professionally recognized standards for Petitioner to enter into B.G.'s flow sheet that B.G. received an amount of Cytoxan that she did not actually receive. Findings 24 - 29, 37 - 41, 128; I.G. Ex. 3E, 3N.

130. Petitioner's failure to enter into B.G.'s flow sheet the amount of chemotherapy drugs actually received by B.G. jeopardized B.G.'s health and safety. Findings 22 - 29, 115 - 116, 121 - 122, 128 - 129; I.G. Ex. 3E, 3N.

131. Petitioner's documentation in B.G.'s medical chart is below professionally recognized standards for the following reasons: the chart does not contain Petitioner's orders; the progress notes do not state the reason Petitioner, at various times during treatment, changed the dosages of chemotherapy he administered to B.G.; and the progress notes do not state the method Petitioner used to administer the chemotherapy drugs. I.G. Ex. 3N at 66 - 72; Tr. at 2766 - 2785; Findings 24 - 29.

132. Petitioner's failure to properly document in B.G.'s flow sheet the amounts or method of administration of the drugs he administered to B.G. is below professionally recognized standards. Findings 24 - 29, 116, 122, 129, 130.

133. Petitioner's contention that B.G. was given the choice of surgery or radiation is not documented in B.G.'s patient chart. P. Ex. 1 at 4; I.G. Ex. 3N.

134. Petitioner did not document in B.G.'s chart whether he explained to B.G. that, if she failed to have radiation treatment for her cervical cancer, she would not be cured. Tr. at 108; I.G. Ex. 3N.

135. Petitioner did not document in B.G.'s chart whether he referred B.G. to a radiation oncologist or whether he suggested even that she see a radiation oncologist. Tr. at 108; I.G. Ex. 3N.

136. Petitioner has not been, at any time relevant to this case, a radiation oncologist.

137. Petitioner did not refer B.G. to a radiation oncologist. P. Ex. 1; I.G. Ex. 3N.

138. Professionally recognized standards mandate that Petitioner should have referred B.G. to a radiation oncologist for a consultation. Tr. at 108 - 118, 1316; Findings 88 - 98, 100.

139. Professionally recognized standards mandate that a gynecologist and a radiation oncologist jointly evaluate and stage the tumor in every patient with cancer of the cervix. P. Ex. 1 at 11 - 12; Tr. at 1942; Findings 88 - 98, 100.

140. Petitioner's failure to refer B.G. to a radiation oncologist was below professionally recognized standards. Tr. at 1316; Findings 135 - 139.

141. Petitioner concedes that B.G.'s decision to refuse radiation treatment was of sufficient importance that it should have been documented in B.G.'s chart. Tr. at 1923.

142. Professionally recognized standards mandate that Petitioner should have ensured that B.G.'s refusal of radiation treatments be an informed refusal, in that all of the consequences were explained fully to her, including the fact that refusing radiation therapy would deprive her of her only chance to be cured. Tr. at 1309 - 1310.

143. Petitioner's failure to document in B.G.'s chart that he informed her of the consequences of not receiving radiation treatment was below professionally recognized standards. Tr. at 109.

144. Petitioner's failure to document that he informed B.G. of the side effects of the chemotherapy drugs he planned to administer to her was below professionally recognized standards. Tr. at 116 - 118; Findings 141 - 143.

145. Petitioner's failure to document the discussions he had with B.G. and her caretaker regarding B.G.'s treatment options was below professionally recognized standards. Tr. at 116 - 118, 1821 - 1822.

146. Petitioner believed that B.G. was mentally impaired and thought she may have had Alzheimer's disease. Tr. at 1310 - 1311, 1820 - 1822, 1932.

147. Assuming Petitioner's belief that B.G. was mentally impaired to be true, Petitioner could not have obtained an informed consent from B.G. sufficient to have enabled Petitioner to administer chemotherapy drugs to her. Tr. at 2757.

148. Assuming Petitioner's belief that B.G. was mentally impaired to be true, Petitioner could not have obtained her informed refusal of the potentially lifesaving option of radiation therapy. Tr. at 2763.

149. When treating a mentally impaired individual, professionally recognized standards of care dictate that the treating doctor must specify clearly in the patient's chart what the patient understood and what the decision was that the patient made, or that the patient was incapable of making a decision. Tr. at 2762.

150. Assuming B.G. had a degree of mental impairment that made her incapable of making a decision about the course of her cancer treatment, a court appointed conservator, guardian, or family member should have made the decision for her. Tr. at 1310 - 1314, 2762.

151. Assuming that B.G.'s caretaker was able to make decisions on B.G.'s behalf regarding treatment options for B.G.'s cervical cancer, professionally recognized standards require that this person be informed so that the caretaker is able to make an informed consent or refusal of treatment on behalf of B.G. Tr. at 1312 - 1315; Findings 141 - 150.

152. There is no documentation or evidence of record to indicate that B.G.'s caretaker was legally able to accept or refuse treatment on behalf of B.G. P. Ex. 1; I.G. Ex. 3E, 3N; Tr. at 1822 - 1829, 2760 - 2764.

153. Petitioner failed to document that he explained to B.G. or her caretaker that radiation treatment was potentially curative and that chemotherapy was not potentially curative. I.G. Ex. 3E, 3N; Tr. at 107 - 110, 2759 - 2763.

154. Petitioner's contention that B.G. (or anyone authorized to act on B.G.'s behalf) refused radiation treatment is unsupported by the evidence of record, not credible, and indicative of Petitioner's lack of trustworthiness. P. Ex 1; I.G. Ex. 3E, 3N; Findings 141 - 142, 152 - 153.

155. It was below professionally recognized standards of care that Petitioner failed to document that B.G., or any person authorized to accept or refuse treatment on B.G.'s behalf, gave an informed refusal of potentially curative or lifesaving radiation treatment. Tr. at 1312 - 1315, 1820 - 1823; I.G. Ex. 3E, 3N; Findings 141 - 154.

156. It was below professionally recognized standards of care that Petitioner failed to document that he explained to B.G. and that she understood, or that he explained to anyone authorized to accept or refuse treatment on her behalf, the side effects of the planned chemotherapy treatment. Tr. at 1820 - 1823, 2760 - 2763; Findings 141 - 155; I.G. Ex. 3N.

157. Petitioner claimed that he was minimizing toxicity to B.G. in accordance with the wishes of B.G.'s caretaker. Tr. at 1828 - 1829.

158. From December 2, 1983 through January 22, 1987, Petitioner documented that he administered chemotherapy consisting of Adriamycin, Vincristine, and Cytoxan to B.G. via infusion on an almost weekly basis. I.G. Ex. 3N.

159. The effects of the amounts and types of drugs that Petitioner documented he administered to B.G. during the course of chemotherapy treatments would have caused toxicity and adverse side effects such that B.G. would have died from the toxic side effects of these drugs had she received them in the amounts Petitioner documented she received. Tr. at 68 - 235, 764 - 787, 966 - 1008, 1069 - 1071, 1083 - 1089, 1302 - 1407; I.G. Ex. 3E, 3N.

160. Petitioner's statement that, in accordance with the wishes of B.G.'s caretaker, he wanted to provide B.G. with chemotherapy that would not make B.G. sick, is contradicted by the types and amounts of chemotherapy drugs that Petitioner documented that he administered to B.G. I.G. Ex. 3E, 3N; Findings 157 - 159.

161. Petitioner's statement that he wanted to provide B.G. with chemotherapy that would not make B.G. sick is not credible and is indicative of Petitioner's lack of trustworthiness. Findings 157 - 160.

162. In order for Petitioner to administer chemotherapy drugs in such a way as to not make B.G. sick, Petitioner would have had to administer the chemotherapy drugs at subtherapeutic doses. Findings 21 - 25; Tr. at 1344 - 1345.

163. Administration of subtherapeutic doses of chemotherapy would be ineffective in treating B.G.'s cancer and could have caused B.G.'s cancer to become more resistant to treatment. Tr. at 1389; see Tr. at 68 - 235, 764 - 787, 966 - 1008, 1069 - 1071, 1302 - 1407; Finding 162.

164. Petitioner's statement that he administered chemotherapy to B.G. in such a manner so as to minimize toxicity to B.G. is directly contradicted by the chemotherapy drugs Petitioner chose to administer to B.G. (Adriamycin, Cytoxan, and Vincristine) are all extremely toxic; and one to eight hour infusions of chemotherapy do nothing to minimize the overall toxicity of the drugs Adriamycin, Cytoxan, and Vincristine. I.G. Ex. 3E, 3N; Tr. at 68 - 235, 764 - 787, 966 - 1008, 1069 - 1071, 1083 - 1089, 1302 - 1407, (especially at 1828 - 1829), 2751 - 2847.

165. Petitioner's statement that he administered chemotherapy to B.G. in such a manner so as to minimize toxicity to B.G. is not credible and is indicative of Petitioner's lack of trustworthiness. Finding 164.

166. To the extent that Petitioner's statement that he was minimizing toxicity to B.G. by administering chemotherapy drugs to B.G. via one to eight hour infusion can be construed to mean that Petitioner was reducing the local toxicity of these drugs, Petitioner's statement, in theory, has some merit. Tr. at 1828 - 1829; Findings 10 - 20, 165.

167. There is no evidence from which I can conclude that B.G. had exhibited any effects from local toxicity such that Petitioner was administering chemotherapy to her to minimize local toxicity. I.G. Ex. 3E, 3N.

168. There is no evidence from which I can conclude that, in administering chemotherapy drugs to B.G. in the manner and amount documented in B.G.'s flow sheet, Petitioner was attempting to minimize local toxicity. I.G. Ex. 3E, 3N.

169. There is no evidence from which I can conclude that, at any time during his treatment of B.G., Petitioner changed the method he was using to administer

chemotherapy drugs to B.G. in response to concerns about local toxicity. I.G. Ex. 3E, 3N.

170. Petitioner's administration to B.G. of chemotherapy via one to eight hour infusions was not done for the purpose of preventing or alleviating local toxicity to B.G. I.G. Ex. 3E, 3N; Findings 164 - 169.

171. Even if Petitioner had been attempting to reduce local toxicity by administering chemotherapy to B.G. over one to eight hour infusions, any reduction of local toxicity that could in theory have occurred is outweighed by the fact that a) the bolus method, if administered properly, works sufficiently well to minimize local toxicity; b) chemotherapy infusions over one to eight hours do not reduce overall toxicity to the patient or increase the rate at which cancer cells are killed; c) the doses of chemotherapy Petitioner documented he administered to B.G. were supralethal, in excess of an amount which would have caused B.G. to die from the side effects of the chemotherapy alone. Tr. at 68 - 235, 764 - 787, 966 - 1008, 1069 - 1071, 1083 - 1089, 1302 - 1407, (especially at 1822 - 1832), 2751 - 2847; I.G. Ex. 3E, 3N; Findings 30 - 42.

172. Radiation treatment of the type that would have been effective in treating B.G.'s cancer would have lasted approximately six weeks. Tr. at 1319, 1329 - 1333.

173. The chemotherapeutic drugs Petitioner documented he administered to B.G. are not generally used to treat cervical cancer, nor are they effective in treating cervical cancer. Tr. at 2771 - 2772.

174. Petitioner treated B.G. with over three years of ineffective chemotherapy. I.G. Ex. 3N; Tr. at 1319.

175. Petitioner's administration of chemotherapy to B.G. via one and eight hour infusions served no medical purpose. Tr. at 1829 - 1830; I.G. Ex. 3E, 3N; Findings 15 - 20, 170 - 171, 174.

176. Petitioner's treatment of B.G. with chemotherapy for over three years was substantially in excess of B.G.'s needs. Findings 173 - 175.

177. Petitioner documented that B.G. made office visits for treatment on approximately a weekly basis from December 2, 1983 through January 22, 1987. I.G. Ex. 3E, 3N.

178. Petitioner's treatment of B.G. with chemotherapy caused B.G. to be inconvenienced and spend excessive amounts of time in Petitioner's office. Tr. at 1343 - 1344.

179. Had Petitioner treated B.G. in accordance with professionally recognized standards and administered radiation treatment to her, her treatment would have lasted approximately six weeks. Tr. at 1343.

180. Petitioner's treatment of B.G. with chemotherapy caused B.G. to be severely inconvenienced and led to a deterioration of B.G.'s quality of life. I.G. Ex. 3N; Tr. at 1340 - 1344.

181. Petitioner's statement that both he and two other physicians performed a pelvic exam upon B.G. is unsupported by the evidence of record and is not credible. I.G. Ex. 3E, 3N; Tr. at 105 - 109, 1816.

182. CEA tests are not useful in the diagnosis and treatment of cancer of the cervix. Tr. at 121 - 122, 785.

183. The CEA tests given to B.G. by Petitioner served no medical purpose for the diagnosis and treatment of B.G.'s cervical cancer. Tr. at 125 - 128; Finding 182; I.G. Ex. 3N.

184. It was below professionally recognized standards and substantially in excess of B.G.'s needs for Petitioner to administer CEA tests to B.G. Findings 182 - 183; I.G. Ex. 3N.

185. All of the chemotherapy treatments given by Petitioner to B.G. were below professionally recognized standards of health care and substantially in excess of B.G.'s needs. Findings 76 - 184; I.G. Ex. 3E, 3N; Tr. at 68 - 235, 764 - 787, 966 - 1008, 1069 - 1071, 1083 - 1089, 1302 - 1407.

186. All of the blood tests given by Petitioner to monitor B.G.'s chemotherapy treatments were substantially in excess of her needs. Finding 185; I.G. Ex. 3E, 3N; Tr. at 68 - 235, 764 - 787, 966 - 1008, 1069 - 1071, 1083 - 1089, 1302 - 1407.

187. Petitioner provided to B.G. items or services that were substantially in excess of her needs and of a quality which failed to meet professionally recognized standards of health care. I.G. Ex. 3N; Tr. at 126 - 129, 783 - 785, 1406 - 1407; Findings 76 - 186.

188. Petitioner's management of B.G.'s oncological care jeopardized B.G.'s health, safety, and well-being. Findings 76 - 187.

Petitioner's testimony regarding his treatment of B.G. is indicative of Petitioner's lack of credibility and lack of trustworthiness.

189. Petitioner's testimony regarding the care and treatment he provided to B.G. is evasive, self-contradictory, inaccurate, and contradicted by the evidence of record. Tr. at 1812 - 2012; Findings 76 - 188.

190. Petitioner's testimony that he provided B.G. with care and treatment that was not substantially in excess of B.G.'s needs or of a quality or type that was below professionally recognized standards of health care is not credible. Findings 76 - 189.

191. Petitioner's testimony regarding the care and treatment he provided to B.G. is indicative of Petitioner's lack of credibility and lack of trustworthiness. Findings 76 - 190.

192. Petitioner's representation to this tribunal that the infusion method of administering chemotherapy is a well-established method of treating cancer patients does not take into account that administration of chemotherapy via infusion is done over a period of 24 to 72 hours, whereas Petitioner documented that he administered chemotherapy to B.G. via infusions of one to eight hours. Tr. at 1829, 1841; I.G. Ex. 3E, 3N; P. Ex. 1.

193. Petitioner's assertion that B.G. initially responded very well to the treatment he administered to her is directly contradicted by the evidence of record, is not credible, and is indicative of Petitioner's lack of trustworthiness. Tr. at 68 - 235, 764 - 787, 966 - 1008, 1069 - 1071, 1083 - 1089, 1302 - 1407, (especially at 1845); I.G. Ex. 3E, 3N.

194. The standard used by medical oncologists since 1980 is called "disease free survival." Tr. at 1369.

195. Disease free survival refers to the amount of time a patient is cancer free. Tr. at 1369 - 1371.

196. B.G. had no disease free survival. I.G. Ex. 3N; Tr. at 1369 - 1371.

197. Petitioner's contention that B.G. met the five-year survival standard for cancer of the cervix because she survived with cancer of the cervix from 1983 through 1988 is indicative of a lack of understanding of the standard used by medical oncologists since 1980. Findings 194 - 196.

198. Petitioner's assertion that B.G. met the five-year survival standard, is directly contradicted by the evidence of record and is indicative of Petitioner's lack of credibility and lack of trustworthiness. Tr. at 1846, 1865; Findings 194 - 197.

199. Petitioner's assertion that all of the treatment he administered to B.G. is the "standard protocol" that was modified to fit B.G.'s needs is directly contradicted by the following: professionally recognized standards mandated that B.G. should have received radiation treatment; the chemotherapy Petitioner documented he administered to B.G. was an extremely toxic combination of chemotherapeutic agents that was administered in supralethal doses; and the amount of chemotherapy Petitioner actually administered to B.G., if any, was not an amount that could have controlled or reduced B.G.'s cancer. Tr. at 68 - 235, 764 - 787, 966 - 1008, 1069 - 1071, 1302 - 1407, (especially at 1849); Findings 76 - 198.

200. Petitioner's attempts to explain and justify why he did not enter into B.G.'s flow sheet the amount of chemotherapy drugs that B.G. actually received are not credible and are indicative of his lack of trustworthiness. Tr. at 1883 - 1884; I.G. Ex. 3N at 71 - 72; P. Ex. 1; Findings 24 - 29; see Tr. at 1812 - 2012.

201. Petitioner's statement that he was not surprised that B.G. had no significant changes in her blood count is indicative of a lack of understanding of the serious side effects of the chemotherapy drugs which Petitioner documented he administered to B.G. Tr. at 1898; I.G. Ex. 3N; Findings 19 - 23.

202. Petitioner's testimony that the chart contained in P. Ex. 1 at 27 (and P. Ex. 1 in general) shows the efficacy of the combination of chemotherapeutic agents he administered to B.G. is entirely contradicted by a complete reading of P. Ex. 1. Tr. at 1908 - 1915.

203. Petitioner gave evasive answers when informed that the chart at P. Ex. 1 at 27 and P. Ex. 1 in general refers to response rates of only single agent chemotherapy. Tr. at 1908 - 1915.

204. Petitioner's attempt to justify his administration of combination chemotherapeutic agents to B.G., based on the information contained in P. Ex. 1, is contradicted by the evidence of record and the information contained in P. Ex. 1, and is indicative of Petitioner's lack of credibility and lack of trustworthiness. Tr. at 1908 - 1915; Findings 79 - 203.

205. Petitioner's assertions that the combination of chemotherapy drugs he administered to B.G. is superior to single agent chemotherapy and does not produce any overlapping toxicity is directly contradicted by the evidence of record. Tr. at 1908 - 1915; I.G. Ex. 3N; P. Ex. 1; Findings 79 - 204.

206. When given the opportunity to do so, Petitioner was not able to cite or produce any evidence which would support his choosing the combination of chemotherapeutic drugs or the amounts of chemotherapeutic drugs he documented he administered to B.G. Tr. at 1908 - 1915; I.G. Ex. 3N; P. Ex. 1; Findings 79 - 205.

207. Petitioner specifically denies that the consulting gynecologist recommended that B.G. have radiation therapy to treat her cervical cancer, despite the presence in the medical records of such a recommendation by the gynecologist. Tr. at 1928 - 1930; I.G. Ex. 3N at 35.

208. Petitioner's denial that the consulting gynecologist recommended that B.G. have radiation therapy to treat her cervical cancer is not credible and is indicative of Petitioner's lack of trustworthiness. Tr. at 1928 - 1930; I.G. Ex. 3N at 35.

209. A CT scan of B.G.'s pelvis performed on September 3, 1985 shows possible recurrence or extension of B.G.'s cancer. Tr. at 1948 - 50; I.G. Ex. 3N at 43.

210. Petitioner's statement that, in September 1985, he changed the treatment he administered to B.G. is contradicted by the evidence of record and by B.G.'s flow sheet. Tr. at 1950; I.G. Ex. 3E, 3N.

211. Petitioner's statement that, in September 1985, he changed the treatment he administered to B.G. is not credible and is indicative of Petitioner's lack of trustworthiness. Finding 210.

212. Petitioner acknowledges there is no basis for performing a CEA test on B.G. on a weekly basis. Tr. at 1956.

213. Petitioner submitted claims to Medicare which indicated that he performed a CEA test on B.G. virtually every week during the period of time he was treating her. Tr. at 1956 - 1958; I.G. Ex. 3E, 3N, 7.

214. Petitioner's assertion that, for the most part, he performed a CEA test on B.G. every two months is directly contradicted by the evidence of record. Tr. at 1957; I.G. Ex. 3E, 3N; Finding 213.

215. Petitioner denies that he performed CEA tests on B.G. on virtually a weekly basis during the entire time he was treating her. Tr. at 1956.

216. Petitioner's assertion that it was a mistake that caused him to submit claims to Medicare in which he indicated he performed a CEA test on B.G. virtually every week during the time that he was treating B.G. is not credible and is indicative of Petitioner's severe lack of trustworthiness. Tr. at 1956 - 1958; Findings 76 - 215.

217. Petitioner's attempts to justify his treatment of B.G. as being in accordance with professionally recognized standards of health care and not substantially in excess of B.G.'s needs are inconsistent, insufficient, self-contradictory, either unsupported or contradicted by the evidence of record, and not credible. P. Ex. 1; Tr. at 68 - 235, 764 - 787, 966 - 1008, 1069 - 1071, 1083 - 1089, 1302 - 1407, 1812 - 2012, 2751 - 2795; Findings 76 - 216.

Petitioner's treatment of Patient D.R.

218. D.R. was an 84-year-old farm laborer who was five feet tall and weighed 100 pounds. I.G. Ex. 30 at 41, 52.

219. D.R. was first seen by Petitioner on October 23, 1985. I.G. Ex. 30 at 401.

220. There are four types of lung cancer -- adenocarcinoma, large cell carcinoma, squamous cell carcinoma, and small cell carcinoma (also called oat cell carcinoma). Tr. at 525 - 527.

221. Adenocarcinoma, large cell carcinoma, and squamous cell carcinoma cannot be treated effectively by chemotherapy for any sustained period of time. Tr. at 525 - 527.

222. Small cell carcinoma can be treated effectively via chemotherapy. Tr. at 525 - 527.

223. Immediately prior to seeing Petitioner, D.R. was diagnosed by a Dr. Salazar as having inoperable non-small cell cancer of the right lung. I.G. Ex. 30 at 35.

224. Non-small cell cancer is the same as large cell cancer. I.G. Ex. 30 at 35; Tr. at 243, 256.

225. Dr. Salazar's diagnosis was based upon exploratory surgery and a tissue biopsy and analysis. I.G. Ex. 30 at 35.

226. Petitioner treated D.R. from October 23, 1985 through April 20, 1987. I.G. Ex. 30 at 52.

227. Complete records of Petitioner's treatment of D.R. exist for the year 1986 only. See I.G. Ex. 30 at 1 - 2.

228. Only Petitioner's treatment of D.R. during the year 1986 is at issue in this case. Findings 226 - 227; I.G. Ex. 3E, 30.

229. To the extent Petitioner's treatment of D.R. is based on a diagnosis by Petitioner that occurred prior to 1986, such diagnosis is relevant to my determination in this case.

230. Professionally recognized standards of health care dictated that Petitioner, in 1986, administer palliative care to D.R., i.e., treat only his symptoms. Tr. at 801, 1413.

231. "Palliative care" is treatment that attempts to alleviate the patient's pain and deal with any adverse symptoms, rather than those that attack the underlying illness. Tr. at 520, 801.

232. D.R. was not a patient whose condition could be palliated with chemotherapy treatments. Tr. at 1439 - 1440.

233. Petitioner's administration of chemotherapy to D.R. was not palliative. Findings 231 - 232.

234. In 1986, Petitioner documented in D.R.'s chart that D.R. made 136 visits to Petitioner's office to obtain chemotherapy treatment. I.G. Ex. 30 at 3 - 5.

235. The combination of drugs that Petitioner documented that he administered to D.R. in 1986 was not effective in treating D.R.'s lung cancer. Tr. at 235 - 328, 788 - 811, 1008 - 1020, 1071 - 1074, 1407 - 1464; I.G. Ex. 3E, 3O.

236. Each of the chemotherapy treatments administered by Petitioner to D.R. in 1986 was medically unnecessary and ineffective in treating D.R.'s illness. Tr. at 242 - 262, 797 - 803, 1410; I.G. Ex. 3E, 3O; see Tr. at 235 - 328, 788 - 811, 1008 - 1020, 1071 - 1074, 1407 - 1464.

237. Petitioner continued to treat D.R. with an ineffective combination of chemotherapy drugs even when it was apparent that the drugs were having no effect on D.R.'s cancer. Tr. at 792 - 804; I.G. Ex. 3E, 3O; Findings 235 - 236.

238. Petitioner's assertion that he chose a regimen of treatment for D.R. that was likely to be least toxic in a man who is 84 years of age is entirely and overwhelmingly contradicted by the evidence and testimony of record, is not credible, and is indicative of Petitioner's lack of trustworthiness. I.G. Ex. 3E, 3O; Tr. at 235 - 328, (especially at 2096 - 2100); see Tr. at 235 - 328, 788 - 811, 1008 - 1020, 1407 - 1464; I.G. Ex. 3E, 3O.

239. Petitioner documented that he subjected D.R. to an inordinate number of office visits (136) that was substantially in excess of D.R.'s needs. I.G. Ex. 3E, 3O; Tr. at 1411 - 1412; Finding 234.

240. Petitioner's treatment of D.R. with chemotherapy significantly decreased D.R.'s quality of life, with no tangible benefit. I.G. Ex. 3O at 20, 24; Tr. at 1407 - 1464; Findings 234 - 239.

241. Petitioner documented that, in 1986, he administered the drugs Adriamycin, Cytoxan, 5-FU, Bleomycin, Vincristine, and BCNU to D.R. I.G. Ex. 3E, 3O.

242. In 1986, D.R. was receiving the drug Lanoxin, which is used in treating heart disorders. Tr. at 1416; I.G. Ex. 3O.

243. D.R. had a heart disorder in 1986 during the time he was receiving chemotherapy treatments from Petitioner. I.G. Ex. 3E, 3O; Tr. at 793 - 796.

244. The drug Adriamycin is cardiotoxic and is contraindicated in patients with heart disorders. Tr. at 1416.

245. Given D.R.'s age and his preexisting heart disorder, it was below professionally recognized standards of health care and substantially in excess of D.R.'s needs for Petitioner to administer the drug Adriamycin to D.R. in 1986. Findings 241 - 244.

246. The amount of Adriamycin which Petitioner documented he gave to D.R. in 1986 was a lethal amount sufficient to cause death from the toxic side effects of this drug. I.G. Ex. 3E, 30 at 8 - 31; Tr. at 243 - 253.

247. D.R. did not die from the toxic side effects of Adriamycin. I.G. Ex. 3E, 30.

248. D.R. did not receive Adriamycin in the amount Petitioner documented that he administered to him. I.G. Ex. 3E, 30; Tr. at 243 - 244; Findings 246 - 247.

249. It was potentially dangerous and life-threatening to D.R. for Petitioner to incorrectly document that D.R. received Adriamycin in amounts which he did not actually receive. Findings 24 - 33, 246 - 248.

250. It was below professionally recognized standards of health care for Petitioner to document in D.R.'s chart that D.R. was receiving an amount of Adriamycin that he was not receiving. Findings 24 - 33, 248 - 249.

251. Bleomycin is not effective in treating non-small cell lung cancer. Tr. at 240, 2859.

252. Bleomycin produces irreversible lung damage. Tr. at 240, 2859.

253. Bleomycin has not been used in treating lung cancer since at least 1982. Tr. at 240, 2859.

254. It was below professionally recognized standards and substantially in excess of D.R.'s needs for Petitioner to administer Bleomycin to D.R. in 1986 for the treatment of D.R.'s non-small cell lung cancer. Findings 43, 251 - 253.

255. Cytoxan is not effective in treating non-small cell lung cancer. Tr. at 243.

256. 5-FU is not effective in treating non-small cell lung cancer. Tr. at 243.

257. Vincristine is not effective in treating non-small cell lung cancer. Tr. at 243.

258. BCNU is not effective in treating non-small cell lung cancer. Tr. at 243.

259. It was below professionally recognized standards of health care and substantially in excess of D.R.'s needs for Petitioner to administer the drugs Cytoxan, 5-FU, BCNU, and Vincristine to D.R. in 1986. Findings 230 - 233, 235 - 237, 241 - 258.

260. In 1986, Vincristine was available in reusable vials of one, two, and five milligrams. Tr. at 1410 - 1411, 2855 - 2856.

261. The maximum dosage of Vincristine which can safely be administered to a normal sized patient at one time is two milligrams. Tr. at 1410 - 1411, 2855 - 2856.

262. Petitioner documented that he administered five milligrams of Vincristine to D.R. on each occasion that he gave the drug to D.R. in 1986. I.G. Ex. 3E, 30 at 83, 194.

263. On each occasion Petitioner submitted a claim for reimbursement for administering Vincristine to D.R., Petitioner billed the Medicare program for five milligrams. I.G. Ex. 30; Tr. at 1410 - 1411, 2855 - 2856.

264. The blood counts that Petitioner documented he performed on D.R. do not support that D.R. received the doses of Cytoxan, Adriamycin, and Vincristine that are documented in the flow sheet. I.G. Ex. 30 at 19.

265. The dosages of Cytoxan which Petitioner documented he gave to D.R. in 1986 were a lethal dose sufficient to cause death from the toxic side effects of this drug. I.G. Ex. 30 at 8 - 31; Tr. at 246 - 251.

266. There is no medical documentation that D.R. had suppression of bone marrow that is exhibited by decreased blood cell counts. I.G. Ex. 30; Tr. at 246 - 247.

267. D.R. exhibited no significant abnormality in his blood cell counts. I.G. Ex. 30; Tr. at 246 - 247, 801 - 802.

268. D.R. did not die from the toxic side effects of Cytoxan. I.G. Ex. 30 at 52; Tr. at 247 - 251, 308 - 309.

269. Petitioner, despite documenting he did so, did not administer the drug Cytoxan to D.R. in any significant amount, if at all. Findings 264 - 268; Tr. at 246 - 247.

270. The maximum tolerable dose of Vincristine for D.R. to have received is three milligrams per month. Tr. at 255.

271. Petitioner documented that, at one point, he administered 10 milligrams of Vincristine to D.R. in a one month period. I.G. Ex. 30; Tr. at 255.

272. Had D.R. received 10 milligrams of Vincristine in one month, he would have been paralyzed in his arms and legs. Tr. at 255.

273. D.R.'s arms and legs did not become paralyzed. I.G. Ex. 3E, 30.

274. Petitioner did not administer Vincristine to D.R. in the amount he claimed to have administered to D.R. Tr. at 255; I.G. Ex. 30; Findings 270 - 273.

275. D.R. did not exhibit any side effects from the drug Bleomycin. I.G. Ex. 30; Findings 266 - 267; Tr. at 253 - 255.

276. D.R. did not receive Bleomycin in the amount Petitioner documented he administered to D.R. Tr. at 253 - 255; Finding 275.

277. It was below professionally recognized standards for Petitioner to have documented in D.R.'s flow sheet that D.R. received chemotherapy doses of Adriamycin, Bleomycin, Cytoxan, and Vincristine in amounts that were different from the amounts of these drugs that Petitioner actually administered to D.R. I.G. Ex. 3E, 30; Findings 21 - 42, 248 - 250, 269, 274, 276 - 277; Tr. at 235 - 328, 788 - 811, 1008 - 1070, 1071 - 1074, 1407 - 1464.

278. X-ray reports of March 26, 1986 and June 6, 1986 showed an increasing and growing tumor mass in D.R.'s chest. I.G. Ex. 30 at 77 - 78.

279. As of September 1986, Petitioner believed that D.R. was having an "excellent response" to the chemotherapy treatment. I.G. Ex. 30 at 340.

280. Over the course of 1986, D.R.'s cancer continued to grow in size and severity. I.G. Ex. 3E, 30; Tr. at 1418 - 1419, 1444; Finding 278.

281. The combination, type, amounts and frequency of drugs that Petitioner documented he administered to D.R. were below professionally recognized standards,

substantially in excess of D.R.'s needs, and were not medically effective nor medically appropriate in the treatment of D.R.'s cancer. Tr. at 235 - 328, 788 - 811, 1008 - 1020, 1071 - 1074, 1407 - 1464; Findings 218 - 280.

282. Petitioner continued to provide the same treatment to D.R. in the face of progressively worsening symptoms and increasing tumor mass. Tr. at 792 - 811, 1418 - 1419, 1444; I.G. Ex. 3E, 3O; Findings 278 - 280.

283. Petitioner failed to change his treatment of D.R. when there was overwhelming objective evidence that the treatment he was using had failed to have any effect on D.R.'s cancer. Tr. at 1418 - 1419, 1444; I.G. Ex. 3E, 3O; Findings 278 - 282.

284. It was below professionally recognized standards of health care for Petitioner to have continued the same course of treatment with D.R. in the face of progressive disease. Tr. at 251 - 252, 266, 797 - 801, 1418 - 1419, 1444; I.G. Ex. 3E, 3O; Findings 278 - 283.

285. Petitioner believed D.R. was a good candidate for chemotherapy treatment because D.R. was fully ambulatory and had an 80 percent Karnofsky Performance Status Score. P. Ex. 2 at 24.

286. A Karnofsky Performance Status Score is not determinative of whether D.R. was a good candidate for chemotherapy. Tr. at 2861.

287. Petitioner's reliance on D.R.'s Karnofsky Performance Status Score in determining whether D.R. was a good candidate for chemotherapy is below professionally recognized standards. Findings 285 - 286.

288. D.R. was not a good candidate for chemotherapy, given his age, the condition of his heart, and the fact that he had non-small cell cancer, which is not curable by chemotherapy. Findings 218, 220 - 225, 230 - 233, 235, 242 - 245; Tr. at 235 - 328, 800 - 802, 1450, 2861; I.G. Ex. 3E, 3O.

289. It was below professionally recognized standards of health care for Petitioner to have administered chemotherapy treatment to D.R. in the manner he purports to have administered it; that is, via one to eight hour infusions. I.G. Ex. 3E, 3O at 20, 24; Findings 10 - 20; Tr. at 234 - 328, 800 - 802.

290. The amounts of the chemotherapeutic agents Cytoxan, Adriamycin, 5-FU, Vincristine, Bleomycin and BCNU that Petitioner documented he gave to D.R. during 1986 were below professionally recognized standards of health care and substantially in excess of D.R.'s needs. I.G. Ex. 3E, 30; Tr. at 235 - 328, 788 - 811, 1008 - 1020, 1071 - 1074, 1407 - 1464; Findings 246 - 277.

291. Petitioner documented that he administered chemotherapy drugs to D.R. during 1986 via one and eight hour infusions on approximately a weekly or biweekly basis. I.G. Ex. 3E, 30.

292. The chemotherapy infusions (one and eight hours) Petitioner documented he administered to D.R. in 1986 contained Adriamycin, Cytoxan, and 5 FU, with occasional Bleomycin, Vincristine, and, on three occasions, BCNU. I.G. Ex. 30 at 3 - 5, 13, 18 - 20.

293. It was of no medical benefit to D.R. for Petitioner to have administered any of the chemotherapy agents he administered to D.R. via a one to eight hour infusion. Tr. at 234 - 328, 788 - 811, 1008 - 1020, 1071 - 1074, 1407 - 1464; I.G. Ex. 3E, 30 at 8 - 31; Findings 10 - 20, 292.

294. Petitioner documented that he administered at least 20 multivitamin injections and vitamin B-12 injections to D.R. during 1986. I.G. Ex. 30.

295. There is no documentation to support Petitioner's contention that D.R.'s medical condition required the administration of any multivitamin injections and vitamin B-12 injections. I.G. Ex. 30; Tr. at 802 - 803, 1426.

296. It was below professionally recognized standards for Petitioner to administer multi-vitamin injections and vitamin B-12 injections to D.R. without documenting the underlying condition that caused D.R. to require such injections. I.G. Ex. 3E, 30 at 25, 29; Tr. at 806.

297. All of the multivitamin injections and vitamin B-12 injections that Petitioner documented he administered to D.R. in 1986 were substantially in excess of D.R.'s needs. Findings 294 - 296.

298. Petitioner documented that he administered three laryngoscopies to D.R. Tr. at 274 - 275; I.G. Ex. 30.

299. A laryngoscope is a device that allows a doctor to look inside the larynx. See Tr. at 274, 275, 326 - 328.

300. Petitioner documented that he used a laryngoscopy on more than one occasion to diagnose that D.R. had oral candidiasis or "thrush". I.G. Ex. 3E, 3O; Tr. at 326 - 327.

301. The diagnosis and treatment of oral candidiasis does not require the use of a laryngoscopy. Tr. at 326 - 327, 803, 1453.

302. Petitioner's use of three laryngoscopies to diagnose and treat D.R.'s oral candidiasis was substantially in excess of D.R.'s needs. Findings 298 - 301.

303. Given D.R.'s condition in 1986, the professionally recognized standard permitted an oncologist to attempt to treat D.R.'s cancer with an approved experimental chemotherapy protocol. Tr. at 258 - 259, 801; Finding 230.

304. Petitioner did not administer to D.R. an approved or legitimate experimental chemotherapy protocol. I.G. Ex. 3E, 3O; see Tr. at 235 - 328, 788 - 811, 1008 - 1020, 1071 - 1074, 1407 - 1464, 2849 - 2863, 2918 - 2928, 2960 - 2961.

305. In some instances, a patient's symptoms may be palliated with chemotherapy. Tr. at 1439 - 1440.

306. Given D.R.'s age and heart problems, Petitioner could not have reasonably expected to palliate D.R.'s symptoms by administering chemotherapy which included the cardiotoxic drug Adriamycin. I.G. Ex. 3E, 3O; Tr. at 1434 - 1436; Findings 231 - 233, 245.

307. Given D.R.'s age and physical problems, Petitioner could not have reasonably expected to palliate D.R.'s symptoms by administering chemotherapy which included the drug Cytoxan (especially in combination with Adriamycin). I.G. Ex. 3E, 3O; Tr. at 235 - 328, 1407 - 1464, 2849 - 2863, 2918 - 2928; Findings 37 - 38, 230 - 233.

308. Given D.R.'s age, the fact that he had one lung removed and the fact that he had chronic obstructive pulmonary disease, Petitioner could not have reasonably expected to palliate D.R.'s symptoms by administering chemotherapy which included the drug Bleomycin, which produces irreversible lung damage. Tr. at 240; Findings 230 - 233, 251 - 253.

309. Petitioner documented that he administered prehydration in conjunction with his administration of chemotherapy drugs to D.R. I.G. Ex. 3E, 3O.

310. None of the chemotherapy drugs administered by Petitioner to D.R. required prehydration. Tr. at 1407 - 1464; I.G. Ex. 3E.

311. Petitioner's providing of prehydration to D.R. was substantially in excess of D.R.'s needs. Tr. at 1413, 1451; I.G. Ex. 3E, 3O; Findings 309 - 310.

312. D.R.'s CEA was within the normal range. Tr. at 239 - 240, 295, 2851 - 2853.

313. CEA studies are not a useful aid in the treatment of large (non small) cell carcinoma, the type of cancer D.R. had. I.G. Ex. 3E; Tr. at 235 - 328; Findings 223 - 224.

314. None of the CEAs which Petitioner documented that he provided to D.R. were medically necessary. Findings 312 - 313.

315. The CEAs which Petitioner documented he provided to D.R. in 1986 were substantially in excess of D.R.'s needs. Findings 312 - 314.

316. None of the CBCs which Petitioner documented that he provided for D.R. in 1986 were medically necessary. I.G. Ex. 3E, 3O; Tr. at 806.

317. None of the venipunctures which Petitioner documented that he provided for D.R. in 1986 were medically necessary. I.G. Ex. 3E, 3O; Tr. at 235 - 328, 806, 1407 - 1464, 2849 - 2863, 2918 - 2928.

318. None of the platelet counts which Petitioner documented that he provided for D.R. in 1986 were medically necessary. I.G. Ex. 3E, 3O; Tr. at 235 - 328, 806, 1407 - 1464, 2849 - 2863, 2918 - 2928.

319. The CEAs, venipunctures, prehydration, and platelet counts that Petitioner provided to D.R. in 1986 were below professionally recognized standards of health care and substantially in excess of D.R.'s needs. I.G. Ex. 3E, 3O; Findings 309 - 318.

320. Petitioner's failure to properly document the actual amounts of chemotherapy drugs that he administered to D.R. jeopardized D.R.'s health, safety, and well-being. Findings 21 - 26, 28, 29, 250, 264, 269, 276 - 277, 281, 283 - 284, 290, 293.

321. Petitioner furnished or caused to be furnished items or services to D.R. that were substantially in excess of D.R.'s needs. Findings 218 - 320; Tr. at 235 - 328, 788 - 811, 1008 - 1020, 1071 - 1074, 1407 - 1464, 2089 - 2283, 2849 - 2863, 2918 - 2928, 2960 - 2961.

322. Petitioner provided items or services to D.R. of a quality which failed to meet professionally recognized standards of health care. Findings 218 - 321; Tr. at 235 - 328, 788 - 811, 1008 - 1020, 1071 - 1074, 1407 - 1464, 2089 - 2283, 2849 - 2863, 2918 - 2928, 2960 - 2961.

323. Petitioner's management of D.R.'s case jeopardized D.R.'s health, safety, and well-being. Findings 219 - 322.

324. Petitioner's attempts to justify his treatment of D.R. are inconsistent, insufficient, and not credible. P. Ex. 2; Tr. at 235 - 328, 788 - 811, 1008 - 1020, 1071 - 1074, 1407 - 1464, 2089 - 2283, 2849 - 2863, 2918 - 2928, 2960 - 2961.

325. The exhibit Petitioner offered into evidence to support his treatment of D.R. does not support or justify his treatment of D.R. P. Ex. 2; Tr. at 2096 - 2099; I.G. Ex. 3E, 3O; see Tr. at 235 - 328, 788 - 811, 1008 - 1020, 1071 - 1074, 1407 - 1464, 2849 - 2863, 2918 - 2928, 2960 - 2961.

Petitioner's testimony regarding his treatment of D.R. is indicative of Petitioner's lack of credibility and lack of trustworthiness.

326. Petitioner's contentions that either he or his office staff knew how much chemotherapy D.R. received, even though the documentation does not reflect the amounts D.R. received, is not credible and is indicative of Petitioner's lack of trustworthiness. Tr. at 1764, 2117 - 2120; I.G. Ex. 3E, 3O; Findings 249 - 250, 254, 259 - 277.

327. Petitioner's statement that he gave D.R. the amounts of chemotherapy drugs documented in D.R.'s flow sheet is contradicted by the evidence, is not credible, and is indicative of Petitioner's lack of trustworthiness. I.G. Ex. 3E, 3O; Tr. at 235 - 328, 788 - 811, 1008 - 1020, 1071 - 1074, 1407 - 1464, 2849 - 2863; Findings 218 - 326.

328. Petitioner's statement that, in the event another doctor would have to treat D.R., someone on Petitioner's staff would be fully able to inform the other doctor of

the precise amounts of chemotherapy D.R. received from Petitioner sufficient to ensure continuity of care is not supported by the evidence of record, is not credible, and is indicative of Petitioner's lack of trustworthiness. Tr. at 2123 - 2125; I.G. Ex. 3E, 3O; Findings 326 - 327.

329. Petitioner's explanations as to why D.R.'s flow sheets reflect that D.R. received a different amount of chemotherapy from that which he claims to have actually administered to D.R. are self-serving, unsupported by the evidence of record, and not credible. Tr. at 2123 - 2130.

330. Petitioner's attempt to blame alleged inadequacies in the Medicare code book for his having billed for an entire vial of a chemotherapeutic agent, even if he administered a lesser amount to D.R., is indicative of Petitioner's lack of trustworthiness. Tr. at 2119 - 2121.

331. On at least three separate occasions, Petitioner submitted reimbursement claims to CA (California) Blue Shield for purportedly having administered Cytoxan to D.R. whereas in fact D.R. did not receive Cytoxan on those three occasions. Tr. at 2131 - 2136.

332. Petitioner blames his office staff for the erroneous billings on the three occasions where CA Blue Shield was billed for Cytoxan and D.R. did not receive it. Tr. at 2131 - 2137.

333. Petitioner's assertion that professionally recognized standards of health care do not mandate that an oncologist keep accurate written records of the total dose of chemotherapy administered to a patient is contradicted by Petitioner's own testimony and the evidence of record and is indicative of Petitioner's lack of credibility and lack of trustworthiness. Findings 21 - 29; Tr. at 1315, 2137 - 2138.

334. Petitioner's evasive and inaccurate testimony regarding the amount of Adriamycin he administered to D.R. is indicative of his lack of credibility and lack of trustworthiness. Tr. at 2140 - 2141.

335. Petitioner did not administer Adriamycin to D.R. over a 24 to 72 hour period. I.G. Ex. 3O.

336. Petitioner did not administer Adriamycin to D.R. via the infusion method. Tr. at 2142 - 2143; Findings 13 - 20, 334 - 335; I.G. Ex. 3E, 3O.

337. Petitioner's assertion that D.R. could tolerate four to five times the amount of Adriamycin (if Petitioner administered Adriamycin to D.R. via the infusion method) is entirely contradicted by the evidence of record and is indicative of Petitioner's lack of trustworthiness and lack of credibility. Tr. at 2142; I.G. Ex. 3E, 3O; Findings 30 - 33, 241 - 250, 306.

338. Petitioner's assertion that D.R. was an "ideal" candidate for chemotherapy is directly contradicted by the evidence and is indicative of Petitioner's lack of credibility and lack of trustworthiness. I.G. Ex. 3E, 3O; Tr. at 2146; Findings 218 - 293.

339. Petitioner's contention that chemotherapy was the only treatment of choice for D.R. is not supported by the evidence. Tr. at 2146 - 2150; I.G. Ex. 3E, 3N; Findings 230 - 234, 338.

340. Petitioner's statement that D.R.'s blood counts did not remain normal during the time he was receiving chemotherapy is directly contradicted by the evidence. Tr. at 2154 - 2155; I.G. Ex. 3O; Tr. at 246 - 247, 801 - 802; Findings 264 - 267.

341. Petitioner's denial that he administered the drug BCNU to D.R. is contradicted by D.R.'s flow sheet which indicates that D.R. received BCNU while under Petitioner's care in 1986. Tr. at 2117, 2156 - 2159; I.G. Ex. 3O at 121, 202.

342. Petitioner's attributing to office or clerical error the fact that Medicare was billed for D.R. receiving BCNU is indicative of Petitioner's lack of credibility and lack of trustworthiness. Tr. at 2156 - 2159; Findings 258 - 259, 341.

343. Petitioner was unable to give any medical justification for his administration of prehydration prior to giving D.R. Adriamycin, Cytoxan, or Vincristine. Tr. at 2165.

344. Petitioner asserts that he knew how much Vincristine he administered to D.R., even though he was unable to give that information in his testimony or point to any documentation in the medical charts to indicate what amount D.R. received. Tr. at 2173 - 2174.

345. Petitioner's assertion that he knew how much Vincristine he was administering to D.R. is indicative of his lack of credibility and lack of trustworthiness. Tr. at 2173 - 2174.

346. Petitioner was evasive when questioned as to why he did not change D.R.'s treatment when confronted with successive chest x-rays indicating D.R.'s cancer was progressing. Tr. at 2175 - 2180; I.G. Ex. 30 at 77 - 81.

347. Petitioner's lack of credibility and lack of trustworthiness is evidenced by his assertion that the notes that accompany D.R.'s chest x-rays (which mention increases in the size of D.R.'s tumor mass) are merely subjective evaluations that cannot be taken at face value. Tr. at 2175 - 2180; I.G. Ex. 30 at 77 - 81.

348. Petitioner's assertion that his treatment of D.R.'s cancer with Cytoxan and Adriamycin helped D.R. is directly contradicted by the evidence. I.G. Ex. 3E, 30; Findings 235 - 250, 255, 259, 264 - 269, 278 - 293; Tr. at 235 - 328, 788 - 811, 1008 - 1020, 1071 - 1074, 1407 - 1464, (especially at 2182 - 2192), 2849 - 2863.

349. Petitioner admitted that he added Bleomycin to D.R.'s chemotherapy regimen of Adriamycin and Cytoxan. Tr. at 2182 - 2192; I.G. Ex. 30 at 89.

350. Petitioner's admission that he administered Bleomycin to D.R. is indicative of a lack of understanding and knowledge about the effects of Bleomycin. Tr. at 1434 - 1435, 2182 - 2192; I.G. Ex. 3E, 30 at 89, 30; Findings 251 - 254.

351. Petitioner's admission that he administered Bleomycin to D.R. is indicative of Petitioner's willingness to provide treatment that is medically inappropriate and ineffective. I.G. Ex. 3E, 30; Tr. at 2182 - 2192; Finding 350.

352. Petitioner's statement that P. Ex. 2 supports his treatment of D.R. is directly contradicted by the evidence of record and is indicative of Petitioner's lack of credibility and lack of trustworthiness. P. Ex. 2; Tr. at 1437 - 1444, (especially at 2192).

353. Petitioner's assertion that D.R. did not exhibit weight loss is directly contradicted by the evidence of record and is indicative of Petitioner's lack of credibility and lack of trustworthiness. Tr. at 2193 - 2195; I.G. Ex. 30 at 51.

Petitioner's treatment of Patient H.W.

354. H.W. was an 82-year-old male who was not complaining of any pain and who was first seen by Petitioner in April of 1985 for cancer of the prostate. P. Ex. 3; I.G. Ex. 3P at 482.

355. Petitioner provided treatment to H.W. as his patient from April 23, 1985 through February 8, 1989. I.G. Ex. 3P at 3 - 4.

356. Petitioner documented that he administered approximately weekly doses of chemotherapy to H.W. from April 23, 1985 through February 8, 1989. I.G. Ex. 3P at 3 - 4.

357. The diagnosis that H.W. had cancer of the prostate was made by a Dr. James Nelson on the basis of a biopsy. P. Ex. 3; I.G. Ex. 3P at 482.

358. Paget's disease is a common disorder of middle-aged and elderly people in which the normal process of bone formation is disrupted, causing the affected bones to weaken, thicken, and become deformed, and which is usually restricted to a limited area of the skeleton. American Medical Association Encyclopedia of Medicine, (Charles B. Claymann, M.D., med. ed., Random House, 1989); Tr. at 813 - 814.[15]

359. Paget's disease can be confused with the appearance of prostate cancer after prostate cancer has metastasized to a patient's bone. Tr. at 813 - 814.

360. Petitioner's office note of June 19, 1985 states a tentative diagnosis that patient H.W. had Paget's disease and no metastasis of his prostate cancer. I.G. Ex. 3P at 478.

361. Two bone scans of H.W. showed that he had Paget's disease and indicated that H.W. did not have metastatic prostate cancer. I.G. Ex. 3P at 178; Tr. at 1509; I.G. Ex. 19 at 5.

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[15] For purposes of this Decision, I take judicial notice of the aforementioned definition of Paget's disease, as it appears in the American Medical Association Encyclopedia of Medicine.

362. At the time he began receiving treatment from Petitioner, H.W. did not exhibit any symptoms of metastatic prostate cancer. I.G. Ex. 3P at 13, 15, 17 - 19.

363. At no time did Petitioner document that H.W. had any symptoms of metastatic prostate cancer. I.G. Ex. 3P.

364. Petitioner claims that the appearance of a lung nodule on a 1988 x-ray justifies a finding that H.W. had metastatic prostate cancer. Tr. at 2284 - 2367; I.G. Ex. 3P at 31.

365. The chemotherapy treatment Petitioner documented he administered to H.W. from April 23, 1985 through February 8, 1987 amounts to a supralethal dose of Cytoxan and a near supralethal dose of 5FU. I.G. Ex. 3P; Tr. at 328 - 428, 811 - 836, 1020 - 1035, 1071 - 1074, 1464 - 1524, 2284 - 2367.

366. Cytoxan causes suppression of bone marrow. Tr. at 339 - 340.

367. Cytoxan given over a period of three and a half years causes leukemia in 5 to 10 percent of the patients receiving the Cytoxan. Tr. at 352.

368. There is nothing in the record to support a finding that H.W. had any suppression of his bone marrow. I.G. Ex. 3E, 3P; Tr. at 341 - 342.

369. Administration of 5FU in therapeutic doses causes suppression of blood cell counts. Tr. at 343.

370. H.W. did not exhibit any prolonged, suppressed blood cell counts that would be associated with receiving therapeutic doses of 5FU. Tr. at 343 - 344, 812 - 814; I.G. Ex. 3E, 3P.

371. Petitioner was unable to state with any degree of specificity how much Cytoxan or 5FU he administered to H.W. Tr. at 2348 - 2350; P. Ex. 3.

372. H.W. did not receive anywhere near the amounts of Cytoxan and 5FU that Petitioner claimed to have administered to him. Findings 365 - 371.

373. Even assuming H.W. had required chemotherapy to treat metastatic prostate cancer, such treatment would not be performed using Cytoxan, as this chemotherapy agent is ineffective in treating metastatic cancer of the prostate. Tr. at 350 - 351.

374. It was not medically necessary for Petitioner to administer Cytoxan and 5FU to H.W. Findings 354 - 373.

375. H.W. would have died had he received the doses of Cytoxan that Petitioner documented he administered to H.W. I.G. Ex. 3E, 3P; Tr. at 328 - 428, 811 - 836, 1020 - 1035, 1071 - 1074, 1464 - 1524, 2284 - 2367.

376. H.W. would have been near death and may have died had he received the doses of 5FU that Petitioner documented he administered to H.W. I.G. Ex. 3E, 3P; Tr. at 328 - 428, 811 - 836, 1020 - 1035, 1071 - 1074, 1464 - 1524, 2284 - 2367.

377. Petitioner's assertion that the appearance of a lung nodule on an x-ray in 1988 justifies the regimen of chemotherapy treatment he administered to H.W. from April 1985 through February 1989 is not credible and is inconsistent with Petitioner's own documentation concluding that H.W. had no metastatic prostate cancer. I.G. Ex 3E, 3P; Tr. at 328 - 428, 811 - 836, 1020 - 1035, 1071 - 1074, 1464 - 1524, 2284 - 2367, 2863 - 2872; Findings 354 - 364.

378. Assuming Petitioner believed that H.W. had metastatic prostate cancer in 1985, professionally recognized standards of health care dictate that he should have obtained a biopsy from H.W. and should not have relied on an x-ray as proof that H.W. had metastatic disease. Tr. at 1500 - 1513.

379. Even assuming that H.W. had metastatic prostate cancer in 1985, professionally recognized standards of health care mandate that Petitioner first attempt to treat the cancer with hormone manipulation rather than administering chemotherapy as a first course of action. Tr. at 814 - 815.

380. Petitioner's assertion that H.W. had metastatic prostate cancer in April 1985 is directly contradicted by the evidence of record. Tr. at 328 - 428, 811 - 836, 1020 - 1035, 1071 - 1074, 1464 - 1524, 2284 - 2367, I.G. Ex. 3E, 3P.

381. Because Petitioner's diagnosis was in conflict with the radiology reports, it was incumbent upon Petitioner to do further studies to show that H.W. had metastatic cancer before initiating chemotherapy. Tr. at 1508 - 1509; I.G. Ex. 3E, 3P.

382. Petitioner failed to document that H.W. was having any adverse symptoms from his prostate cancer. I.G. Ex. 3E, 3P; Tr. at 328 - 428, 823, 1464 - 1524.

383. During the time Petitioner treated H.W., H.W.'s prostate cancer was confined to the prostate and had not spread. I.G. Ex. 3E, 3P; Tr. at 328 - 348, 811 - 836, 1464 - 1524.

384. Professionally recognized standards of health care dictate that, in treating H.W. during the period of time which Petitioner treated him, Petitioner should not have administered treatments to him simply because he had prostate cancer that was contained within the prostate, but simply should have monitored him and begun treatment if his symptoms worsened, indicating the disease was progressively worsening. Tr. at 823 - 824; see Tr. at 328 - 428, 1464 - 1524.

385. H.W.'s prostate cancer was not progressively worsening. Tr. at 328 - 428, 811 - 836, 1464 - 1524; I.G. Ex. 3E, 3P.

386. During the time Petitioner treated H.W., H.W. was not exhibiting symptoms related to his prostate cancer. Tr. at 335; I.G. Ex. 3E, 3P; Findings 354 - 364, 382 - 385.

387. Professionally recognized standards of health care dictated that, in treating a patient such as H.W., whose prostate cancer was not progressive and had not spread outside of the prostate, the oncologist do nothing as long as the cancer is not causing symptoms. Tr. at 334 - 339, 824.

388. Even if H.W. had prostate cancer that had metastasized to the bone, the professionally recognized standard of health care would have been to treat it with hormone therapy and to treat any bone pain that H.W. may have had with localized radiation. Tr. at 328 - 428, 811 - 836, 1020 - 1035, 1464 - 1524.

389. Professionally recognized standards of health care for H.W.'s case dictated that, since H.W. had no symptoms and no sign of progressive disease, Petitioner should have monitored H.W. periodically, administering no treatment as long as H.W. had no symptoms and no sign of progressive disease; performed an orchiectomy on H.W.; or administered hormone therapy to H.W. Tr. at 328 - 428, 811 - 836, 1020 - 1035, 1071 - 1074, 1464 - 1524.

390. An "orchiectomy" is a surgical procedure in which the patient's testicles are removed. Tr. at 825.

391. Professionally recognized standards of health care dictated that Petitioner was obligated to document in his treatment notes that H.W. was offered the orchiectomy option and refused it before choosing to treat him with chemotherapy. Tr. at 1485 - 1486.

392. Petitioner never documented in his notes that H.W. was offered and refused an orchiectomy as a curative measure. I.G. Ex. 3E, 3P; Tr. at 2295, 2320 - 2322.

393. Treating H.W.'s localized prostate cancer with hormone therapy, localized radiation, or surgical removal of the prostate would have been within professionally recognized standards. Tr. at 356 - 359.

394. Hormone therapy for prostate cancer involves removing the male hormone upon which the cancer feeds. Tr. at 819 - 821.

395. Hormone therapy can be accomplished by removal of the testicles, treatment with the hormone estrogen, or treatment with a "hormone blocker" which is a substance that interferes with the production or uptake of the male hormone. Tr. at 357, 819 - 821.

396. The hormone blockers ("leuprolide" and "flutamide") which would be treatment options today were not readily available during the time Petitioner began treating H.W. Tr. at 363.

397. At the time during which Petitioner was treating H.W., H.W. had a history of heart problems and hypertension. I.G. Ex. 3P at 14, 18; Tr. at 328 - 428, 1464 - 1524.

398. Estrogen treatment can aggravate heart problems. Tr. at 360, 825.

399. Estrogen could have been administered to treat H.W.'s cancer as long as H.W. was carefully monitored. Tr. at 355 - 361, 829 - 831.

400. Removal of the prostate has many adverse side effects. Tr. at 358, 367 - 368.

401. Removal of the prostate would not be indicated in H.W.'s case because of the risks associated with the operation and the availability of other preferable

treatment options, such as hormone manipulation and radiation. Tr. at 328 - 428, 811 - 836, 1020 - 1035, 1464 - 1524.

402. Prostate cancer does not respond reliably to chemotherapy. Tr. at 819.

403. Prostatic Acid Phosphatase (PAP) is a component of total acid phosphatase. Tr. at 1471 - 1472.

404. PAP cannot be higher than total acid phosphatase. Tr. at 1471 - 1472; Finding 403.

405. Neither the PAP nor the prostate specific antigen (PSA) test results indicated that H.W.'s prostate cancer was growing. Tr. at 345 - 346, 818 - 819.

406. During the time in which H.W. was being treated by Petitioner, H.W.'s prostate cancer was not spreading and had not spread outside of the prostate. I.G. Ex. 3E, 3P; Tr. at 328 - 428, 811 - 836, 1020 - 1035, 1071 - 1074, 1464 - 1524, 2284 - 2367, 2863 - 2872; Findings 385, 387.

407. Petitioner's use of the PAP test to diagnose and monitor H.W. was in accordance with professionally recognized standards. Tr. at 346.

408. The PAP results showed that the chemotherapy treatment that Petitioner documented he administered had no effect on H.W.'s cancer. Tr. at 346, 817 - 818.

409. Professionally recognized standards of health care dictate use of chemotherapy to treat metastatic cancer of the prostate only in patients who have received hormone treatment and who did not respond to it and who have received and not responded to radiation therapy. Tr. at 351.

410. Petitioner did not document that he explained the treatment options to H.W., including radiation and hormone therapy. I.G. Ex. 3E, 3P.

411. It was below professionally recognized standards of health care for Petitioner not to document that he explained the treatment options to H.W. Tr. at 328 - 428, 811 - 836, 1020 - 1035, 1071 - 1074, 1464 - 1524.

412. It was below professionally recognized standards of health care for Petitioner not to document that he considered using hormone therapy and the reasons he rejected the available hormonal therapy options. I.G. Ex. 3E, 3P; Tr. at 369 - 372.

413. It was below professionally recognized standards of health care for Petitioner not to document that he considered using radiation treatment and the reasons he rejected using it to treat H.W.'s localized cancer. I.G. Ex. 3E, 3P; Tr. at 369 - 372.

414. Chemotherapy could not cure H.W.'s prostate cancer. Tr. at 367.

415. Even if chemotherapy were used to treat metastatic cancer in a patient who had not responded to either hormone treatment or radiation therapy, such chemotherapy is palliative only and not curative. Tr. at 351.

416. Even when the correct dosages and types of drugs are used, chemotherapy can be used to palliate pain only for short periods of time, i.e., approximately 6 to 14 weeks. Tr. at 1486.

417. The chemotherapy treatment which Petitioner documented that he administered to H.W. was not palliative. I.G. Ex. 3E, 3P; Tr. at 328 - 428, 811 - 836, 1020 - 1035, 1071 - 1074, 1464 - 1524, 2284 - 2367; Findings 356, 414 - 416.

418. The chemotherapy treatment which Petitioner documented that he administered to H.W. was not effective in the treatment of H.W.'s prostate cancer. I.G. Ex. 3E, 3P; Tr. at 328 - 428, 811 - 836, 1020 - 1035, 1071 - 1074, 1464 - 1524, 2284 - 2367; Findings 354, 355, 373 - 374, 384, 388, 405, 408, 415 - 417.

419. It was below professionally recognized standards of health care and substantially in excess of H.W.'s needs for Petitioner to treat H.W. with chemotherapy using the frequency, amounts, and types of drugs that he did. Findings 354 - 418; I.G. Ex. 3E, 3P; Tr. at 328 - 428, 811 - 836, 1020 - 1035, 1071 - 1074, 1464 - 1524, 2284 - 2367.

420. It was below professionally recognized standards of health care for Petitioner to treat H.W.'s prostate cancer with chemotherapy, given the stage of the disease and the lack of documented symptoms, and without first trying effective means of treatment such as hormonal therapy or radiation. Findings 354 - 419; I.G. Ex. 3E, 3P; Tr. at 328 - 428, 811 - 836, 1020 - 1035, 1071 - 1074, 1464 - 1524, 2284 - 2367.

421. It was below professionally recognized standards of health care and substantially in excess of H.W.'s needs for Petitioner to treat H.W. for over three years of

chemotherapy treatments. Findings 354 - 420; I.G. Ex. 3E, 3P; Tr. at 328 - 428, 811 - 836, 1020 - 1035, 1071 - 1074, 1464 - 1524, 2284 - 2367.

422. It was below professionally recognized standards of health care and substantially in excess of H.W.'s needs for Petitioner to treat H.W. with Cytoxan, a chemotherapeutic agent that is not effective in treating metastatic prostate cancer. Findings 354 - 421; I.G. Ex. 3E, 3P; Tr. at 328 - 428, 811 - 836, 1020 - 1035, 1071 - 1074, 1464 - 1524, 2284 - 2367.

423. It was below professionally recognized standards of health care for Petitioner not to document H.W.'s symptoms and progress. I.G. Ex. 3E, 3P; Tr. at 328 - 428, 811 - 836, 1020 - 1035, 1071 - 1074, 1464 - 1524, 2284 - 2367.

424. It was below professionally recognized standards of health care and substantially in excess of H.W.'s needs for Petitioner to continue to administer chemotherapy from April 1985 through February 1989 without documenting H.W.'s symptoms that the treatment was designed to alleviate or without sufficiently documenting any progress made by H.W. I.G. Ex. 3E, 3P; Tr. at 328 - 428, 811 - 836, 1020 - 1035, 1071 - 1074, 1464 - 1524, 2284 - 2367.

425. It was below professionally recognized standards of health care for Petitioner not to enter in H.W.'s flow sheet the actual and precise amounts of drugs that H.W. received. Findings 354 - 424; I.G. Ex. 3E, 3P; Tr. at 328 - 428, 811 - 836, 1020 - 1035, 1071 - 1074, 1464 - 1524, 2284 - 2367.

426. Petitioner jeopardized the health, safety, and well-being of H.W. by not entering on H.W.'s flow sheets the actual amounts of drugs that H.W. received. Findings 354 - 425.

427. Petitioner's outpatient notes on H.W. were vague, unclear, and, in some cases even, not written by Petitioner. Tr. at 375 - 376; I.G. Ex. 3P at 365, 373, 375.

428. Petitioner's outpatient notes on H.W. were below professionally recognized standards of health care. Finding 427; Tr. at 375 - 376.

429. Petitioner administered chemotherapy to H.W. via one and eight hour intravenous infusions. I.G. Ex. 3E, 3P.

430. It was substantially in excess of H.W.'s needs for Petitioner to administer CBCs and platelet counts to H.W. Tr. at 1487; I.G. Ex. 3E, 3P; Tr. at 325 - 428, 811 - 836, 1464 - 1524.

431. Petitioner's care of H.W. reflects a lack of understanding of professionally recognized standards of health care in the treatment and management of prostate cancer. Findings 354 - 430.

432. Petitioner's attempts to justify his treatment of H.W. are inconsistent, inadequate, and not credible. P. Ex. 3; Tr. at 328 - 428, 811 - 836, 1020 - 1035, 1071 - 1074, 1464 - 1524, 2284 - 2367, 2863 - 2872; Findings 354 - 431.

Petitioner's testimony regarding his care and treatment of H.W. is indicative of Petitioner's lack of credibility and lack of trustworthiness.

433. Petitioner's testimony, that he believed that, when he first examined H.W., H.W. had metastatic prostate cancer, is directly contradicted by the evidence of record, is not credible, and is indicative of Petitioner's lack of trustworthiness. Tr. at 2286; I.G. Ex. 3P at 48; see I.G. Ex. 3P; Findings 354 - 364, 377 - 383.

434. Petitioner asserted that his plan for treating H.W. was based on the following factors: H.W.'s refusal to have orchiectomy; H.W.'s extremely high blood pressure and congestive heart failure prevented him from administering hormone therapy; and H.W.'s only remaining treatment option was chemotherapy. Tr. at 2287.

435. Petitioner assertion's that H.W. had incurable metastatic cancer of the prostate when he first began treating H.W. in April of 1985 is not credible and is indicative of Petitioner's lack of credibility and lack of trustworthiness. Tr. at 2296; Findings 354 - 364, 377 - 383.

436. Petitioner conceded that there is nothing in the medical records that shows that he conducted any type of physical examination of H.W.'s prostate. Tr. at 2303.

437. Petitioner contends that the page in the medical records that shows that he conducted a physical examination of H.W.'s prostate is missing from the I.G.'s medical records. Tr. at 2303.

438. The I.G. gave Petitioner the opportunity to submit rebuttal materials before the I.G. made a final determination to accept the PRO's recommendation to exclude Petitioner. I.G. Ex. 3B, 3G, 3M; I.G.'s February 10, 1992 letter to Petitioner.

439. Petitioner was given ample opportunity to submit all records relevant to the treatment of the seven patients at issue in this case. I.G.'s February 10, 1992 letter to Petitioner; Petitioner's March 31, 1992 letter requesting hearings; see my numerous prehearing orders and rulings in this case.

440. Petitioner did not submit any evidence that supports his contention that he conducted a physical examination of H.W.'s prostate. Tr. at 2302 - 2305; Findings 354 - 439.

441. Petitioner's contention that the page in the medical records that shows he performed a physical examination of H.W.'s prostate is missing is not corroborated by any evidence, is not credible, and is indicative of Petitioner's lack of trustworthiness. Findings 354 - 440.

442. Petitioner's statement that he did not document that H.W. had refused orchiectomy because another doctor had informed Petitioner of H.W.'s refusal is indicative of a lack of understanding of the reasons for documenting a patient's condition. Tr. at 2320 - 2322.

443. Petitioner's assertion that chemotherapy causes nausea and vomiting only when it is not given in proper doses is directly contradicted by the evidence of record and Petitioner's own testimony. Tr. at 2296, 2317 - 2318; Findings 21 - 28.

444. Petitioner's assertion that chemotherapy causes nausea and vomiting only when it is not given in proper doses is indicative of Petitioner's lack of credibility and lack of trustworthiness. Finding 443.

445. Petitioner's attempts to blame computer error for erroneous results of PAP tests he administered to H.W. are self-serving and not credible. Tr. at 2334.

446. Petitioner's own testimony and other evidence of record directly contradict Petitioner's assertion that the doses of chemotherapy he administered to H.W. in 1988 and 1989 are those that are contained in H.W.'s flow sheet. Tr. at 2343 - 2346.

447. Petitioner's assertion is not credible that, from 1984 until 1988, the doses of chemotherapy he administered to H.W. are not contained in the flow sheet but are contained in the route slip. Tr. at 2343 - 2346.

448. Petitioner gave evasive, self-serving answers in response to questions about how much H.W. actually received of the chemotherapy drugs listed in H.W.'s flow sheet. Tr. at 2343 - 2351.

449. Petitioner admitted that H.W.'s flow sheets do not accurately reflect the amount of chemotherapy medication Petitioner administered to H.W. Tr. at 2347; I.G. Ex. 3P at 83 - 84.

450. Petitioner's assertion that, despite inaccuracies in H.W.'s flow sheet, he could keep track of the amount of chemotherapy he was administering to H.W. because, at the time he was treating H.W., he had only four or five patients who were receiving chemotherapy, is unsupported by the evidence of record, is not credible, and is indicative of Petitioner's lack of credibility and lack of trustworthiness. Tr. at 2347 - 2349.

451. Petitioner's attempt to blame his nursing staff for inaccuracies in H.W.'s flow sheet and for his inability to be able to determine how much chemotherapy H.W. actually received are indicative of Petitioner's lack of credibility and lack of trustworthiness. Tr. at 2348 - 2351.

452. Petitioner's progress note, in which he stated that H.W. had excellent performance and showed improvement, is directly contradicted by the evidence of record and is indicative of Petitioner's willingness to resort to distortion to justify his treatment of patients. Tr. at 2352 - 2355; I.G. Ex. 3E, 3P (especially 3P at 457).

453. Petitioner's progress note that H.W. had excellent performance despite clear evidence to the contrary is indicative of his lack of credibility and lack of trustworthiness. Findings 354 - 452.

454. Petitioner's assertion that there is no standard for documentation in a patient's chart is directly contradicted by the evidence of record and by Petitioner's own testimony in which he noted several important reasons for a treating oncologist or other physician to properly document a patient's chart to indicate precisely the course of treatment that is being followed by the treating physician. Tr. at 1315, 2361 - 2362; Findings 24 - 29.

Petitioner's treatment of Patient J.W.

455. J.W. first obtained treatment from Petitioner in 1979. I.G. Ex. 3Q, 11, 12.

456. In 1979, J.W. was a 24-year-old male with a history of malignant melanoma that had spread to his lymph nodes. I.G. Ex. 11, 12.

457. J.W. had the lymph nodes removed and subsequently developed brain metastasis, which also was surgically removed in 1980. I.G. Ex. 3Q, 11, 12.

458. J.W. was given several postoperative radiation treatments by a Dr. Hittle in 1980, but did not complete his treatment. I.G. Ex. 11, 12; Tr. at 1528.

459. In May 1983, J.W. underwent an extensive workup at the University of Texas' M.D. Anderson Hospital and Tumor Institute (Anderson Hospital) located in Houston, Texas. I.G. Ex. 15; Tr. at 1544.

460. Anderson Hospital is an institution that is recognized as one of this country's premier institutions in treating cancer. I.G. Ex. 15; Tr. at 1544.

461. The May 1983 workup and subsequent biopsy by Anderson Hospital found no cancer in J.W. I.G. Ex. 14, 15, 17.

462. On May 18, 1983, a Dr. Nicholas Papadopoulos reported no evidence of measurable malignant melanoma below J.W.'s neck. I.G. Ex. 15; Tr. at 1544.

463. Dr. Papadopoulos' May 18, 1983 evaluation did note the presence of a soft tissue mass involving the roof of the mouth and sinus area (nasopharynx) and stated that the mass was biopsied by a Dr. Medina and showed no malignancy. I.G. Ex. 15.

464. Another follow-up report by Dr. Papadopoulos, dated June 24, 1983, noted that the mass in J.W.'s nasopharynx area persisted, and that he was awaiting comment from a Dr. Medina at the Head and Neck Clinic. I.G. Ex. 17 at 1 - 2.

465. Petitioner's treatment of J.W. from February 11, 1985 through November 22, 1989 only is at issue in this case. I.G. Ex. 3Q.

466. J.W.'s condition prior to February 11, 1985 is relevant and probative as to whether Petitioner furnished or caused to be furnished items or services from February 11, 1985 through November 22, 1989 that were substantially in excess of J.W.'s needs or of a quality which fails to meet professionally recognized standards of health care. Findings 455 - 464.

467. The treatment and care Petitioner received from the Anderson Hospital in 1983 is relevant to whether, from February 11, 1985 through November 22, 1989, Petitioner furnished or caused to be furnished services to J.W. that were substantially in excess of J.W.'s needs and of a quality which fails to meet professionally recognized standards of health care. Findings 459 - 464.

468. A Magnetic Resonance Imaging (MRI) report dated March 26, 1986 states that the findings were consistent with the presence of a recurrent tumor with surrounding edema. P. Ex. 4 at 12.

469. The March 26, 1986 MRI is not determinative that J.W. had a recurrence of his cancer. Tr. at 1549.

470. Professionally recognized standards of health care dictate that, in J.W.'s case, upon receiving information such as that contained in the March 26, 1986 MRI, the oncologist take into consideration J.R.'s previous negative biopsies, his clean bill of health from the Anderson Hospital, and confirm or disprove the MRI results with a biopsy. Tr. at 1549.

471. Petitioner did not perform or order a biopsy to confirm or disprove the March 26, 1986 MRI results. I.G. Ex. 3E, 3Q.

472. An MRI report dated August 15, 1986 notes that any abnormality observed is likely due to postsurgical change, but did not rule out a possible recurrence of J.W.'s cancer. P. Ex. 4 at 13.

473. An MRI report dated January 20, 1987 found no evidence of any active disease and specifically notes that the area in which the abnormality which appears in the MRI is smaller than it was in the August 18, 1986 MRI. P. Ex. 4 at 14.

474. The January 20, 1987 MRI report concludes that the abnormality seen in the MRI is the result of normal postoperative changes. P. Ex. 4 at 14.

475. The three MRI reports -- March 26, 1986; August 15, 1986; and January 20, 1987 -- collectively establish that there was no progression of J.W.'s brain cancer during that period of time. Tr. at 1548, 1560 - 1561, 2875 - 2876; Findings 468 - 474.

476. Excepting the March 26, 1986 MRI, no other MRI report from February 11, 1985 through November 22, 1989 notes any active metastasis or presence of disease in J.W. I.G. Ex. 3E, 3Q (especially at 12 - 22); Findings 468 - 475.

477. J.W. did not have cancer (or metastatic melanoma) subsequent to his surgery in 1980. Tr. at 464, 514 - 515, 855 - 859; I.G. Ex. 3E, 3Q.

478. J.W. did not have cancer subsequent to his workup at the Anderson Hospital in May and June of 1983. Findings 455 - 477; Tr. at 428 - 515, 837 - 864, 1035 - 1049, 1071 - 1074, 1525 - 1563 (especially at 1531 - 1532), 2873 - 2874.

479. J.W. had epilepsy since the age of 12. I.G. Ex. 3Q.

480. Petitioner was aware of J.W.'s epilepsy. I.G. Ex. 3Q at 66; Tr. at 2383.

481. Petitioner failed to take into account J.W.'s history of epilepsy as a possible cause of J.W.'s seizures. Findings 479 - 480; Tr. at 433; I.G. Ex. 3Q at 66.

482. J.W.'s seizures were the result of his epilepsy and not the result of any metastatic disease. Tr. at 428 - 515 (especially at 433), 837 - 864, 1035 - 1049, 1071 - 1074, 1464 - 1524, 2872 - 2879, 2931 - 2937; I.G. Ex. 3E, 3Q; Findings 477 - 481.

483. Petitioner has failed to show any persuasive evidence that J.W. had any type of cancer subsequent to J.W.'s surgery in 1980. I.G. Ex. 3E, 3Q; Tr. at 428 - 515, 837 - 864, 1035 - 1049, 1071 - 1074, 1464 - 1524, 2378 - 2469, 2872 - 2879, 2931 - 2937.

484. Petitioner concluded that J.W. had melanoma[16] that had metastasized to the brain upon first examining J.W. in 1979. P. Ex. 4; Tr. at 2383 - 2385.

485. Petitioner remained convinced that J.W. had metastatic melanoma such that, from February 11, 1985 through November 22, 1989, Petitioner administered chemotherapy to J.W. to treat him for melanoma that had metastasized to the brain. Tr. at 2378 - 2469; P. Ex. 4; I.G. Ex. 3E, 3Q.

486. Petitioner's conclusion that J.W. had melanoma that had metastasized to the brain at any time subsequent to 1980 is directly contradicted by the evidence of record. P. Ex. 4; Tr. at 428 - 515, 837 - 864, 1035 - 1049, 1071 - 1074, 1464 - 1524, (especially 2378 - 2469), 2872 - 2879, 2931 - 2937; I.G. Ex. 3E, 3Q; Finding 485.

487. Chemotherapy treatments are unlikely to have any effect on a cancer that has spread to the brain because of the difficulty of getting therapeutic doses of chemotherapy through the barrier between the brain and the bloodstream. Tr. at 2876.

488. The professionally recognized standard of health care for treating J.W. from February 11, 1985 through November 22, 1989 was to observe J.W. and treat him with antiepileptic medications. Tr. at 855 - 859; I.G. Ex. 3E, 3Q.

489. Petitioner's treatment of J.W. with chemotherapy drugs from February 11, 1985 through November 22, 1989 was below professionally recognized standards of health care and substantially in excess of J.W.'s needs.[17]

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[16] The term melanoma refers to a specific type of cancer. I use the terms "cancer" and "melanoma" interchangeably when referring to J.W. because melanoma is the specific type of cancer for which J.W. was receiving treatment from Petitioner. The references to metastatic melanoma refer to the fact that Petitioner believed J.W.'s melanoma had metastasized in J.W.'s brain.

[17] The I.G. has placed no records into evidence that demonstrate the types and amounts of chemotherapy Petitioner administered to J.W. between 1979 (when Petitioner first examined and diagnosed J.W.) and February 11, 1985. Admittedly, this date is somewhat arbitrary and may seem abrupt to the reader. I take this cutoff merely at face value, i.e., that the I.G. simply

Findings 455 - 488; Tr. at 428 - 515 (especially at 465), 837 - 864, 1035 - 1049, 1071 - 1074, 1464 - 1524.

490. Petitioner did not refer J.W. to a radiation oncologist subsequent to February 11, 1985. I.G. Ex. 3E, 3Q.

491. Petitioner documented that he administered BCNU to J.W. from April 11, 1985 through July 6, 1989. I.G. Ex. 3E, 3Q.

492. The amount of BCNU that Petitioner documented that he gave to J.W. is a lethal dose that would have killed J.W. had J.W. received it. Tr. at 845, 1533.

493. J.W. did not die from the effects of BCNU. I.G. Ex. 3E, 3Q.

494. J.W. did not receive BCNU in the amounts indicated by Petitioner's flow sheets. Finding 491 - 493.

495. It was below professionally recognized standards of health care for Petitioner to document that he administered an amount of BCNU to J.W. that J.W. did not receive. Findings 21 - 29, 494.

496. Petitioner's administration of BCNU to J.W. from April 11, 1985 through July 6, 1989 was below professionally recognized standards of health care and substantially in excess of J.W.'s needs, due to the following: J.W. did not have evidence of metastatic melanoma in his brain at any time subsequent to 1983, and Petitioner administered BCNU to J.W. at irregular and varied intervals. Tr. at 428 - 515, 837 - 864, 1035 - 1049, 1071 - 1074, 1525 - 1563; I.G. Ex. 3E, 3Q; Findings 491 - 495.

497. Given the irregular intervals at which Petitioner administered BCNU to J.W., Petitioner's administration of BCNU to J.W. from April 11, 1985 through July 6, 1989 was below professionally recognized standards of health care.

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does not have sufficient records to document Petitioner's care of J.W. during this period. I do not infer from the absence of the records to imply either that Petitioner's treatment of J.W. between 1979 and February 11, 1985 was or was not in accordance with professionally recognized standards. Likewise, I do not infer from the absence of data that Petitioner's treatment of J.W. between 1979 and February 11, 1985 either was or was not substantially in excess of J.W.'s needs.

Tr. at 428 - 515, 837 - 864, 1035 - 1049, 1071 - 1074, 1525 - 1563; I.G. Ex. 3E, 3Q.

498. Petitioner documented in J.W.'s chart that he administered the drug Bleomycin to J.W. on multiple occasions between June 2, 1988 through March 2, 1989. I.G. Ex. 3E, 3Q (especially at 146 - 148).

499. The drug Bleomycin does not have any effect on melanoma. Tr. at 449 - 451.

500. The drug Bleomycin has adverse side effects such as causing lung damage. Finding 252.

501. It was harmful to J.W.'s health, safety, and well-being and of no medical benefit to J.W. for Petitioner to administer Bleomycin to J.W. in the amounts Petitioner documented he administered to J.W. I.G. Ex. 3E, 3Q; Findings 498 - 500.

502. Petitioner's administration of Bleomycin to J.W. at sporadic intervals -- June 2, 1988 through March 2, 1989 -- was below professionally recognized standards of health care and substantially in excess of J.W.'s needs. I.G. Ex. 3E, 3Q (especially at 146 - 148); Tr. at 428 - 515 (especially at 450 - 451), 837 - 864, 1035 - 1049, 1071 - 1074, 1525 - 1563; Findings 498 - 501.

503. Petitioner documented in J.W.'s chart that he administered the drug Vincristine to J.W. on multiple occasions from April 6, 1985 through September 7, 1989. I.G. Ex. 3E, 3Q; Tr. at 453 - 454.

504. Vincristine is not a drug that is useful or effective in the treatment of metastatic melanoma. Tr. at 453 - 454.

505. Petitioner documented that he administered Vincristine to J.W. in an amount that would have left J.W. unable to walk. Tr. at 448 - 449.

506. There is no documentation in J.W.'s chart that he suffered any form of paralysis from Vincristine. I.G. Ex. 3E, 3Q.

507. Petitioner did not administer the drug Vincristine to J.W. in the amounts he documented in J.W.'s flow sheet. Findings 503 - 506.

508. Petitioner administered Vincristine to J.W. in such a manner that he jeopardized J.W.'s health, safety, and well-being. Findings 24 - 29, 42, 507.

509. Petitioner's administration of Vincristine to J.W. at sporadic intervals from April 11, 1985 through September 7, 1989 was below professionally recognized standards of health care and substantially in excess of J.W.'s needs. I.G. Ex. 3E, 3Q; Tr. at 428 - 515, 837 - 864, 1035 - 1049, 1071 - 1074, 1525 - 1563; Findings 503 - 508.

510. Assuming Petitioner was convinced that the biopsies of J.W. at the Anderson Hospital were incorrect, professionally recognized standards of health care dictated that Petitioner order another biopsy taken to confirm the presence of cancer. Tr. at 1546 - 1549.

511. Because Petitioner was aware of the information contained in the three MRIs, J.W.'s medical history, and the negative biopsy from the Anderson Hospital, it was below professionally recognized standards of health care and substantially in excess of J.W.'s needs for Petitioner to treat J.W. with chemotherapy without performing a biopsy to confirm the presence of cancer. Tr. at 1546 - 1549; Findings 455 - 486, 510.

512. Petitioner's treatment of J.W. over a four-year period with chemotherapy, from 1985 through 1989, was below professionally recognized standards of health care and substantially in excess of J.W.'s needs. Findings 455 - 511.

513. Even assuming J.W. did have cancer subsequent to his surgery in 1980 at the Anderson Hospital, professionally recognized standards of health care dictated that Petitioner should have referred J.W. to a radiation oncologist for a consultation before administering chemotherapy. Tr. at 857, 1561, 2876; Findings 455 - 511.

514. Petitioner's assertion that he did not refer J.W. to a radiation oncologist because J.W. could not tolerate any more radiation is not supported by the evidence of record and is not credible. I.G. Ex. 3E, 3Q; Tr. at 2392.

515. Petitioner's failure to refer J.W. to a radiation oncologist before administering chemotherapy to him in 1985 was below professionally recognized standards of health care. Tr. at 2392.

516. Petitioner's misdiagnosis of J.W.'s condition and administration of chemotherapy drugs to J.W. between

April 11, 1985 and September 7, 1989[18] subjected J.W. to serious and unnecessary risks. I.G. Ex. 3Q; Findings 455 - 515.

517. Even assuming that Petitioner's decision to treat J.W. with chemotherapy was in accordance with professionally recognized standards of health care (which it was not), the dosages Petitioner gave to J.W. as documented in the flow sheet were below professionally recognized standards of health care and substantially in excess of J.W.'s needs. Tr. at 1527; I.G. Ex. 3E, 3Q.

518. Petitioner documented in J.W.'s flow sheet that he gave J.W. the drug DTIC in sporadic dosages of 150 milligrams.[19] See, e.g., I.G. Ex. 3Q at 145.

519. The appropriate method for administration of DTIC is to give between 125 - 250 milligrams per square meter (body surface area) for five consecutive days. Tr. at 1534.

520. J.W. was 6 feet 1 inch tall, and weighed 195 pounds, giving him a body surface area in excess of one square meter. See I.G. Ex. 3Q at 54.

521. Petitioner's administration of DTIC to J.W. was below professionally recognized standards of health care, in that Petitioner administered doses of DTIC in an erratic and sporadic manner and that Petitioner administered DTIC to J.W. eight years after the last evidence of tumor. I.G. Ex. 3E, 3Q; Tr. at 454; Findings 518 - 520.

522. For purposes of this Decision, the term "protocol" means the treatment of cancer patients with specified types and dosages of chemotherapy drugs, administered at specific intervals. See Tr. at 1534 - 1535, 1554 - 1555; P. Ex. 4

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[18] I.G. Ex. 3Q does not reflect that Petitioner administered any chemotherapy to J.W. on February 11, 1985 or on November 22, 1988. Instead, the record reflects that Petitioner claimed to have administered chemotherapy to J.W. starting on April 11, 1985 through September 7, 1988.

[19] DTIC is the abbreviated name for the drug Dacarbazine, which is used in the treatment of metastatic melanoma. I.G. Ex. 3Q at 1, 6; P. Ex. 4 at 17 - 20.

523. Petitioner asserts that he administered chemotherapy drugs to J.W. in accordance with the BOLD protocol.[20] Tr. at 2378 - 2469; P. Ex. 4.

524. The types of drugs Petitioner documented that he gave to J.W. are not in accordance with the BOLD protocol. Tr. at 1534 - 1554.

525. The dosages of drugs Petitioner documented that he gave to J.W. are not in accordance with the BOLD protocol. Tr. at 1534 - 1554.

526. The frequency of administration of the drugs Petitioner documented that he gave to J.W. are not in accordance with the BOLD protocol. Tr. at 1534 - 1554.

527. The method of administration of the drugs Petitioner documented that he gave to J.W. are not in accordance with the BOLD protocol. Tr. at 1534 - 1554.

528. The BOLD protocol is not effective against metastatic melanoma, except in some patients with soft tissue or lung metastasis. P. Ex. 4 at 17.

529. J.W. did not have either soft tissue or lung metastasis. I.G. Ex. 3E, 3Q; Tr. at 1536.

530. Petitioner's contention that he administered the BOLD protocol to J.W. is not credible. P. Ex. 4; Findings 522 - 529.

531. Petitioner's contention that he administered the BOLD protocol to J.W. is an attempt to justify the medically inappropriate course of treatment and administration of drugs that Petitioner gave to J.W. Findings 522 - 530.

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[20] The BOLD protocol, or regimen, is the administration of the chemotherapy drugs Bleomycin, Vincristine, Lomustine, and DTIC for the treatment of metastatic melanoma. The drug Vincristine is also called "Oncovin." The first letter of each of the drugs used in the protocol spell the word BOLD, hence the name for the protocol. The drugs used in the BOLD protocol are administered in very specific amounts and on very specific intervals called cycles. P. Ex. 4 at 17 - 20; I.G. Ex. 3Q at 17.

532. Petitioner documented that he ordered numerous CEA (carcino embryonic antigen) tests for J.W. between February 1985 and November 1989. I.G. Ex. 3Q; see Findings 48 - 50.

533. Malignant melanoma does not produce CEA. Tr. at 860.

534. CEA tests are useless in the diagnosis and treatment of malignant melanoma. Finding 533; Tr. at 860.

535. Petitioner's ordering of CEA tests for J.W. from February 1985 to November 1989 was below professionally recognized standards of health care and substantially in excess of J.W.'s needs. Tr. at 860; Findings 532 - 534.

536. Petitioner documented that he ordered complete blood counts (CBCs) and numerous platelet counts for J.W. from February 1985 to November 1989. I.G. Ex. 3E, 3Q.

537. The CBCs and platelet counts ordered by Petitioner for J.W. from February 1985 to November 1989 were not medically necessary. Tr. at 1535, 1556; Finding 536.

538. The CBCs and platelet counts ordered by Petitioner from February 1985 to November 1989 for J.W. were substantially in excess of J.W.'s needs. Finding 537.

539. Petitioner's ordering of CBCs and platelet counts for J.W. from February 1985 to November 1989 was below professionally recognized standards of health care. Tr. at 1535, 1556; Findings 536 - 538.

540. None of the treatment administered by Petitioner subsequent to J.W.'s surgery in 1983 had any bearing on the fact that J.W.'s cancer stopped growing subsequent to that surgery, without any recurrence. Tr. at 2932; see Tr. at 428 - 515, 837 - 864, 1035 - 1049, 1071 - 1074, 1525 - 1563; Findings 455 - 539; I.G. Ex. 3E, 3Q.

541. Petitioner jeopardized the health and well-being of J.W. by incorrectly diagnosing and treating his epileptic symptoms as metastatic melanoma. Tr. at 428 - 515, 837 - 864, 1035 - 1049, 1071- 1074, 1525 - 1563.

542. Petitioner furnished or caused to be furnished to J.W. items and services that were substantially in excess of his needs and of a quality which failed to meet professionally recognized standards of health care. I.G. Ex. 3E, 3Q, 8; Tr. at 428 - 515, 837 - 864, 1035 - 1049,

1071 - 1074, 1525 - 1563, 2378 - 2469, 2863 - 2872; Findings 455 - 541.

543. Petitioner's attempts to justify his medical treatment of J.W. are inconsistent, insufficient, and not credible. P. Ex. 4; Tr. at 428 - 515, 837 - 864, 1035 - 1049, 1071 - 1074, 1525 - 1563, 2378 - 2469, 2863 - 2872.

Petitioner's testimony regarding his care and treatment of J.W. is indicative of Petitioner's lack of credibility and lack of trustworthiness.

544. Petitioner's assertion that the MRI findings in 1986 and 1987 definitely showed that J.W. had metastatic melanoma in his brain is directly contradicted by the evidence of record and is indicative of Petitioner's lack of credibility and lack of trustworthiness. Tr. at 2399, 2411; Findings 455 - 543.

545. Petitioner's claim that, as of June 2, 1988, he placed J.W. on the BOLD regimen is entirely contradicted by the evidence of record and is indicative of Petitioner's lack of credibility and lack of trustworthiness. Tr. at 2400 - 2404; Findings 522 - 531.

546. Petitioner's assertion that persons who reviewed Petitioner's treatment of J.W. marvelled at the fact that he had cured J.W. of his metastatic melanoma is entirely contradicted by the evidence and is indicative of Petitioner's willingness to misstate the record, and is further indicative of Petitioner's lack of credibility and lack of trustworthiness. Tr. at 2405; Findings 455 - 545.

547. Petitioner was unable to remember the name of the doctor to whom he claims to have referred J.W. and was unable to point to a chart or any documentation to support his assertion that he referred J.W. to another doctor for further surgery. Tr. at 2378 - 2469.

548. Petitioner's assertion that he referred J.W. to another doctor for further surgery is not supported by any evidence in the record and is not credible. I.G. Ex. 3E, 3N; Tr. at 2412 - 2414.

549. Petitioner's assertion that he referred J.W. to another doctor for further surgery is indicative of Petitioner's lack of credibility and lack of trustworthiness. Finding 548.

550. Petitioner's assertion that there is no maximum safe dosage of Vincristine as long as the patient exhibits no side effects is directly contradicted by the evidence of record, is not credible, and is indicative of Petitioner's willingness to resort to distorting facts to justify his treatment of patients. Findings 21 - 28, 42; Tr. at 2420.

551. Petitioner gave self-contradictory, evasive testimony when responding to questions regarding whether the entries in J.W.'s flow sheet contained the actual doses of Vincristine Petitioner administered to J.W. Tr. at 2418 - 2421; I.G. Ex. 3Q.

552. Petitioner was unable to read and interpret his own documentation in J.W.'s flow sheet. Tr. at 2423 - 2424; I.G. Ex. 3Q at 142.

553. The customary dosage of Vincristine for adults is 1.4 milligrams per meter squared. I.G. Ex. 3V at 20.

554. Petitioner was unable to articulate any reason for him to have administered Vincristine to J.W. in a dosage at variance with the usual dosage. Findings 550 - 553; I.G. Ex. 3Q at 142; Tr. at 2423 - 2425.

555. Petitioner's assertion that he was following the BOLD protocol in treating J.W. is contradicted by Petitioner's own testimony. Findings 530 - 531; Tr. at 2424 - 2432.

556. Petitioner is unable to give any legitimate medical reason as to why he altered the treatment called for in the BOLD protocol when he administered chemotherapy to J.W. Tr. at 2425 - 2432.

557. Petitioner's assertion that he did not administer the drugs CCNU, DTIC, or Vincristine in accordance with the BOLD protocol in order to make allowances for J.W.'s chemotherapy-induced sickness and inability to come in for treatment is not supported by the evidence. I.G. Ex. 3E, 3Q; Tr. at 428 - 515, 837 - 864, 1035 - 1049, 1525 - 1563, 2425 - 2432.

558. Petitioner's assertion that he did not administer the drugs CCNU, DTIC, or Vincristine in accordance with the BOLD protocol in order to make allowances for J.W.'s chemotherapy-induced sickness and inability to come to Petitioner's office for treatment is directly contradicted by evidence indicating that Petitioner administered these drugs to J.W. in doses that were more than what was customarily given and thereby actually

increased the chances of J.W. having chemotherapy-induced sickness and side effects. Tr. at 2425 - 2432.

559. Petitioner's stated reasons for deviating from the BOLD protocol in providing treatment to J.W. are not credible and are indicative of Petitioner's lack of credibility and lack of trustworthiness. Tr. at 2429; Findings 555 - 558.

560. Petitioner's evasive testimony when confronted with the fact that his own exhibit shows that the BOLD protocol only has a modest response rate in treating metastatic melanoma is indicative of Petitioner's lack of credibility and lack of trustworthiness. Tr. at 2433 - 2434; P. Ex. 4 at 20.

561. Petitioner's assertion that he was not using CEA as a diagnostic test for J.W.'s malignant melanoma, but rather because he was checking the accuracy of the CEA test for Abbott Labs, is unsupported by any affirmative evidence, is contradicted by the fact that Petitioner billed Medicare for the CEA tests he administered to J.W., is not credible, and is indicative of Petitioner's lack of trustworthiness. Tr. at 2108 - 2109, 2345 - 2346; I.G. Ex. 3E, 3Q.

562. Petitioner admitted that he did not always make complete entries in J.W.'s charts. Tr. at 2438 - 2439.

563. Petitioner's failure to make complete entries in J.W.'s charts is indicative of his inability to follow professionally recognized standards of health care even when he is cognizant of such standards. Findings 27, 562.

564. Petitioner's assertion that the type and amount of drugs he administered to J.W. from February 11, 1985 through November 22, 1989, is a "proven" combination, is directly contradicted by the evidence of record, is not credible, and is indicative of Petitioner's lack of trustworthiness. Tr. at 2444; Findings 455 - 543, 553 - 560.

565. Petitioner is unable to provide any valid medical rationale for administering the types and dosages of drugs he documented he administered to J.W. from February 11, 1985 through November 22, 1989. Tr. at 2378 - 2469; Findings 455 - 564.

566. Petitioner is unable to provide any legitimate or credible reason for departing from the BOLD protocol by modifying the types and dosages of drugs he documented he

administered to J.W. subsequent to June 2, 1988. Findings 555 - 560; Tr. at 2444 - 2467.

567. Petitioner's testimony regarding his treatment of J.W. from February 11, 1985 through November 2, 1989 demonstrates Petitioner's lack of ability to practice oncology in accordance with professionally recognized standards of health care and is indicative of Petitioner's lack of trustworthiness. Tr. at 2378 - 2469; P. Ex. 4; I.G. Ex. 3E, 3N; Findings 455 - 566.

Petitioner's treatment of patient J.L.

568. J.L. was a 64-year-old man who had his left lung surgically removed in February 1986 and who had inoperable, advanced squamous cell cancer of the lung. I.G. Ex. 3R at 20 - 23; Tr. at 516, 518, 865.

569. Chemotherapy does not, to any significant degree, cure, prevent the spread of, or prevent the growth of squamous cell cancer. Tr. at 516 - 520, 869 - 870.

570. Petitioner first became involved in the treatment of J.L. on March 12, 1986. I.G. Ex. 3R.

571. Petitioner's treatment of J.L. in 1986 only is at issue before me in this case. I.G. Ex. 3R at 1; Tr. at 866.

572. On March 12, 1986, Petitioner started J.L. on a regimen of chemotherapy consisting of Cytoxan, Methotrexate, and Adriamycin, administered on virtually a weekly basis through December 19, 1986. I.G. Ex. 3R at 2, 12 - 14.

573. On May 16, 1986, Petitioner administered 5FU to J.L. I.G. Ex. 3R at 2, 12 - 14.

574. On August 15, September 5, and October 3, 1986, Petitioner administered doses of Bleomycin to J.L. I.G. Ex. 3R at 2, 12 - 14.

575. The standard of care for the treatment of J.L.'s squamous cell cancer in 1986 was to administer localized radiation therapy to the tumor that remained in J.L.'s chest. Tr. at 520, 867 - 869.

576. Chemotherapy does not predictably prolong survival in patients, such as J.L., who have squamous cell lung cancer. Tr. at 515 - 575, 869 - 870.

577. In a letter dated October 15, 1986, another physician recommended that Petitioner treat J.L. with localized radiation. Tr. at 868; I.G. Ex. 3R at 48.

578. Professionally recognized standards of health care for the treatment of patients, such as J.L., with squamous cell lung cancer mandated that an oncologist who did not use radiation therapy had to have documented his reasons for not doing so before he administered chemotherapy. I.G. Ex. 3E, 3R; Tr. at 515 - 575, 864 - 889 (especially at 873 - 874), 1049 - 1056, 1077 - 1081.

579. Petitioner did not document his reasons for failing to administer radiation therapy to J.L. I.G. Ex. 3E, 3R; P. Ex. 5.

580. It was below professionally recognized standards of health care for Petitioner not to document his reasons for failing to administer radiation therapy to J.L. before using chemotherapy to treat J.L. Findings 578 - 579.

581. Professionally recognized standards of health care for the treatment of J.L. mandated that, once Petitioner chose to administer chemotherapy, he should have monitored the growth or shrinkage of J.L.'s cancer to enable him to know whether the treatment he was administering was effective or not effective. Tr. at 864 - 889, 1049 - 1056, 1077 - 1081.

582. Petitioner failed to monitor the progression or decline of J.L.'s cancer in 1986 sufficiently to enable him to know whether J.L.'s cancer was growing or shrinking. I.G. Ex. 3E, 3R; Tr. at 864 - 889, 1049 - 1056, 1077 - 1081.

583. Petitioner's failure to monitor the progression or decline of J.L.'s cancer in 1986 was below professionally recognized standards of health care. Findings 581 - 582.

584. Professionally recognized standards of health care mandated that Petitioner's administration of chemotherapy to J.L. be discontinued or modified when it was not effective, such as is the case in the face of progressive disease. Tr. at 871.

585. There is insufficient evidence to support the I.G.'s contention that, in this case during 1986, Petitioner administered to J.L. chemotherapy treatments in the face of progressive disease. Tr. at 876.

586. Petitioner's decision to administer chemotherapy to J.L. in 1986, while somewhat at odds with what most oncologists would have generally done, was within professionally recognized standards of health care. Tr. at 869 - 870.

587. The drugs that were used by Petitioner to treat J.L. are sometimes used in treating squamous cell cancer, provided that these drugs are given in appropriate doses. I.G. Ex. 3E, 3R; Tr. at 515 - 575, 864 - 889, 1049 - 1056, 1077 - 1081.

588. The drugs that Petitioner administered in 1986 to treat J.L. are never useful in treating squamous cell cancer in the amounts Petitioner documented that he administered to J.L. I.G. Ex. 3E, 3R; Tr. at 515 - 575, 864 - 889, 1049 - 1056, 1077 - 1081.

589. The doses of Adriamycin, Cytoxan, and Methotrexate that Petitioner documented that he gave to J.L. in 1986 are supralethal doses which would have killed J.L. I.G. Ex. 3E, 3R; Tr. at 515 - 575, 864 - 889 (especially at 876 - 881), 1049 - 1056, 1077 - 1081.

590. J.L. did not die from the effects of supralethal doses of Adriamycin, Cytoxan, or Methotrexate that Petitioner documented J.L. received in 1986. I.G. Ex. 3E, 3R.

591. Chemotherapy always has adverse effects on normal tissue when it is given in doses that are sufficient to cause shrinkage in the growth of lung cancer. Tr. at 876 - 877; Findings 21 - 23.

592. Had J.L. received amounts of Adriamycin, Cytoxan, or Methotrexate in 1986 sufficient to cause shrinkage in J.L.'s cancer, J.L. would have exhibited the adverse side effects in his normal tissues. Tr. at 526 - 535, 876 - 883.

593. J.L.'s normal tissues exhibited no effects in 1986 from the chemotherapy treatment he received from Petitioner. I.G. Ex. 3E, 3R; Tr. at 526 - 535, 876 - 877.

594. J.L. did not receive the doses of Adriamycin, Cytoxan, and Methotrexate that Petitioner claims to have administered to him in 1986. Tr. at 526 - 535, 871, 876 - 882; Findings 592 - 593.

595. In 1986, J.L. received doses of Adriamycin, Cytoxan, and Methotrexate which were insufficient to have any effect on either J.L.'s cancer or his normal tissues. Tr. at 880 - 883; Findings 591 - 593.

596. Petitioner did not administer chemotherapy to J.L. in 1986 in an amount that could cause shrinkage of his cancer. Tr. at 881 - 883; Finding 595.

597. Petitioner failed to administer chemotherapy to J.L. in 1986 in an amount that could have improved J.L.'s condition. Tr. at 881 - 883; Findings 591 - 596.

598. It was below professionally recognized standards of health care for Petitioner not to have administered chemotherapy to J.L. in 1986 in an amount that could have improved J.L.'s condition. Findings 591 - 597.

599. It was below professionally recognized standards of health care for Petitioner in 1986 to document in the flow sheet that J.L. received an amount of chemotherapy drugs that he did not actually receive. Tr. at 515 - 575, 876 - 882; Findings 24 - 29, 587 - 598.

600. Petitioner jeopardized J.L.'s health, safety, and well-being in 1986 by documenting in J.L's flow sheet that J.L. had received an amount of drugs that J.L. did not actually receive. Findings 21 - 29, 599.

601. In 1986, Petitioner jeopardized J.L.'s health, safety, and well-being by subjecting J.L. to subtherapeutic doses of chemotherapy that could actually increase the cancer's resistance to future treatments. Tr. at 1389; see Finding 171.

602. On virtually every occasion on which Petitioner administered chemotherapy to J.L. in 1986, he did so via infusions over a period of one to eight hours. I.G. Ex. 3E, 3R.

603. Infusions of one and eight hours served no medical purpose in the treatment of J.L. (at any time, including 1986). Tr. at 515 - 575, 880; I.G. Ex. 3E, 3R.

604. It was substantially in excess of J.L.'s needs and below professionally recognized standards of health care for Petitioner to have administered chemotherapy to J.L. in 1986 via one- and eight-hour infusions. Findings 568 - 603; I.G. Ex. 3E, 3R; see Tr. at 515 - 575, 864 - 889, 1049 - 1056, 1077 - 1081, 2879 - 2886.

605. Petitioner admits that he did not administer infusions to J.L. of 24 hours or more despite billing Medicare for infusions 24 hours or more. P. Ex. 17 at 25; Tr. at 2509.

606. Petitioner's statement that, because he administered chemotherapy to J.L. via infusion, it was not critical to keep track of the total amount of chemotherapy J.L. received in 1986 is contradicted by the evidence, contradicted by Petitioner's own testimony, is not credible, and is indicative of Petitioner's lack of trustworthiness. Tr. at 2509 - 2512; Findings 21 - 29.

607. Petitioner's assertion that, by administering chemotherapy to J.L. in 1986 via infusion, he caused J.L. to have a dramatic reduction of cardiac toxicity, better response rate, and less side effects, is directly contradicted by the evidence and is indicative of Petitioner's lack of credibility and lack of trustworthiness. Tr. at 2512; Findings 568 - 603.

608. Petitioner's assertion that an eight-hour infusion is an accepted method of administering chemotherapy because Medicare has a code for billing eight-hour infusions is directly contradicted by the evidence, is not credible, and is indicative of Petitioner's lack of trustworthiness. Tr. at 1170 - 1171, 2513; P. Ex. 19 at 11; Finding 912 (appearing subsequently in this section).

609. None of the CBCs, venipunctures, and platelet counts given by Petitioner to J.L. in 1986 were medically necessary. Tr. at 541 - 543, 886 - 889; I.G. Ex. 3E, 3R.

610. All of the CBCs, venipunctures, and platelet counts given by Petitioner to J.L. in 1986 were substantially in excess of J.L.'s needs. I.G. Ex. 3E, 3R; Tr. at 515 - 575, 864 - 889, 1049 - 1056, 1077 - 1081; Finding 609.

611. A study cited by Petitioner to support his administration of Adriamycin, Cytoxan, and Methotrexate to J.L. for the treatment of J.L.'s squamous cell carcinoma is a study which relates to adenocarcinoma and not squamous cell carcinoma. P. Ex. 5 at 9 (especially chart marked in the text as "Table 18-41").

612. J.L. had squamous cell carcinoma, which is not an adenocarcinoma. Tr. at 2880 - 2883.

613. Petitioner did not treat J.L. using the same types and amounts of chemotherapy referenced in the study he cited. P. Ex. 5; Tr. at 2880 - 2883.

614. Petitioner gave evasive answers when questioned about the efficacy of chemotherapy and radiation in the treatment of squamous cell cancer. Tr. at 2516 - 2517.

615. The test results cited by Petitioner to support his treatment of J.L. do not in fact support the means Petitioner used to treat J.L. in 1986. P. Ex. 5; I.G. Ex. 3E, 3R; Tr. at 889, 2880 - 2883; Findings 611 - 614.

616. Petitioner's management of J.L.'s case in 1986 jeopardized the health, safety, and well-being of J.L. Findings 568 - 615.

617. Petitioner provided to J.L. in 1986 items or services that were substantially in excess of J.L.'s needs and below professionally recognized standards of health care. I.G. Ex. 3E, 3R; P. Ex. 5; Tr. at 515 - 575, 864 - 889, 1049 - 1056, 1077 - 1081, 2470 - 2535, 2879 - 2886; Findings 568 - 615.

618. Petitioner's attempts to justify his treatment of J.L. in 1986 are inconsistent, inadequate, and not credible. I.G. Ex. 3E, 3R; P. Ex. 5; Tr. at 515 - 575, 864 - 889, 1049 - 1056, 1077 - 1081, 2470 - 2523, 2879 - 2886; Findings 568 - 617.

Petitioner's testimony regarding his treatment of J.L. is indicative of Petitioner's lack of credibility and lack of trustworthiness.

619. Petitioner's assertion that his administration of chemotherapy to J.L. from March 12, 1986 through December 12, 1986 caused J.L. to have no evidence of measurable cancer such that Petitioner could discontinue the treatment is directly contradicted by the evidence, is not credible, and is indicative of Petitioner's lack of trustworthiness. Tr. at 2473 - 2476; P. Ex. 5; I.G. Ex. 3E, 3R; Tr. at 515 - 575, 864 - 889, 1049 - 1056, 1077 - 1081.

620. Petitioner's assertion that P. Ex. 5 supports the treatment he documented that he provided to J.L. from March 12, 1986 through December 12, 1986 is directly contradicted by the evidence, is not credible, and is indicative of Petitioner's lack of trustworthiness. P. Ex. 5; I.G. Ex. 3E, 3R; Tr. at 567, 889, 2474.

621. Petitioner's statement that there is significant evidence from literature and seminars that support his use of infusional chemotherapy is misleading in that infusional chemotherapy occurs over a period of 24 to 72 hours, whereas Petitioner administered infusions over a

period of one to eight hours to J.L. Tr. at 2487 - 2488; I.G. Ex. 3E, 3R; Findings 11 - 20.

622. Petitioner's statement that there is significant evidence from literature and seminars that support his use of infusional chemotherapy is indicative of his willingness to use misleading statements to justify his treatment of patients and is further indicative of his lack of credibility and lack of trustworthiness. Finding 621.

623. Petitioner admits that it is important for him to know the precise quantities of chemotherapy drugs he administered to J.L. in 1986. Tr. at 2502 - 2512.

624. Petitioner's contradictory, evasive testimony in response to questions asking him about how much chemotherapy he administered to J.L. in 1986 is indicative of Petitioner's lack of credibility and lack of trustworthiness. Tr. at 2502 - 2512.

625. Petitioner's evasive answers in response to questioning about the efficacy of chemotherapy and radiation are indicative of Petitioner's lack of credibility and lack of trustworthiness. Tr. at 2516 - 2517; I.G. Ex. 3R at 48.

Petitioner's treatment of patient H.S.

626. H.S. was an 80-year-old man with cardiac disease and chronic obstructive pulmonary disease who was first seen by Petitioner on April 30, 1985. I.G. Ex. 3S at 504, 559 - 560; Tr. at 578.

627. H.S. was treated by Petitioner from April 30, 1985 through April 1988. I.G. Ex. 3S; Tr. at 890.

628. H.S. was diagnosed by another physician as having Kaposi's sarcoma. Tr. at 578.

629. Kaposi's sarcoma is a disease that may be cancer-related which causes an overgrowth of irregular, tumor-like cells. Tr. at 581 - 582.

630. Kaposi's sarcoma occurs in two forms. Tr. at 581 - 586.

631. One form of Kaposi's sarcoma is a slow growing, almost always nonlethal form which occurs predominately in elderly people and which causes localized skin lesions usually limited to the lower extremities with no

involvement of the internal organs. Tr. at 581 - 586, 890 - 892, 1565.

632. The second form of Kaposi's sarcoma is a rapid growing form that occurs in persons that have AIDS. This form tends to cause lesions involving the head, neck, upper body, internal organs, and parts of the body other than the skin. Tr. at 581 - 586, 890 - 892.

633. H.S. had non-AIDS related Kaposi's sarcoma. I.G. Ex. 3E, 3S; Tr. at 581 - 586, 890 - 892, 1564 - 1566.

634. Localized radiation therapy is almost always effective in treating non-AIDS related Kaposi's sarcoma. Tr. at 898 - 890, 1566.

635. Petitioner did not administer radiation therapy to H.S. I.G. Ex. 3E, 3S.

636. Petitioner documented that he administered Adriamycin to H.S. in an amount sufficient to cause severe suppression of H.S.'s blood counts. Tr. at 905.

637. H.S. did not exhibit any suppression of his blood counts. I.G. Ex. 3S.

638. Petitioner documented that he administered to H.S. an amount of Adriamycin sufficient to kill H.S. Tr. at 903 - 905.

639. H.S. did not die from the effects caused by excessive amounts of Adriamycin. I.G. Ex. 3S.

640. Petitioner did not administer Adriamycin to H.S. in amounts approaching anywhere near the amounts in H.S.'s flow sheet. Findings 636 - 639; Tr. at 894 - 909, 1563 - 1608.

641. It was below professionally recognized standards of health care and jeopardized H.S.'s health, safety, and well-being for Petitioner to document in H.S.'s flow sheet that he administered Adriamycin to H.S. in an amount that H.S. did not receive. Tr. at 894; Findings 15 - 29, 640.

642. The drug Velban can be effective in treating Kaposi's sarcoma when it is used in therapeutic doses. Tr. at 901.

643. Administration of even one dose of Velban in the amount documented in H.S.'s flow sheet would cause a significant decrease in H.S.'s white blood cell counts. I.G. Ex. 3S at 21.

644. H.S. did not exhibit any decrease in his white blood cell count associated with receiving therapeutic doses of the drug Velban. I.G. Ex. 3E, 3S; Tr. at 890 - 909, 1056 - 1064.

645. Petitioner's administration of Velban to H.S. did not improve H.S.'s Kaposi's sarcoma. I.G. Ex. 3E, 3S; Tr. at 900 - 903.

646. Petitioner failed to administer the drug Velban to H.S. in therapeutic doses or amounts that could alleviate H.S.'s Kaposi's sarcoma. I.G. Ex. 3E, 3S; Tr. at 900 - 903; Findings 642 - 645.

647. It was below professionally recognized standards of health care for Petitioner to administer the drug Velban in doses to that could not alleviate H.S.'s Kaposi's sarcoma. I.G. Ex. 3E, 3S; Tr. at 900 - 902; Finding 646.

648. Petitioner's administration of the drugs Adriamycin, Bleomycin, and Velban to H.S. via one and eight hour infusions was not medically necessary. I.G. Ex. 3S; Tr. at 906; Findings 10 - 20.

649. Petitioner's administration of the drugs Adriamycin, Bleomycin, and Velban to H.S. via one and eight hour infusions was below professionally recognized standards of health care and substantially in excess of H.S.'s needs. Findings 10 - 20, 648.

650. Petitioner failed to document the progression of H.S.'s Kaposi's sarcoma over time sufficient to enable him to assess whether the treatment he was administering to H.S. was not effective. I.G. Ex. 3E, 3S; P. Ex. 24/1, 24/2, 25/1, 25/2[21]; Tr. at 890 - 909, 1056 - 1064, 1563 - 1608.

651. It was below professionally recognized standards of health care for Petitioner not to document the progression of H.S.'s Kaposi's sarcoma over time sufficient to enable him to assess whether the treatment

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[21] Instead of being numbered consecutively, these four Petitioner's exhibits were marked as P. Ex. 24/1, 24/2, 25/1.

he was administering to H.S. was not effective. I.G. Ex. 3E, 3S; P. Ex. 24/1, 24/2, 25/1, 25/2; Tr. at 890 - 909, 1056 - 1064, 1563 - 1608.

652. It was below professionally recognized standards of health care for Petitioner not to document in H.S.'s chart why he chose not to administer radiation therapy to treat H.S.'s Kaposi's sarcoma. Tr. at 890 - 909, 1056 - 1064, 1563 - 1608.

653. It was below professionally recognized standards of health care for Petitioner not to document that H.S. refused radiation treatment before proceeding with chemotherapy treatment. Tr. at 907; I.G. Ex. 3E, 3S.

654. Petitioner did not stop the administration of the chemotherapy drugs he was administering to H.S. when there was evidence that H.S.'s Kaposi's sarcoma was progressing. Tr. at 890 - 909, 1056 - 1064, 1563 - 1608.

655. It was below professionally recognized standards of health care for Petitioner to continue to administer a combination of chemotherapy drugs to H.S. in the face of evidence that these drugs were not effective in alleviating H.S.'s condition. Tr. at 577 - 678, 890 - 909, 1056 - 1064, 1563 - 1608.

656. It was below professionally recognized standards of health care for Petitioner not to change the treatment he was administering to H.S. in the face of progressive disease. Tr. at 577 - 678, 890 - 909, 1056 - 1064, 1563 - 1608.

657. A June 21, 1985 chest x-ray of H.S. showed a pulmonary nodule. I.G. Ex. 3E, 3S; Tr. at 897.

658. H.S.'s pulmonary nodule later disappeared. I.G. Ex. 3E, 3S; Tr. at 897.

659. Petitioner stated that the June 21, 1985 chest x-ray of H.S. showed that: the pulmonary nodule was evidence of metastatic cancer; his treatment of H.S. with chemotherapy was justified; and the treatment he administered to H.S. was beneficial. Tr. at 2536 - 2643, 2652 - 2655.

660. Petitioner's testimony that the June 21, 1985 chest x-ray of H.S. showed that: the pulmonary nodule was evidence of metastatic cancer; his treatment of H.S. with chemotherapy was justified; and the treatment he administered to H.S. was beneficial -- is contradicted by the evidence of record and is not credible. I.G. Ex. 3E,

3S; Tr. at 577 - 678, 890 - 909, 1056 - 1064, 1563 - 1608, 2536 - 2643 (especially at 2539 - 2545), 2886 - 2897, 2945 - 2957.

661. It was below professionally recognized standards of health care for Petitioner to use the June 21, 1985 chest x-ray of H.S. as a basis to subject H.S. to lengthy chemotherapy treatments. I.G. Ex. 3E, 3S; Tr. at 577 - 678, 890 - 909, 1056 - 1064, 1563 - 1608, 2536 - 2643, 2886 - 2897, 2945 - 2957; Findings 657 - 660.

662. Petitioner's statement that the lung nodule that appeared on H.S.'s chest x-ray was malignant is contradicted by the evidence of record. I.G. Ex. 3E, 3S; Tr. at 577 - 678, 890 - 909, 1056 - 1064, 1563 - 1608, 2536 - 2643 (especially at 2544), 2886 - 2897, 2945 - 2957; Findings 657 - 661.

663. CEA plays no role in the monitoring of Kaposi's sarcoma. Tr. at 905.

664. CEA played no role as a screening test in H.S.'s case. Tr. at 1569 - 1571.

665. Petitioner stated that he performed CEA tests on H.S. because he was concerned that H.S. would get a second malignancy or lymphoma. P. Ex. 6.

666. The CEA tests administered by Petitioner to H.S. were not medically indicated or medically necessary. I.G. Ex. 3E, 3S; Tr. at 890 - 909, 1569 - 1571.

667. The CEA tests administered by Petitioner were substantially in excess of H.S.'s needs. Findings 628, 633, 663 - 666.

668. There is no documentation in the record that supports that H.S. had pernicious anemia (which would necessitate vitamin B-12 injections). Tr. at 890 - 909, 1563 - 1608; I.G. Ex. 3E, 3S.

669. The venipunctures, vitamin B-12 injections, and platelet counts that Petitioner administered to H.S. were medically unnecessary. I.G. Ex. 3E, 3S; Tr. at 906; see Tr. at 577 - 678, 890 - 909, 1563 - 1608.

670. The venipunctures, vitamin B-12 injections, and platelet counts that Petitioner administered to H.S. were substantially in excess of H.S.'s needs. Findings 668 - 669.

671. Petitioner performed tests of H.S.'s Digoxin levels that were substantially in excess of H.S.'s needs. Tr. at 908.

672. H.S. had chronic obstructive pulmonary disease during the period of time Petitioner was administering Bleomycin to him. I.G. Ex. 3S; Tr. at 1572.

673. The drug Bleomycin causes severe lung damage. Tr. at 1572; Findings 43, 252.

674. The drug Bleomycin was contraindicated in the treatment of H.S. Tr. at 1572.

675. Petitioner's administration of Bleomycin to H.S. was below professionally recognized standards of health care and substantially in excess of H.S.'s needs. Tr. at 1572; Findings 671 - 674.

676. H.S. was admitted to the hospital on April 16, 1988 with a diagnosis of pneumonia of both lungs. I.G. Ex. 3S at 28.

677. Petitioner administered chemotherapy treatment consisting of Bleomycin to H.S. on April 15, 1988 and billed for an intermediate office visit. I.G. Ex. 3S at 231; Tr. at 1575 - 1576.

678. In 1988, an intermediate office visit consisted of an examination of more than one body system, including examination of the patient's heart, lungs, abdomen, and talking to the patient to see how the patient was feeling. Tr. at 1577.

679. Petitioner should have found that H.S. had pneumonia had he properly performed an intermediate office visit of H.S. on April 15, 1988. Tr. at 1574 - 1575.

680. Petitioner did not document that he found anything medically wrong with H.S. when he examined him on April 15, 1988. I.G. Ex. 3S; Tr. at 1574 - 1575.

681. Petitioner's failure to document that he found anything medically wrong with H.S. on April 15, 1988 was below professionally recognized standards of health care. Tr. at 1574 - 1575; I.G. Ex. 3E, 3S; Findings 677 - 680.

682. Petitioner's failure to document that, when he examined H.S. on April 15, 1988, H.S. had pneumonia requiring treatment raises a serious question of whether Petitioner actually saw or examined H.S. on April 15, 1988. Findings 677 - 681.

683. H.S. died on April 19, 1988. I.G. Ex. 3S at 25.

684. Petitioner's diagnosis of H.S. as having Kaposi's sarcoma that had metastasized to other parts of H.S.'s body is not supported by the evidence. Tr. at 577 - 678, 890 - 909, 1056 - 1064, 1563 - 1608, (especially at 2536 - 2643); P. Ex. 6; I. G. Ex. 3S.

685. Petitioner's statement that H.S. had Kaposi's sarcoma that had metastasized to other parts of H.S.'s body is not credible and is indicative of Petitioner's lack of trustworthiness. Tr. at 2538 - 2540; Finding 684.

686. Petitioner's statement that H.S. had a "hybrid type" of Kaposi's sarcoma is not supported by the evidence. Tr. at 577 - 678, 890 - 909, 1056 - 1064, 1563 - 1608, 2536 - 2643 (especially at 2541 - 2542), 2652 - 2655.

687. Petitioner's statement that H.S. had a "hybrid type" of Kaposi's sarcoma is not credible. Finding 686.

688. Petitioner's statement that there is no standard of care for the treatment of patients with Kaposi's sarcoma is directly contradicted by the evidence. Tr. at 577 - 678, 890 - 909, 1056 - 1064, 1563 - 1608, (especially at 2542 - 2544); I.G. Ex. 3E, 3S.

689. Petitioner's statement that there is no standard of care for the treatment of patients with Kaposi's sarcoma is not credible. Finding 688.

690. Petitioner asserted that H.S. was a unique patient such that it was doubtful that there was a standard of care that would apply to H.S.'s care and treatment. Tr. at 2543 - 2544.

691. Petitioner's testimony that H.S. was a unique patient such that it was doubtful that there was a standard of care applicable to H.S.'s care and treatment is directly contradicted by the evidence of record. I.G. Ex. 3E, 3S; Tr. at 577- 678, 899 - 909, 1056 - 1064, 1563 - 1608, (especially at 2543 - 2544), 2886 - 2897.

692. Petitioner's testimony that H.S. was a unique patient such it was doubtful that there was a standard of care that would apply to H.S.'s care and treatment is not credible. Findings 690 - 691.

693. Petitioner's attempts to justify his treatment of H.S. as being entirely within professionally recognized standards of health care are inconsistent, inadequate, and not credible. P. Ex. 6; Tr. at 577 - 678, 890 - 909, 1056 - 1064, 1563 - 1608, 2536 - 2643, 2652 - 2655, 2886 - 2897; Findings 626 - 692.

694. Petitioner's attempts to justify his treatment of H.S. as not being substantially in excess of H.S.'s needs are inconsistent, inadequate, and not credible. P. Ex. 6; Tr. at 577 - 678, 890 - 909, 1056 - 1064, 1563 - 1608, 2536 - 2643, 2652 - 2655, 2886 - 2897; Findings 626 - 692.

695. Petitioner's treatment of H.S. was below professionally recognized standards of health care and substantially in excess of H.S.'s needs. Findings 626 - 694.

Petitioner's testimony regarding his treatment of H.S. is indicative of Petitioner's lack of credibility and lack of trustworthiness.

696. Petitioner's assertion that H.S. had a hybrid type of Kaposi's sarcoma is directly contradicted by the evidence and Petitioner's own testimony and is indicative of Petitioner's lack of credibility and lack of trustworthiness. I.G. Ex. 3E, 3S; Tr. at 2564.

697. Petitioner's assertion that H.S. had Kaposi's sarcoma on both lower extremities is contradicted by Petitioner's own medical records and charts and is indicative of Petitioner's lack of credibility and lack of trustworthiness. I.G. Ex. 3E, 3S at 496, 559; P. Ex. 6; Tr. at 2566 - 2572.

698. Petitioner's assertion that the contraindications for administering Adriamycin in an 80-year-old patient are no different than the contraindications for administering it to anyone else is contradicted by the evidence of record and is indicative of Petitioner's lack of credibility and lack of trustworthiness. Tr. at 2572 - 2573; see Tr. at 577 - 678, 890 - 909, 1056 - 1064, 1563 - 1608; I.G. Ex. 3E, 3S.

699. That Petitioner blames the lack of a Medicare code for the fact that he billed for the full vial of drugs rather than the amount he actually administered to H.S. is indicative of Petitioner's lack of credibility and lack of trustworthiness. Tr. at 2575.

700. Petitioner's assertion that either he was aware of the amounts of chemotherapy he administered to H.S. because, during the time H.S. was received chemotherapy from Petitioner, Petitioner was treating only a small number of patients with chemotherapy is directly contradicted by the following: a) the evidence; b) Petitioner's admission that nothing in H.S.'s medical records indicates the amount of chemotherapy H.S. was receiving; c) Petitioner's inability to specify how many other patients were receiving chemotherapy during the time H.S. was receiving it (1985 - 1987); and d) Petitioner's inability to state, even within a general range, the amount of chemotherapy he administered to H.S. I.G. Ex. 3E, 3S; Tr. at 577 - 678, 890 - 909, 1056 - 1064, 1563 - 1608, (especially at 2575 - 2577).

701. Petitioner's assertion that he was aware of the amounts of chemotherapy he administered to H.S. is indicative of Petitioner's lack of credibility and lack of trustworthiness. Finding 700.

702. Petitioner admits that the amounts of Velban and Bleomycin he administered to H.S. were significantly less than the amounts entered on H.S.'s medical charts. Tr. at 2578.

703. Petitioner's failure to enter into H.S.'s chart the amounts of Velban and Bleomycin he administered to H.S. is indicative of Petitioner's lack of credibility and trustworthiness. Findings 700 - 702.

704. That Petitioner administered Bleomycin to H.S. in the presence of advanced chronic obstructive pulmonary disease is indicative of Petitioner's lack of understanding and ability to treat patients in accordance with professionally recognized standards of health care. Tr. at 2580 - 2582; I.G. Ex. 3E, 3S at 35; Findings 43, 252.

705. Petitioner's assertion that H.S.'s metastasis disappeared as a result of the chemotherapy treatments administered to H.S. by Petitioner is directly contradicted by the fact H.S. did not have metastasis. P. Ex. 6 at 6 - 7; Tr. at 577 - 678, 890 - 909, 1056 - 1064, 1563 - 1608, (especially at 2595 - 2598); I.G. Ex. 3E, 3S; Findings 626 - 695.

706. Petitioner's assertion that H.S.'s metastasis disappeared as a result of the chemotherapy treatments Petitioner administered to H.S. is indicative of Petitioner's lack of credibility and lack of trustworthiness. Findings 626 - 695, 705.

707. Petitioner admits that when his office submits a claim to Medicare, Petitioner is the one who is responsible for the accuracy of that claim. Tr. at 2600 - 2601.

708. Petitioner's attempt to deflect responsibility for submitting claims to Medicare for performing CBCs and platelet counts that were substantially in excess of H.S.'s needs is indicative of Petitioner's lack of credibility and lack of trustworthiness. Tr. at 2599 - 2601; Finding 707.

709. Petitioner's assertion that he performed CBCs and platelet counts together when treating H.S. because the technology did not exist to perform the tests separately is contradicted by the evidence, is not credible, and is indicative of Petitioner's lack of trustworthiness. I.G. Ex. 3E, 3S; Tr. at 577 - 678, 890 - 909, 1056 - 1064, 1563 - 1608, (especially at 2600 - 2601); Findings 669 - 670.

710. Petitioner is unable to provide a credible reason or justification as to why he saw H.S. in his office 49 times (in 52 weeks) in 1986, 51 times (in 52 weeks) in 1987, and four times (in one month) in January 1988. Tr. at 2605.

711. Petitioner's inability to provide a credible reason or justification as to why he saw H.S. in his office on almost a weekly basis for over two years is indicative of Petitioner's lack of credibility and lack of trustworthiness. Findings 710.

712. The day before H.S. was admitted to the hospital with bilateral pneumonia, Petitioner documented that he administered Bleomycin to H.S. Tr. at 2613 - 2616; I.G. Ex. 3S at 34 - 36.

713. Petitioner states that he was unaware that H.S. had even a cough or a cold for several days prior to H.S.'s admission to the hospital. Tr. at 2616 - 2618; I.G. Ex. 3S at 36.

714. The fact that Petitioner continued to treat H.S. with drugs with high pulmonary toxicity and did not recognize that H.S. had pneumonia is indicative of Petitioner's lack of understanding of professionally recognized standards of health care, is indicative of Petitioner's failure to properly treat H.S.'s condition, and is evidence of Petitioner's inability to comply with professionally recognized standards of health care. Findings 672 - 683, 713.

715. Petitioner's attempt to explain as a typographical error his billing Medicare for Vincristine that, according to Petitioner's flow sheets, was not received by H.S., is not credible and is indicative of Petitioner's inability to follow proper Medicare billing procedures. Tr. at 2629; I.G. Ex. 3S at 106.

716. Petitioner's failure to properly document that H.S. received medication in the amounts and types Petitioner billed Medicare for is indicative of Petitioner's lack of trustworthiness. Tr. at 2630 - 2641; I.G. Ex. 3S at 359; Findings 640 - 641, 646 - 647, 715.

717. The exhibit submitted by Petitioner as P. Ex. 6 to support his treatment of H.S. is the result of a study involving patients whose median age was 35 and who had AIDS-related Kaposi's sarcoma. P. Ex. 6; Tr. at 2640.

718. Petitioner has offered nothing that is persuasive which would support his treatment of H.S. as being in accordance with professionally recognized standards and not substantially in excess of H.S.'s needs. P. Ex. 6; I.G. Ex. 3E, 3S; Tr. at 577 - 678, 890 - 909, 1056 - 1064, 1563 - 1608.

719. That Petitioner would believe that P. Ex. 6 would support his treatment of H.S. is indicative of Petitioner's lack of understanding of proper treatment of patients with Kaposi's sarcoma, Petitioner's inability to comply with professionally recognized standards, and Petitioner's lack of credibility and trustworthiness. Findings 626 - 718.

Petitioner's treatment of patient R.N.

720. The I.G. has based its action against Petitioner on his treatment of R.N. in 1986 only. February 10, 1992 Notice Letter.

721. To the extent that Petitioner's treatment or diagnosis of R.N. in years prior to or subsequent to 1986 is relevant to my determination as to whether Petitioner provided care within professionally recognized standards and substantially in excess of R.N.'s needs during 1986, such treatment is relevant to my determination here.

722. R.N. first was seen by Petitioner on December 28, 1983. I.G. Ex. 3E, 3T at 24.

723. At the time he first was seen by Petitioner, R.N. was a 64- year-old man with cancer of the prostate. I.G. Ex. 3E, 3T.

724. R.N.'s prostate cancer had been confirmed by biopsy. I.G. Ex. 3E, 3T; Tr. at 682.

725. A January 12, 1984 bone scan report revealed that R.N. had metastatic, stage IV cancer. P. Ex. 7; Tr. at 912, 1612.

726. Petitioner diagnosed R.N. as having stage IV carcinoma of the prostate. I.G. Ex. 3T at 24.

727. From the time Petitioner first saw R.N. on December 28, 1983, R.N. had metastatic prostate cancer. Tr. at 912; I.G. Ex. 3E, 3T.

728. Stage IV carcinoma of the prostate is cancer of the prostate that has spread beyond the prostate and metastasized to other body and organ systems. I.G. Ex. 3E; Tr. at 696.

729. There was no treatment available which could have cured R.N.'s cancer in 1986. Tr. at 1639.

730. The professionally recognized standard of health care in 1986 (and currently) was to palliate R.N.'s symptoms and attempt to get R.N.'s disease into remission. Tr. at 1611.

731. Hormonal therapy was the treatment that stood the best chance to get R.N.'s metastatic cancer into remission. Tr. at 679 - 752, 911 - 957, 1064 - 1068, 1608 - 1654.

732. Prostate cancer feeds on male hormone. Tr. at 918.

733. Hormone therapy for prostate cancer reduces the cancer by introducing additional female hormone (estrogen) into the body, which, in turn, effectively decreases the production of the male hormone upon which the cancer feeds. Tr. at 917 - 918.

734. Hormone therapy for prostate cancer can also work by removal of the site of production of the male hormone, the testicles, through an orchiectomy. I.G. Ex. 3E, 3T at 13 - 28.

735. Petitioner administered Adriamycin and Cytoxan to R.N. via one and eight hour infusions on an almost weekly basis throughout 1986. I.G. Ex. 3E, 3T.

736. Petitioner administered 5FU to R.N. on 3/31, 6/23, 9/17, 9/24, 9/29, and 10/10 in 1986. I.G. Ex. 3E, 3T.

737. Petitioner administered 5FU to R.N. via one to eight hour infusion on at least seven occasions in 1986. I.G. Ex. 3E, 3T.

738. Petitioner's administration in 1986 of Adriamycin and Cytoxan 5FU to R.N. via infusion was below professionally recognized standards of health care and substantially in excess of R.N.'s needs. Tr. at 679 - 752, 911 - 957, 1064 - 1068, 1608 - 1654, 2898 - 2907.

739. Petitioner administered Cisplatinum to R.N. via one to eight hour infusion on 3/31, 6/23, 8/22, 9/15, 10/14, and 12/10 in 1986. I.G. Ex. 3E, 3T at 3 - 4, 86.

740. Cisplatinum could have been an effective agent to treat R.N.'s metastatic prostate cancer in 1986. Tr. at 947 - 948.

741. Professionally recognized standards of health care dictated that Petitioner should have stopped administering Adriamycin and Cytoxan before beginning the administration of Cisplatinum in 1986. Tr. at 948.

742. It was below professionally recognized standards of health care for Petitioner to fail to cease administering Adriamycin and Cytoxan before administering Cisplatinum to R.N. in 1986. Tr. at 948.

743. Petitioner began administering 5FU to R.N. in July 1986. Tr. at 949; I.G. Ex. 3E, 3T.

744. Professionally recognized standards of health care dictated that Petitioner cease administering Adriamycin and Cytoxan to R.N. before administering 5FU. Tr. at 949 - 951.

745. It was below professionally recognized standards of health care for Petitioner to administer 5FU to R.N. in 1986 in conjunction with a failed regime of Adriamycin and Cytoxan. Tr. at 948 - 951.

746. In early 1984, Petitioner began administering to R.N. three milligrams of Estramustin also, which consists of the hormone estrogen in combination with a chemotherapy agent. I.G. Ex. 3E, 3T; Tr. at 914.

747. Estramustine hydrochloride is known as Emcyt. I.G. Ex. 3T at 17.

748. Petitioner's administration of emcyt in three-milligram doses to R.N. from early 1984 through November 1984 was within professionally recognized standards of health care. I.G. Ex. 3E, 3T; Tr. at 940 - 941.

749. In November 1984, Petitioner ceased administering Emcyt and switched to DES to treat R.N. I.G. Ex. 3E, 3T; Tr. at 940 - 942.

750. DES is a synthetic compound, similar to estrogen, that is used in the treatment of prostate cancer via hormonal therapy. Tr. at 689, 916.

751. DES causes the body to decrease and potentially stop its production of the male hormone. Tr. at 916.

752. R.N. had no previous history of heart disease such that treatments involving the hormone estrogen were contraindicated. Tr. at 918; I.G. Ex. 3E, 3T.

753. Petitioner administered DES to R.N. beginning in November 1984 through February 5, 1986. Tr. at 916, 944; I.G. Ex. 3E, 3T.

754. Petitioner did not administer DES to R.N. after February 1986. Tr. at 944 - 947.

755. Petitioner did not administer any other type of hormone therapy to R.N. after February 1986. Tr. at 944 - 947; Findings 753 - 754.

756. Bone scans in August 1984 and 1985 show marked improvement in R.N.'s cancer. Tr. at 915; I.G. Ex. 3E, 3T.

757. A bone scan performed in March 1986 shows that R.N.'s cancer was again growing. Tr. at 915; I.G. Ex. 3E.

758. A bone scan performed in June 1986 shows that R.N.'s cancer had become worse in the period between the March 1986 and June 1986 bone scans. Tr. at 915 - 916; I.G. Ex. 3E, 3T.

759. R.N.'s condition continued to worsen from June 1986 through the end of the year. I.G. Ex. 3E, 3T; Tr. at 915 - 916.

760. On April 2, 1987, R.N. died from the effects of metastatic prostate cancer. Tr. at 916 - 917; I.G. Ex. 3E, 3T.

761. In 1986, the professionally recognized standard for the treatment of R.N.'s metastatic prostate cancer was to use hormone therapy rather than chemotherapy, unless hormone therapy had been attempted and failed or unless there was some medical reason not to administer hormone therapy. Tr. at 714 - 715, 916 - 919, 1608 - 1654.

762. In 1986, the professionally recognized standard for the treatment of R.N.'s metastatic prostate cancer mandated that Petitioner treat the cancer with hormone therapy involving some form of estrogen, hormone blocker, or orchiectomy (removal of the testicles), and to treat R.N.'s bone pain and any symptomology caused by his metastatic cancer. Tr. at 684, 917 - 957, 1064 - 1654; I.G. Ex. 3E, 3T.

763. In 1986, the professionally recognized standard for the treatment of R.N.'s metastatic prostate cancer mandated that, in the event R.N.'s cancer continued to progress in the face of treatment with one form of hormone therapy, successive hormonal manipulations should be attempted using different drugs or orchiectomy. I.G. Ex. 3E, 3T; Tr. at 679 - 752, 911 - 957, 1064 - 1068, 1608 - 1654, 2989 - 2907.

764. R.N. never exhibited symptoms that would be associated with receiving the amounts of Adriamycin and Cytoxan that Petitioner documented in R.N.'s flow sheet as having been administered to R.N. by Petitioner during 1986. I.G. Ex. 3E, 3T; Tr. at 679 - 752, 911 - 957, 1064 - 1068, 1608 - 1654, 2898 - 2907.

765. R.N. would have died from the toxic effects of Adriamycin and Cytoxan had he, in reality, received these two drugs in 1986 in the amounts Petitioner documented he administered to R.N.

766. R.N. did not die from the toxic effects of Adriamycin and Cytoxan. I.G. Ex. 3E, 3T; see Tr. at 679 - 752, 911 - 957, 1064 - 1068, 1608 - 1654.

767. In 1986, R.N. did not receive the drugs Adriamycin and Cytoxan in the amounts that appear in R.N.'s flow sheet. Findings 764 - 766.

768. In 1986, it was below professionally recognized standards of health care for Petitioner to record on R.N.'s flow sheet amounts of Adriamycin and Cytoxan that R.N. did not receive. Tr. at 911 - 957 (especially at 949), 1064 - 1068, 1608 - 1654, 2898 - 2907; Findings 24 - 29.

769. Petitioner jeopardized R.N.'s health, safety, and well-being by failing to enter into R.N.'s flow sheet the precise amounts of Adriamycin and Cytoxan that R.N. received during 1986. Findings 24 - 29, 768.

770. Petitioner did not document that Petitioner had discussed with R.N. at any time, including 1986, the option of orchiectomy as a possible treatment for R.N.'s cancer and that R.N. refused orchiectomy as a treatment option. I.G. Ex. 3E, 3T.

771. In 1986, it was below professionally recognized standards for Petitioner to administer chemotherapy treatments to R.N. without first discussing with R.N. orchiectomy and other hormonal manipulation treatments as an alternative and documenting that R.N. refused treatment by hormonal manipulation. I.G. Ex. 3E, 3T; Tr. at 911 - 957 (especially at 926), 1064 - 1068, 1608 - 1654.

772. Petitioner's treatment of R.N.'s prostate cancer with hormone therapy via use of one-milligram doses of the drug DES was within professionally recognized standards of health care for the period of time from when Petitioner began to treat R.N. with DES until there was objective evidence that the cancer had continued to grow (the June 1986 bone scan). Tr. at 690 - 695, 918 - 957.

773. Once there was objective evidence that R.N.'s tumor had continued to grow, professionally recognized standards of health care dictated that Petitioner should have increased the dosage of DES or other estrogen, or used another form of hormonal therapy, such as orchiectomy, to achieve suppression of all male hormones. Tr. at 919 - 957.

774. Only after all male hormones have been suppressed can an oncologist determine whether prostate cancer remains dependent upon male hormone or has the ability to grow independent of male hormone. Tr. at 919 - 957.

775. Only after all male hormones have been suppressed can an oncologist determine whether the prostate cancer is treatable with hormone therapy. Tr. at 919 - 957, 1608 - 1654.

776. In most patients, one-milligram doses of DES have little chance of suppressing all of the male hormones. Tr. at 919 - 957.

777. In 1986, professionally recognized standards of health care dictate that, during the time when Petitioner was administering DES to R.N., Petitioner should have administered a blood test to R.N. to determine if he had achieved suppression of the male hormones. Tr. at 919 - 957; I.G. Ex. 3E, 3T; Findings 773 - 776.

778. Petitioner did not administer a blood test to R.N. at any time during 1986 that would have allowed Petitioner to determine that he had achieved suppression of all of the male hormones. Tr. at 919 - 957; I.G. Ex. 3E, 3T.

779. In 1986, Petitioner did not administer a blood test to R.N. that would have allowed Petitioner to determine whether treatment of R.N.'s cancer via hormonal manipulation was effective. Tr. at 919 - 957; I.G. Ex. 3E, 3T; Findings 773 - 778.

780. Petitioner's failure to administer a blood test to R.N. in 1986 to determine the level of male hormones present in R.N. was below professionally recognized standards of health care. Tr. at 919 - 957, 1608 - 1654; I.G. Ex. 3E, 3T.

781. Petitioner never showed nor demonstrated that R.N.'s cancer was hormone-independent. Tr. at 919 - 957; I.G. Ex. 3E, 3T.

782. In 1986, it was below professionally recognized standards of health care for Petitioner to administer chemotherapy to R.N. without first proving that R.N.'s cancer was hormone-independent. Tr. at 935 - 957; I.G. Ex. 3E, 3T; Findings 773 - 781.

783. R.N. developed thrombophlebitis in July 1986. I.G. Ex. 3E, 3T; P. Ex. 7; Tr. at 693 - 694.

784. Subsequent to finding that R.N. had developed thrombophlebitis in July 1986, Petitioner stopped administering DES to R.N. and instead administered Leupron. P. Ex. 7; Tr. at 694; I.G. Ex. 3T at 80 - 83.

785. Leupron would have the same general effect on R.N.'s cancer
as DES but with much less chance of aggravating R.N.'s thrombophlebitis. Tr. at 694.

786. Petitioner's discontinuation of DES and choosing to administer Leupron in or around July 1986 was in accordance with professionally recognized standards of health care, in that Leupron would have much less chance of aggravating R.N.'s thrombophlebitis. Tr. at 694, 1645.

787. Petitioner documented that in 1986, he administered weekly to R.N. one and eight hour infusions of the chemotherapy drugs Adriamycin and Cytoxan, with the drug Cisplatinum interspersed in the mix at irregular, approximately monthly intervals. I.G. Ex. 3E, 3T.

788. Petitioner documented that he administered to R.N. in 1986 the chemotherapy drug 5FU on the following dates: 9/17, 9/24, 9/29, 11/24, 12/10, 12/17 of 1986 (and on several occasions during 1987). I.G. Ex. 3T at 82 - 83.

789. It is of no medical benefit to the patient to be given the drugs Adriamycin or Cytoxan via infusion of one to eight hours. Tr. at 724; Findings 10 - 20.[22]

790. On each occasion in 1986 that Petitioner administered the drugs Adriamycin and Cytoxan to R.N., he did so via a one to eight hour infusion. I.G. Ex. 3E, 3T.

791. It was below professionally recognized standards of health care and substantially in excess of R.N.'s needs for Petitioner to administer Adriamycin, Cytoxan, and 5FU to R.N. via a one to eight hour infusion. I.G. Ex. 3T; Tr. at 724, 911 - 957, 1064 - 1068, 1608 - 1654; Findings 787 - 790.

792. It was within professionally recognized standards of health care to administer the drug Cisplatinum by infusion. Tr. at 724.

793. The chemotherapy agents Cisplatinum and 5FU, in theory, can be effective in treating metastatic prostate cancer. Tr. at 947 - 950.

794. In 1986, it was below professionally recognized standards of health care for Petitioner to continue to administer Adriamycin and Cytoxan to R.N. in the face of progressive metastatic disease. Findings 756 - 760; I.G. Ex. 3E, 3T; Tr. at 947 - 950, 1621 - 1623.

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[22]Adriamycin, infused over a 24-hour period, does exhibit reduced cardiotoxicity. Tr. at 1338.

795. In 1986, it was below professionally recognized standards of health care for Petitioner to begin to administer Cisplatinum and 5FU to R.N. without first stopping the administration of Adriamycin and Cytoxan, which had proven ineffective. I.G. Ex. 3E, 3T; Tr. at 947 - 950, 1621 - 1623.

796. Petitioner failed to document that he actually saw R.N. on each of the 32 occasions in 1986 that he billed for an office visit.[23] I.G. Ex. 3T; Tr. at 724.

797. It was below professionally recognized standards of health care for Petitioner to bill Medicare for an office visit where he failed to document that he had actually seen R.N. Tr. at 727.

798. The 32 office visits that Petitioner provided to R.N. were substantially in excess of R.N.'s needs. I.G. Ex. 3T; Tr. at 724.

799. Acid phosphatase tests need be performed only once every three months to track the progression of a patient with prostate cancer. Tr. at 721.

800. Acid phosphatase tests can be performed at more frequent intervals for brief periods in the event the form of treatment the patient is receiving is changed. Tr. at 721 - 722.

801. Petitioner's testing of acid phosphatase of R.N. every month was substantially in excess of R.N.'s needs. Tr. at 722.

802. Petitioner's documentation of R.N.'s condition via his outpatient notes does not meet professionally recognized standards of health care. Tr. at 722 - 723.

803. There is no evidence in the record that would support Petitioner's inference that he was treating R.N. for bladder cancer. I.G. Ex. 3E, 3T; Tr. at 741.

804. There is no evidence in the record that would support a finding that R.N.'s cancer at any time was or became resistant to treatment by hormone manipulation. I.G. Ex. 3E, 3T.

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[23] My review of the record reveals that Petitioner billed for 34 office visits for R.N. in 1986. However, since counsel for the I.G. alleges that only 32 office visits occurred, I make this lesser amount my Finding.

805. Petitioner's assertion that R.N.'s cancer was resistant to hormone treatment is not credible. Findings 720 - 804.

806. Petitioner mistakenly ascribed that it was the chemotherapy treatments that he was administering to R.N. that had reduced R.N.'s cancer when, in fact, it was the hormone treatment that had reduced R.N.'s cancer. Tr. at 924.

807. CEA plays no role in following the course of or testing for prostate cancer. Tr. at 718 - 719, 951.

808. In 1986, it was substantially in excess of R.N.'s needs for Petitioner to administer CEA tests to R.N. Tr. at 718 - 719, 950 - 951.

809. The chemotherapy that Petitioner provided to R.N. in 1986 was below professionally recognized standards of health care and substantially in excess of R.N.'s needs, both in types of drugs used and in the method of administration (one to eight hour infusions). Findings 720 - 804.

810. All of the CBCs that Petitioner administered to R.N. in 1986 were unnecessary. Findings 768 - 769, 809; Tr. at 720 - 721, 952.

811. All of the CBCs that Petitioner administered to R.N. in 1986 were substantially in excess of R.N.'s needs. Finding 810.

812. All of the venipunctures that Petitioner administered to R.N. in 1986 were medically unnecessary. Finding 809, 810; Tr. at 720 - 721, 952 - 953.

813. All of the venipunctures that Petitioner administered to R.N. in 1986 were substantially in excess of R.N.'s needs. Findings 812; Tr. at 720 - 721, 952 - 953.

814. All of the platelet counts that Petitioner administered to R.N. in 1986 were medically unnecessary. Findings 809; Tr. at 720 - 721, 952 - 953.

815. All of the platelet counts that Petitioner administered to R.N. in 1986 were substantially in excess of R.N.'s needs. Finding 814; Tr. at 720 - 721, 952 - 953.

816. Petitioner's treatment of R.N. in 1986 was substantially in excess of R.N.'s needs. Findings 720 - 815.

817. Petitioner's treatment of R.N. in 1986 was below professionally recognized standards of health care. Findings 720 - 815.

818. Through his treatment of R.N. in 1986, Petitioner has demonstrated that he was not familiar with the necessary concepts and treatment options available to oncologists in 1986 to treat metastatic prostate cancer. Findings 720 - 817.

819. Through his treatment of R.N. in 1986, Petitioner jeopardized R.N.'s health, safety, and well-being. Findings 720 - 818.

820. Petitioner's attempts to justify his treatment of R.N. in 1986 as being entirely within professionally recognized standards, health care are inconsistent, inadequate, and not credible. P. Ex. 7; Tr. at 2656 - 2737; Findings 720 - 819.

821. Petitioner's attempts to justify his treatment of R.N. in 1986 as not being substantially in excess of R.N.'s needs are inconsistent, inadequate, and not credible. P. Ex. 7; Tr. at 2656 - 2737; Findings 720 - 820.

Petitioner's testimony regarding his treatment of R.N. is indicative of his lack of credibility and lack of trustworthiness.

822. Petitioner's assertion that R.N.'s bone pain was well controlled with Demerol is contradicted by the fact that Demerol is not a very good agent for control of bone pain, and is indicative of Petitioner's lack of credibility and lack of trustworthiness. I.G. Ex. 3E, 3T at 16 - 18; Tr. at 2677.

823. Petitioner's self-contradictory testimony on the issue of whether R.N.'s flow sheet reflects the doses of chemotherapy and other medications Petitioner administered to R.N. is indicative of Petitioner's lack of credibility and lack of trustworthiness. Tr. at 2683 - 2685; I.G. Ex. 3T at 81 - 83.

824. Petitioner gave conflicting, evasive testimony when asked to state the time period during which he had problems with the Medicare billing codes. Tr. at 2683 - 2687.

825. Petitioner's conflicting, evasive testimony regarding the period of time he alleges he had difficulty with the Medicare billing codes is indicative of his lack of credibility and lack of trustworthiness. Tr. at 2683 - 2687; Finding 824.

826. That Petitioner blames his nursing staff for the fact that R.N.'s flow sheets do not reflect the amount of Adriamycin R.N. actually received is indicative of Petitioner's unwillingness to take responsibility for the care and treatment of R.N. Tr. at 2689 - 2690; I.G. Ex. 3T at 77.

827. That Petitioner blames his nursing staff for the fact that R.N.'s flow sheets do not reflect the amount of Adriamycin R.N. actually received is indicative of Petitioner's lack of credibility and lack of trustworthiness. Finding 826.

828. Petitioner's assertion that side effects are not an integral part of chemotherapy is directly contradicted by the evidence and Petitioner's own testimony, is indicative of Petitioner's willingness to distort the record and is further indicative of Petitioner's lack of credibility and lack of trustworthiness. Tr. at 2693; Findings 21 - 29.

829. Petitioner's self-contradictory, conflicting testimony about whether he read R.N.'s bone scan reports is indicative of Petitioner's lack of credibility and lack of trustworthiness. Tr. at 2700; see Findings 756 - 760.

830. Petitioner's inability to articulate any reason for his erratic administration of Cisplatinum to R.N. in August and September 1986 is indicative of: Petitioner's failure to treat R.N. in accordance with professionally recognized standards of health care; Petitioner's lack of credibility; and Petitioner's lack of trustworthiness. Tr. at 2700 - 2702; I.G. Ex. 3E, 3T.

831. The exhibit submitted by Petitioner to support his treatment of R.N. completely contradicts Petitioner's assertion as to the validity of the chemotherapy treatment he administered to R.N. P. Ex. 7 at 11; Tr. at 2705 - 2706.

832. The study cited by Petitioner is applicable to patients that received orchiectomy, DES, and combination chemotherapy, all of which R.N. did not receive. P. Ex. 7; Tr. at 2711 - 2712.

833. Petitioner's assertion that the study he submitted supports that his treatment of R.N. gave R.N. a 63 percent increase in five-year survival is directly contradicted by an accurate reading of the study and is indicative of Petitioner's lack of credibility and lack of trustworthiness. Tr. at 2705 - 2712; P. Ex. 7.

Petitioner's billing practices

834. At all times relevant to this case, Blue Shield of California (CA Blue Shield) has been the Medicare carrier. Tr. at 1098.

835. At all times relevant to this case, CA Blue Shield has had the responsibility of receiving and processing, which includes reviewing and auditing, claims from beneficiaries throughout northern California, except for the southern counties. Tr. at 1098.

836. Arthur J. Meharg is the director of Medicare administration for CA Blue Shield. Tr. at 1099.

837. Mr. Meharg has worked with the Medicare program for 26 years. Tr. at 1100.

838. As director of Medicare administration for CA Blue Shield, Mr. Meharg is responsible for all prepayment and postpayment review of medical claims submitted by CA Blue Shield providers. Tr. at 1100.

839. Mr. Meharg oversees the utilization and review branch of CA Blue Shield. Tr. at 1101.

840. Utilization review examines a provider's entire practice for a given period of time. Tr. at 1101.

841. Front-end review is a claim-by-claim review process, also called "prepayment review." Tr. at 1101.

842. Prepayment review begins when Medicare claims are sorted by computer according to a specific Medicare provider's number(s) and the claims are reviewed by a nurse technician. Tr. at 1111 - 1114.

843. Nurse technicians reviewing Medicare claims have access to physician advisors who have experience in the area of medical specialty in which the claims are categorized. Tr. at 1111 - 1112.

844. A physician advisor becomes involved in the prepayment review process only at the request of the nurse technician. Tr. at 1117, 1269 - 1271.

845. There is no requirement that a claim that a nurse technician approves for payment be reviewed by a physician. However, a nurse technician cannot deny a claim for reimbursement unless a physician advisor is consulted and gives his or her approval to deny payment of the claim. Tr. at 1156 - 1157, 1269 - 1271.

846. A physician advisor is not involved if a nurse technician approves payment of a particular claim. Tr. at 1156 - 1157.

847. Some of Petitioner's claims on the seven patients at issue here were denied in prepayment review. Tr. at 1271.

848. Prepayment review is a time consuming process that is very expensive to the carrier. Tr. at 1111 - 1112.

849. In conducting prepayment review, the reviewer examines only the individual claim that is submitted and accepts the provider's diagnosis at face value -- the reviewer does not examine services that may have been rendered to that patient at any time preceding the date of that particular claim, nor does the reviewer examine the medical records of the patient. Tr. at 1111 - 1112, 1195 - 1196.

850. In conducting prepayment review, the reviewer does not examine the medical records of the patient who is being treated. Tr. at 1112 - 1113, 1195 - 1196.

851. Prepayment review does not examine the treatment of the patient over a period of time. Tr. at 1112 - 1113, 1195 - 1196; Findings 849 - 850.

852. Prepayment review is not conducive to examining the propriety or course of treatment given by an oncologist to a patient over a period of time. Tr. at 1195 - 1196; Findings 841 - 851.

853. On prepayment review (also called front-end review), the claims are pulled by a computer and transferred to a nurse advisor for review. Tr. at 1114.

854. The reviewer conducting prepayment review does not have medical records to assist in the review process; he or she merely checks that the diagnosis on the claim meets the service that the physician billed for. Tr. at 1204.

855. Claims are generally denied on prepayment review either because the service provided is not reimbursable or the service is being provided in an excessive manner. Tr. at 1199 - 1200.

856. Prepayment review is not conducive to detecting services that were not provided as claimed or that are not medically necessary. Tr. at 1112 - 1113, 1195 - 1196; Findings 841 - 855.

857. Postpayment review (also called utilization review) is a comprehensive review of a provider's treatment of patient(s) in which the reviewer examines the medical records, patient charts, and supporting documentation related to the treatment of patient(s) over a period of time, e.g., six months to a year. Tr. at 1112 - 1113, 1195 - 1196, 1203 - 1205.

858. Postpayment review examines the medical records and other documentation related to a provider's treatment of patient(s) and compares it to the claims that were submitted in conjunction with the provider's treatment of that particular patient to ensure: that the provider's diagnosis and treatment of the patient (Medicare beneficiary) was appropriate; that the provider billed his or her services in accordance with Medicare requirements; and that the provider was reimbursed in accordance with Medicare requirements. Tr. at 1203 - 1204; Finding 857.

859. Encompassed in the postpayment review process is a comprehensive review of the provider's medical records and his or her diagnosis and treatment of patient(s) over a period of time, e.g., six months to a year. Tr. at 1205.

860. The Medicare Carrier's Manual is designed as an instruction for any provider who is billing the Medicare program. Tr. at 1264.

861. The Medicare Carrier's Manual is available upon request, via purchase. Tr. at 1263.

862. HCFA policy, the Medicare Carrier's Manual, and the multiple bulletins that are routinely sent to Medicare providers inform providers that all services that are provided to the patient on a particular date need to be stated on one claim form. Tr. at 1162 - 1163, 1257 - 1263.

863. In the event the services are too numerous to place on the same claim form, Medicare directs providers to clip the claim forms together. Tr. at 1163, 1223.

864. On numerous occasions, claims submitted by Petitioner did not comport with the directives that all services provided on a particular date be contained in one claim. Tr. at 1259 - 1264.

865. "Fragmenting" of claims occurs when a provider breaks a given procedure code into subcomponents, causing the reimbursement that provider receives to be greater than if the provider had used only the single appropriate billing code. Tr. at 1102.

866. Fragmenting of claims can occur also where a provider sends claims for reimbursement for services performed on the same day to different claims processing centers. Tr. at 1103.

867. Submitting claims for reimbursement to different claims processing centers enables the provider to avoid detection of duplicative or excessive billing. I.G. Ex. 7; Tr. at 1103 - 1105; see Tr. at 1158.

868. Petitioner's fragmenting of his claims hampered CA Blue Shield's efforts to review Petitioner's care of patients and monitor his billing practices over a period of time. Tr. at 1223 - 1226; Findings 864 - 867.

869. Petitioner would provide services to a patient during the course of one or two days and then split the submission of his claims for reimbursement such that CA Blue Shield would receive Petitioner's claims on two separate occasions, spaced six months to a year apart. Tr. at 1223 - 1226.

870. Petitioner exhibited a pattern of fragmenting his claims for reimbursement in that, instead of submitting at one time all his claims for reimbursement for services provided to a patient on a particular day, he would submit several different forms and stagger the times he submitted the forms. Tr. at 1158, 1177 - 1181, 1223 - 1226.

871. Beginning in 1986, CA Blue Shield allowed Petitioner to submit claims electronically. Tr. at 1181.

872. At all times relevant to this case, as a condition of being allowed to submit claims electronically, CA Blue Shield required providers to sign an agreement to certify

that the services being rendered and billed for are true and accurate. Tr. at 1197 - 1198.

873. Petitioner exhibited a pattern of fragmenting the claims he submitted via the electronic claims submission process. Tr. at 1191.

874. Petitioner's pattern of fragmenting claims, both those that were electronically submitted and those that were not, made it difficult for CA Blue Shield to detect deficiencies related to his treatment of patients and his billing practices. I.G. Ex. 7 at 2; Tr. at 1103 - 1104, 1112 - 1113, 1119, 1158, 1177 - 1180, 1223 - 1226.

875. "Upcoding" is where providers attempt to bill a higher-level service than was actually rendered or required, to increase revenue. Tr. at 1102.

876. In 1979, CA Blue Shield placed Petitioner on prepayment review of all of his Medicare claims. Tr. at 1106 - 1107, 1147.

877. In 1980, a Dr. Rosenbaum (a CA Blue Shield cancer specialist and oncologist) met with Petitioner and, as a result of that meeting, decided to reduce the prepayment review of all of Petitioner's claims to a prepayment review of some of his claims. Tr. at 1109 - 1110, 1147.

878. After meeting with Dr. Rosenbaum, Petitioner was placed on partial prepayment review. Tr. at 1147.

879. Petitioner remained on partial prepayment review until 1985, when another oncologist, Dr. Bohannon, asked to review some claims and recommended Petitioner again be placed on full prepayment review. Tr. at 1109 - 1110, 1147.

880. In 1987, Petitioner was again placed on full prepayment review of all of his claims. Tr. at 1118, 1147, 1159 - 1160.

881. Petitioner remained on full prepayment review through 1989. Tr. at 1159 - 1160.

882. CA Blue Shield informed Petitioner in 1987 of the difficulties they had found with his billing and treatment practices. I.G. Ex. 3F, 3G.

883. As early as August 14, 1987, Petitioner was informed that it was not acceptable to bill for a drug in an amount that was not actually administered to the patient. I.G. Ex. 3G, 3J.

884. As early as August 3, 1987, Petitioner was informed that the medical records he keeps on each patient should reflect the amount of medication each patient actually receives. I.G. Ex. 3F, 3J.

885. As early as August 14, 1987, Petitioner was informed of many of the deficiencies regarding patient care and documentation of services provided that eventually led to the instant action. I.G. Ex. 3G, 3J.

886. In 1987, CA Blue Shield met with Petitioner and informed him of specific deficiencies regarding his incorrect billing practices, his inaccurate charting of medication administered to patients, his inappropriate and excessive use of laboratory procedures, and his excessive use of office visits. I.G. Ex. 3F, 3G, 3H, 3I, 3J; Tr. at 1122 - 1123.

887. In August 1988, CA Blue Shield went to Petitioner's office to review Petitioner's records of treating medical patients. Tr. at 1124 - 1126.

888. Petitioner's records were difficult for the CA Blue Shield reviewers to decipher because Petitioner's records: were organized based on the type of service that was provided rather than according to the treatment given to an individual patient; often did not contain sufficient documentation to support Petitioner's claim for services on a particular date; contained few notations in the patients' charts; and had reports which did not contain laboratory results at regular intervals in the charts, but instead were bundled in one section of the chart. Tr. at 1124 - 1129.

889. Subsequent to August 1988, CA Blue Shield kept Petitioner on prepayment review and began to review Petitioner's treatment of patients via postpayment review. Tr. at 1130 - 1131.

890. Between 1985 and 1989, Petitioner had three Medicare provider numbers. Tr. at 1142.

891. Petitioner was paid the following amounts by CA Blue Shield as reimbursement for Medicare claims he submitted under provider number ZZZ-9081: $53,943.19 in 1988 and $44,997.16 in 1989, for a total of $98,940.35. Tr. at 1142 - 1143.

892. Petitioner was paid the following amounts by CA Blue Shield as reimbursement for Medicare claims he submitted under provider number 00-A-263360: 1985 -- $788,835.94; 1986 -- $906,764.28; 1987 -- $416,630.70; 1988 --

$564,514.04; 1989 -- $534,538.60; for a total of $3,211,283.56. Tr. at 1142 - 1143.

893. Petitioner was paid the following amounts by CA Blue Shield as reimbursement for Medicare claims he submitted under provider number 00-A-263361: 1985 -- $185.20; 1986 -- $537.43; 1987 -- $712.89; for a total of $1,435.60. Tr. at 1142 - 1143.

894. From 1985 through 1989, Petitioner received $3,311,659.51 in reimbursement from CA Blue Shield. Tr at 1143 - 1144.

895. From 1985 through 1989, Petitioner submitted claims for reimbursement to CA Blue Shield for over twice the amount he actually received in reimbursement. Tr. at 1144.

896. Petitioner has been a Medicare provider at least since 1979. Tr. at 1139.

897. Since 1979, CA Blue Shield sent Petitioner Medicare bulletins that discuss the appropriate ways to bill Medicare for services. Tr. at 1139 - 1140.

898. As of 1979, Medicare had placed Petitioner on notice that the manner in which he was billing for his Medicare services was not correct. Tr. at 1147; Findings 896 - 897.

899. Petitioner admitted that it was his practice to bill for the vial size of a drug when he would administer only a portion of that vial to a patient and would discard the unused portion even though it was reusable. Tr. at 1128; I.G. Ex. 3G, 3H, 3I, 3J.

900. Petitioner was instructed on numerous occasions to bill for the amount of drug that he actually administered to the patient. Tr. at 1128, 1152; I.G. Ex. 3G, 3H, 3I, 3J.

901. Petitioner's assertion that at least two Blue Shield personnel directed him to submit claims to Medicare for chemotherapy in the manner in which he did is contradicted by the evidence of record. Tr. at 2235, 2240 - 2242; I.G. Ex. 3H; P. Ex. 14.

902. During 1987 and on several subsequent occasions, Petitioner requested that, if Blue Shield would tell him how to bill correctly, he would follow their instructions. Tr. at 1152.

903. During 1987 and on several subsequent occasions, Petitioner was specifically instructed by Blue Shield on how to bill correctly. Tr. at 1152 - 1153; Findings 882 - 886; 902.

904. Blue Shield officials instructed Petitioner to follow the instructions that were published in the Medicare bulletins. Tr. at 1153.

905. In a letter dated September 3, 1987, Petitioner acknowledged that he understood he should bill Medicare for only the dosages of chemotherapy he administered to the patient, and further indicated that he would enter onto the patient's flow sheets only the amount of chemotherapy that was actually received by the patient. I.G. Ex. 3J.

906. Petitioner, despite repeated assertions that he would do so, never complied with the instructions given to him by CA Blue Shield on how to bill correctly for his services. Tr. at 1152; I.G. Ex. 3E, 3F, 3G, 3H, 3I, (especially 3J), 3K, 3L, 3M, 3N, 3O, 3P, 3Q, 3R, 3S, 3T; Findings 834 - 905.

907. Petitioner's assertion that he was willing to comply with Medicare billing practices if only Medicare would give him instructions is contradicted by the evidence of record, is not credible, and is indicative of Petitioner's lack of trustworthiness. Findings 1 - 906; Tr. at 2247 - 2248; I.G. Ex. 3E, 3F, 3G, 3H, 3I, (especially 3J), 3K, 3L, 3M, 3N, 3O, 3P, 3Q, 3R, 3S, 3T.

908. Petitioner blames his office and nursing staff for his problems with Medicare billing. Tr. at 2214 - 2224.

909. A June 12, 1987 letter from Medicare to Petitioner is not relevant to the issue of whether Petitioner violated section 1156 of the Act in his treatment of any of the seven patients on which evidence was presented in this case. P. Ex. 14.

910. Petitioner's repeated assertion that CA Blue Shield instructed him to bill for the vial amount of a drug, rather than the actual amount he administered, is contradicted by the evidence of record, is not credible, and is indicative of Petitioner's lack of trustworthiness. I.G. Ex. 3G, 3H, 3I, (especially 3J); Findings 834 - 909; Tr. at 1765 - 1767, 1786 - 1788, 1793 - 1794, 1806 -1807, 2261 - 2281, 2869 - 2870; I.G. Ex. 3H; see Tr. at 1812 - 2737.

911. That, in 1980, CA Blue Shield's removal of Petitioner from full prepayment review and his placement on partial prepayment review was not the result of Petitioner's cooperation or compliance with CA Blue Shield's billing instructions or procedures. Tr. at 1154.

912. The existence of a code for a particular service, e.g., eight hour infusion, does not mean that service is an allowable service that will be paid by the Medicare carrier. Tr. at 1170 - 1171.

913. Prepayment review does not assess a physician's treatment of patients over time and does not question the diagnosis made by the physician. Tr. at 1177 - 1180, 1195 - 1196; Findings 841 - 856.

914. CA Blue Shield's prepayment review of Petitioner's records did not assess Petitioner's treatment of patients over time and it was assumed that Petitioner's diagnoses were correct. Tr. at 1177 - 1180, 1195 - 1196; Findings 841 - 856, 911 - 913.

915. CA Blue Shield's prepayment review of Petitioner from 1980 through 1985 examined Petitioner's billing for laboratory and oncology services only and did not examine Petitioner's billing for office visits. Tr. at 1177.

916. Prepayment review was not adequate to detect most of the problems with Petitioner's billings and treatment of patients. Tr. at 1158, 1177 - 1182, 1195 - 1196; Findings 841 - 856, 913 - 914.

917. Only a more thorough review, e.g., a postpayment review, was able to determine that Petitioner did not have supporting documentation in his records to corroborate his billings or justify his treatment of the patients at issue here. Tr. at 1158, 1177 - 1182, 1195 - 1196.

918. CA Blue Shield conducted a study in which it reviewed the claims submitted by Petitioner for the treatment of 50 Medicare beneficiaries and found that CA Blue Shield had paid, and Petitioner had received, $340,466.36 in overpayments. Tr. at 1185 - 1187.

919. Petitioner was informed that he had received overpayments from CA Blue Shield in the amount of $340,466.36, plus interest. Tr. at 1185 - 1187; I.G. Ex. 7.

920. CA Blue Shield is entitled to question the propriety of a claim, even if that claim is paid after a prepayment review. Tr. at 1192 - 1193.

921. The fact that CA Blue Shield may pay a claim after prepayment review is not a tacit approval by CA Blue Shield of Petitioner's billing for Medicare services or treatment of patients. Tr. at 1192 - 1193.

922. Petitioner never was informed that CA Blue Shield, in paying for a claim Petitioner had submitted through prepayment review, was endorsing that Petitioner had provided items or services in accordance with professionally recognized standards of health care, that were not substantially in excess of patients' needs, or that Petitioner actually had provided services as claimed. Tr. at 1194.

923. It was not until 1988 that CA Blue Shield began conducting postpayment review of Petitioner's billing and treatment practices. Tr. at 1195.

924. Ms. Doris Schell has been a special investigator for the utilization review department of CA Blue Shield for five years. Tr. at 1202.

925. Utilization review is the same thing as postpayment review. Tr. at 1203 - 1204.

926. Ms. Schell performed a comprehensive medical review and audit of Petitioner's medical billing practice, covering Medicare payments made to Petitioner from January 1985 through September 1989, involving 121 patients. Tr. at 1208 - 1211.

927. Ms. Schell's review of the medical records of 121 of Petitioner's patients did not reveal a single instance where Petitioner had placed written orders in the patients' charts. Tr. at 1218.

928. Ms. Shell's review of Petitioner's practice during the period 1985 through 1989 found that: Petitioner had overutilized chemotherapy, office visits, diagnostic tests, and laboratory tests; the diagnoses that were written on Petitioner's claim forms were often not substantiated in the medical records; Petitioner had submitted claims for reimbursement for office visits where there was no documentation in the patient's chart that would support that Petitioner examined the patient on that particular day; and Petitioner had submitted (and had been reimbursed for) claims for visiting his patients

in the hospital, where, on the day the visit was supposed to have occurred, the patient was discharged from the hospital. Tr. at 1220 - 1221.

929. From January 1, 1985 through September 30, 1989, Petitioner was overpaid the following amounts with regard to his treatment of the seven patients at issue in this case:

a. Approximately $34,000 for his treatment of D.R.;

b. Approximately $35,000 in overpayment for his medical treatment of B.G.;

c. Approximately $14,000 in conjunction with his treatment of J.L.;

d. Approximately $27,000 in conjunction with his treatment of R.N.;

e. Approximately $20,000 in conjunction with his treatment of H.S.;

f. Approximately $21,500 in conjunction with his treatment of J.W.;

g. Approximately $20,500 in conjunction with his treatment of H.W.

Tr. at 1228 - 1235.

930. In instances where CA Blue Shield denied payment, Petitioner was informed specifically about what the reviewers had found and why payment was denied. Tr. at 1266 - 1267.

931. In instances where the denial of payment was based on medical records or reports, a copy of the document the reviewers used to determine overpayment was included in the correspondence that was sent to Petitioner. Tr. at 1266 - 1267.

932. Some of Petitioner's claims on these seven patients at issue were denied in prepayment review. Tr. at 1271.

933. CA Blue Shield offers a procedure called a "fair hearing" whereby a provider can challenge CA Blue Shield's disallowances of reimbursement. Tr. at 1283 - 1284.

934. Petitioner wrote to CA Blue Shield and requested a "fair hearing." Tr. at 1284 - 1285.

935. Pursuant to Petitioner's request, CA Blue Shield scheduled two "fair hearings" to address Petitioner's disallowances. Tr. at 1283 - 1284.

936. Petitioner did not show up at either of the scheduled "fair hearings." Tr. at 1283 - 1284.

I have the authority to increase the term of Petitioner's exclusion beyond the 10 years originally proposed by the I.G.

937. An exclusion issued pursuant to section 1128(b)(6)(B) of the Act will be for a period of three years unless certain specified aggravating factors are present. 42 C.F.R. § 1001.701(d)(paraphrase).

938. An exclusion pursuant to section 1128(b)(6)(B) for a period of at least three years is justified in this case. Findings 1 - 936.

939. Only the following factors may be considered aggravating and a basis for lengthening the term of Petitioner's exclusion:

a. The violations were serious in nature and occurred over a period of one year or more;

b. The violations had a significant adverse physical, mental or financial impact on program beneficiaries or other individuals;

c. The individual or entity has a prior criminal, civil or administrative sanction record; or

d. The violation resulted in financial loss to Medicare or the State health care programs of $1500 or more.

42 C.F.R. § 1001.701(d)(2)(i) - (iv).

940. Only the following factors may be considered mitigating and a basis for reducing the period of Petitioner's exclusion:

a. There were few violations and they occurred over a short period of time; or

b. Alternative sources of the type of health care items or services furnished by the individual or entity are not available.

42 C.F.R. § 1001.701(3)(i) and (ii).

941. The aggravating factor at 42 C.F.R. § 1001.701(d)(2)(i) is present in this case. Findings 1 - 936.

942. The aggravating factor at 42 C.F.R. § 1001.701(d)(2)(ii) is present in this case. Findings 1 - 936.

943. The aggravating factor at 42 C.F.R. § 1001.701(d)(2)(iii) is present in this case. Findings 1 - 936.

944. The aggravating factor at 42 C.F.R. § 1001.701(d)(2)(iv) is present in this case. Findings 1 - 936.

945. The mitigating factor at 42 C.F.R. § 1001.701(d)(3)(i) is not present in this case. Tr. at 1812 - 2737; Findings 1 - 936; I.G. Ex. 1 - 19; P. Ex. 1 - 25/2

946. Petitioner has not alleged the mitigating factor that appears at 42 C.F.R. § 1001.701(d)(3)(ii). P. Ex. 1 - 25/2; Findings 1 - 945.

947. The mitigating factor at 42 C.F.R. § 1001.701(d)(3)(ii) is not present in this case. P. Ex. 1 - 25/2; I.G. Ex. 1 - 19; Tr. at 1 - 2994; Findings 1 - 946.

948. The existence of four aggravating factors and the absence of any mitigating factors supports that Petitioner should be excluded for a term of greater than three years. Findings 937 - 947.

949. I have the authority to increase the term of Petitioner's exclusion beyond the length imposed or proposed by the I.G. Sections 205(b) and 1128(b)(6)(B) of the Act; 42 C.F.R. § 1005.20(b).

Petitioner should be permanently excluded from Medicare and State Health Care Programs.

950. Petitioner understands that a patient's flow sheet should accurately reflect what drugs Petitioner actually administered to the patient and the amounts the patient actually received. Tr. at 1865 - 1866; I.G. Ex. 3J; Finding 27.

951. Petitioner failed to record properly on each of these seven patients' flow sheets the amount of chemotherapy that the patient actually received, instead entering into their charts the amount of chemotherapy for which he billed Medicare. Tr. at 2118 - 2124, 2135 - 2138, 2575.

952. With regard to all seven of these patients, Petitioner provided care below professionally recognized standards of health care by failing to record on each patient's flow sheet the precise amount and type of chemotherapy each patient received. Findings 1 - 937, (especially at 116, 122, 129, 132, 200 - 201, 248 - 250, 269, 274, 276, 290, 320, 322, 324 - 325, 327, 329, 342, 345, 372, 425 - 426, 432, 446 - 449, 489, 494, 507, 594 - 595, 599, 617 - 618, 641, 693 - 695, 700, 767 - 768, 820 - 821, 826 - 827).

953. Petitioner jeopardized the health, safety, and well-being of each of these seven patients by failing to record on each patient's flow sheet the precise amount and type of chemotherapy each patient received -- especially the following: Adriamycin, Cytoxan, and Vincristine to B.G and D.R., Cytoxan to H.W.; Vincristine to J.W.; Adriamycin, Cytoxan, and Methotrexate to J.L.; Adriamycin and Velban to H.S.; Adriamycin and Cytoxan to R.N. Tr. at 254; I.G. Ex. 30 at 8 - 31; Findings 1 - 833, (especially at 21 - 44, 188, 323, 426, 497, 508, 521, 525, 542, 551, 600, 616, 641, 769, 819).

954. Petitioner's statement that he was instructed by the Medi-Cal carrier (CA Blue Shield) to record on the patient's flow sheet the amount of chemotherapy drugs he billed for rather than the amount he administered to the patient is not supported by any affirmative evidence, is directly contradicted by testimony from a representative of CA Blue Shield, and is contrary to Petitioner's own statement. I.G. Ex. 3J; Findings 876, 882 - 886, 896 - 910.

955. Petitioner's statement that he was instructed by CA Blue Shield to record on the patient's flow sheet the amount of chemotherapy drugs he billed for rather than the amount he administered to the patient is not credible and is a self-serving attempt to mitigate the inappropriate and substandard care he provided. Finding 954.

956. Petitioner has demonstrated a disturbing tendency to blame Medicare (CA Blue Shield), his nursing staff, and doctors who filled in for him while he was away from the office for discrepancies in billing and omissions and

errors in his treatment of these seven patients. Tr. at 1886, 2120 - 2121, 2135 - 2138, 2155 - 2160, 2712 - 2715, 2723; Findings 189 - 217, 326 - 353, 433 - 454, 544 - 567, 619 - 625, 696 - 719, 822 - 833, 905 - 910.

957. Petitioner has demonstrated through his testimony and practices a disturbing lack of knowledge regarding the medically appropriate treatment of these seven cancer patients. Tr. at 1812 - 2737; Findings 1 - 936.

958. Petitioner has demonstrated through his treatment of these seven patients that he is unable or unwilling to adequately document his diagnoses and treatment of these seven patients in accordance with professionally recognized standards of health care. Findings 1 - 936.

959. In treating the seven patients at issue in this case, Petitioner has not practiced oncology in accordance with professionally recognized standards. Findings 1 - 936.

960. Petitioner has demonstrated a disturbing tendency to administer chemotherapy in one to eight hour infusions in the absence of any supporting medical reason for doing so. Findings 1 - 936.

961. Petitioner has demonstrated an unfamiliarity with the concepts and principles needed to treat these seven cancer patients in accordance with professionally recognized standards of health care.[24] Findings 1 - 936.

962. Petitioner has demonstrated a disturbing tendency to offer weak, unsupported, post hoc rationalizations to explain his treatment of these seven patients. Tr. at 1812 - 2737; Findings 1 - 936, (especially at 189 - 217, 326 - 353, 433 - 454, 523 - 531, 544 - 567, 619 - 625, 696 - 719, 822 - 833, 905 - 910).

963. Petitioner has demonstrated a disturbing tendency to testify that he administered chemotherapy to patients in accordance with a recognized protocol, when, in fact, the protocol he claims to have used as his basis for treating

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[24] In making this Finding, I recognize that there exist several instances in the record where Petitioner acted in accordance with professionally recognized standards and, in doing so, demonstrated some knowledge of appropriate treatment of patients. See Findings 407, 586, 740 - 741, 748. However, the evidence examined and weighed in its entirety, overwhelmingly supports this Finding.

the patient is dissimilar in many important and relevant aspects to the treatment the patient actually received. Findings 1 - 936 (especially at 238, 303, 304, 338, 377, 380, 523 - 531, 622).

964. Petitioner has demonstrated a disturbing tendency to continue with a course of treatment in the face of objective evidence that it is not reducing or having any discernible effect upon the patient's illness (or, having any effect on the patient at all). Findings 1 - 936.

965. Petitioner has demonstrated a disturbing tendency to administer CEA tests that are not medically necessary. Findings 1 - 936 (especially at 48 - 50, 182 - 184, 212 - 214, 312 - 315, 319, 532 - 535, 561, 663 - 667, 807 - 808).

966. Petitioner has demonstrated a disturbing tendency to administer CBCs, platelet counts and venipunctures that are not medically necessary. Findings 1 - 936 (especially at 45 - 47, 316 - 317, 430, 536 - 539, 609 - 610, 708 - 709, 810 - 816).

967. Petitioner has demonstrated a disturbing tendency to administer vitamin B-12 injections that are not medically necessary and therefore substantially in excess of his patients' needs. Findings 1 - 936 (especially at 294 - 297, 668 - 670).

968. Petitioner has demonstrated a disturbing tendency to provide his patients with office visits that are substantially in excess of their needs. Findings 176 - 180, 239 - 240, 798, 886.

969. Petitioner has demonstrated a disturbing tendency to administer laboratory tests and procedures, complete and partial blood counts and platelet counts, venipunctures, and CEA tests that are substantially in excess of patients' needs. Findings 965 - 966.

970. Petitioner has demonstrated a disturbing tendency to be unable or unwilling to articulate and follow a medically logical, coherent plan, or rationale, in accordance with professionally recognized standards of health care, for the treatment of these seven cancer patients. Findings 1 - 936.

971. Petitioner has demonstrated a disturbing tendency to fail to make a diagnosis and plan of treatment that is appropriately supported with medical documentation. Findings 1 - 936.

972. Through his treatment of these seven patients, Petitioner has demonstrated an inability or unwillingness to treat patients in accordance with professionally recognized standards of health care. Findings 1 - 971.

973. Petitioner has demonstrated a disturbing tendency to potentially endanger the health and safety of his patients through his failure to provide care in accordance with professionally recognized standards of health care. Findings 1 - 972.

974. Petitioner is not a credible witness. Findings 1 - 973.

975. Petitioner is not a trustworthy individual. Findings 1 - 974.

976. Petitioner has provided care that is substantially in excess of patients' needs and below professionally recognized standards of health care over a period of more than six years. Findings 1 - 936 (especially at 77, 465).[25]

977. Petitioner has demonstrated an egregious pattern of noncompliance with professionally recognized standards of health care such that he has subjected these seven patients to risks. Findings 1 - 976.

978. Petitioner has demonstrated an egregious pattern of noncompliance with professionally recognized standards of health care such that he has disregarded these seven patients' health, safety, well-being, and quality of life. Findings 1 - 977.

979. Petitioner has demonstrated an egregious pattern of providing care that is substantially in excess of the needs of these seven patients such that he has subjected them to risks. Findings 1 - 976.

980. Petitioner has demonstrated an egregious pattern of providing care that is substantially in excess of the needs of these seven patients such that he has disregarded the patients' health, well-being, and quality of life. Findings 1 - 977.

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[25] Petitioner's treatment of B.G. began in September 1983, and his treatment of J.W. ended on November 22, 1989. Petitioner's treatment of all other patients is interspersed throughout this period.

981. Petitioner believes that he was underpaid by Medicare and that Medicare payments "are a joke." Tr. at 1993.

982. Petitioner has demonstrated a contempt for the Medicare system that has been reflected in his treatment of these seven patients. Findings 1 - 981.

983. Petitioner was advised by CA Blue Shield specifically to bill for the closest amount of cumulative vial sizes (e.g., when 25 milliliters of a drug were used, to bill for three 10 milliliter vials) and Medicare specifically advised him not to bill for one dose and throw the remainder of the drug away. Tr. at 1886, 2927 - 2928; I.G. Ex. 3H, 3J.

984. Petitioner has demonstrated a willingness to blame Medicare for his having billed Medicare for an entire vial of chemotherapy drug although the chemotherapy drugs administered by Petitioner, with the exception of Bleomycin, came in reusable vials and the billing codes were adequate for this purpose. Tr. at 2575, 2855 - 2857, 2867 - 2870, 2895 - 2896, 2927 - 2928; I.G. Ex. 3E, 3F, 3G, 3H, 3I, 3J; Findings 1 - 936 (especially at 326 - 330, 447 - 451, 565, 624, 834 - 936).

985. Petitioner's contention that his infusion treatments of these seven patients was justified on the basis that administration of chemotherapy via a one to eight hour infusion minimized local toxicity to them and increased the kill rate of cancer cells is completely refuted by the following factors:

a. Petitioner never documented that any of these seven patients had any side effects from local toxicity;

b. Petitioner's administration of chemotherapy via a one to eight hour infusion was not medically appropriate or justified in the treatment regimen of B.G., D.R., H.W., J.W., J.L., H.S., and R.N (with the exception of Cisplatinum to R.N.);

c. Petitioner should have used the bolus method which, if administered properly or via a saline, works sufficiently well to minimize local toxicity;

d. Petitioner should have known that chemotherapy infusions over one to eight hours do not reduce the more important overall toxicity to the patient nor do such infusions cause any increase in the rate at which cancer cells are killed;

e. Although on many occasions Petitioner recorded that he administered supralethal doses of drugs to these seven patients, in many instances Petitioner administered doses, if any, of chemotherapy drugs -- Adriamycin, Cytoxan, and Vincristine to B.G and D.R., Cytoxan to H.W.; Vincristine to J.W.; Adriamycin, Cytoxan, and Methotrexate to J.L.; Adriamycin and Velban to H.S.; Adriamycin and Cytoxan to R.N. -- which were insufficient to have any curative effect on the patient's cancer.

f. The dosage of chemotherapy Petitioner in fact administered to each of these seven patients had no chance of curing or reasonably treating their cancers (with the exception of J.W., who had no cancer) because the treatments failed to have the side effects associated with therapeutic dosages, and could have actually have caused their cancers to become more resistant to treatment; and

g. The frequency with which Petitioner administered these chemotherapeutic agents is directly antithetic to reducing toxicity.

Tr. at 68 - 752, 764 - 957, 966 - 1074, 1077 - 1081, 1083 - 1089, 1302 - 1654, (especially 1822 - 1832), 2751 - 2847; I.G. Ex. 3E, 3N, 3O, 3P, 3Q, 3R, 3S, 3T; Findings 1 - 833.

986. Petitioner has demonstrated a willingness to give testimony that is not credible and that is directly contradicted by the evidence. Findings 1 - 936 (especially at 189 - 217, 326 - 353, 433 - 454, 523 - 531, 544 - 567, 619 - 625, 696 - 719, 822 - 833, 905 - 910).

987. Petitioner has demonstrated a willingness to misstate the record in attempts to justify his treatment of these seven patients. Findings 1 - 936.

988. Petitioner has demonstrated that he is untrustworthy such that, if given the opportunity, he will provide substandard and excessive care to beneficiaries and recipients of federally funded health care programs. Findings 1 - 987.

989. Petitioner has demonstrated that he believes his treatment of these seven patients was within professionally recognized standards of health care and not substantially in excess of their needs. Findings 1 - 988.

990. Petitioner has demonstrated contempt for the Medicare program, for persons responsible for administering and policing it, and for this administrative process. Tr. at 1960 - 2070, 2100 - 2104, 2643 - 2651; Findings 1 - 989.

991. Petitioner has demonstrated a continuing and egregious pattern of violations including his: willingness to jeopardize the health, safety, and well-being of patients by providing inadequate and ineffective diagnoses and care that was severely below professionally recognized standards or substantially in excess of patients' needs; failure to understand or recognize the reasons the care he administered was not in accordance with professionally recognized standards of health care or substantially in excess of patients' needs; lack of remorse for his actions; willingness to give evasive and unsupported testimony that borders upon fabrication; willingness to blame others for his own actions; and willingness to submit fragmented claims and engage in improper billing practices such that it is extremely unlikely that Petitioner at any time in the future could be entrusted to treat Medicare beneficiaries or recipients of State health care programs. Findings 1 - 990.

992. To allow Petitioner to ever again be a provider participating in Medicare and State health care programs in light of this record would place beneficiaries and recipients in unnecessary risk of harm to their health, safety, and well-being. Findings 1 - 991.

993. To allow Petitioner to ever again be a provider participating in Medicare and State health care programs in light of this record would place the programs at severe risk of abuse or misuse from Petitioner's activities. Findings 1 - 992.

994. Exclusions issued pursuant to section 1128(b)(6)(B) are remedial in nature.

995. A remedial exclusion in this case encompasses a permanent exclusion, as Petitioner has demonstrated: an egregious pattern of violations that jeopardized the health, safety, and well-being of these seven patients; a willingness to make hollow excuses for his conduct; a failure, in many instances, to recognize the seriousness of his conduct; a failure, in many instances, to recognize the potential and actual harm and risk in which he placed these seven program recipients; a lack of remorse for his conduct and actions in the treatment of these seven patients; nothing in the record from which I

can conclude with any degree of certainty or probability that Petitioner will, at any point in the future, change his conduct to conform with professionally recognized standards of health care; and, finally, a willingness to continue with the same pattern of conduct, even while being subject to prepayment and postpayment review. Findings 1 - 994.

996. Petitioner should be excluded permanently from being a provider in the Medicare and State health care programs. Findings 1 - 995; section 1128(b)(6)(B) of the Act.

DISCUSSION

Due to the gravity, volume, complexity, and duration of the harm Petitioner caused the seven Medicare patients (whose extensive patient records are set forth in this record) and the programs, I have chosen to make extensive findings of fact and conclusions of law. It is only after Petitioner's conduct is scrutinized in its entirety that its ramifications to his patients and the programs become clear. Moreover, such scrutiny justifies the extraordinary sanction of a permanent exclusion. No other remedy will adequately protect the health and welfare of program recipients and beneficiaries and the financial integrity of the programs.

For purposes of brevity, I will not repeat in this Discussion the circumstances of Petitioner's conduct and its effect of patients and the programs, but rather will summarize my findings and provide record citation support for them. The record amply supports that the I.G. has authority to exclude Petitioner and that the only exclusion which will adequately protect the program is to ban Petitioner permanently from being a program provider. Findings 1 - 996.

Section 1128(b)(6)(B) of the Act provides that the Secretary of Health and Human Services (Secretary) and her lawful delegate, the I.G., have the authority to exclude from participation in Medicare and State health care programs any individual or entity that the Secretary (or the I.G.) determines to have:

> furnished or caused to be furnished items or services to patients (whether or not eligible for benefits under title XVIII or under a State health care program) substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care.

In this case, the record is replete with instances of Petitioner having both furnished or causing to be furnished items or services substantially in excess of patients' needs. Findings 1 - 833. The record is replete also with Petitioner furnishing items or services to patients of a quality which fails to meet professionally recognized standards of health care. Findings 1 - 833. Accordingly, there is no question that the I.G. had the authority to exclude Petitioner in this case. Findings 1 - 833.

The regulations at 42 C.F.R. § 1001.701 provide that "an exclusion imposed in accordance with section 1128(b)(6)(B) of the Act will be for a period of three years, unless specific aggravating or mitigating factors form a basis for lengthening or shortening the period." The record of this case contains persuasive, overwhelming, and unrefuted evidence of the presence and seriousness of all four aggravating factors specified in the regulations. Findings 939 - 944. The record is devoid of any evidence of either of the mitigating factors. Findings 945 - 947. Accordingly, the I.G. had the authority to exclude Petitioner for more than three years. Finding 948.

The I.G. chose to exclude Petitioner for a term of 10 years. However, this case, from the outset, has been governed by section 205(b) of the Act and regulations at 42 C.F.R. § 1005.20(b). Section 205(b) of the Act provides that hearings regarding provider exclusions from Medicare and State health care programs be conducted de novo. The regulations at 42 C.F.R. § 1005.20(b) explicitly provide that I may "affirm, increase, or reduce the penalties, assessment or exclusion imposed by the I.G. or reverse the imposition of the exclusion." The only constraint on my authority is imposed by 42 C.F.R. § 1005.4(c)(6), which does not allow me to reduce an exclusion to zero. Accordingly, from the outset of Petitioner's request for hearing, the parties have been on notice of and subject to provisions that provide for my authority to determine an appropriate term of exclusion for Petitioner, which includes significantly reducing the term of exclusion to something other than zero or to increase it to any term that fits the remedial purposes of the act.[26]

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[26] By regulation, the Secretary limits the authority of an administrative law judge to reduce an exclusion, but does not limit a judge from increasing an exclusion. The regulatory silence on the issue of the judge's authority to increase the exclusion is an indication of

During the hearing, I reminded the parties of my authority to affirm, increase or reduce the 10-year term of exclusion imposed by the I.G. Additionally, after the hearing, I provided the parties with the opportunity to brief the issue of my authority to impose a term of exclusion that is greater than the 10 years imposed by the I.G. I gave the parties the opportunity also to brief the issue of whether, assuming I have the authority to increase the term of exclusion, the record of this case provides adequate justification for my doing so.

There is no inherent right on the part of a physician to participate as a provider in the Medicare system. Koppel v. Heckler, 797 F.2d 858, 864 (10th Cir. 1986); Oberlander v. Perales, 740 F.2d 116, 120 (2d Cir. 1984). In keeping with this principle, as this case amply illustrates, elderly or ill Medicare beneficiaries and Medicaid recipients "often do not have the physical, mental or financial resources to be effective advocates on their own behalf in the event that they receive incompetent or inadequate care." Martin Weissman, DAB CR116, at 37 (1991). My responsibility is to weigh the need to protect program participants from an untrustworthy provider, as Petitioner is shown to be on this record, and to determine at what point in time Petitioner will no longer pose a threat to the program to warrant his future participation as a provider. The ultimate length of the exclusion is to be remedial and not punitive. Greene v. Sullivan, 731 F. Supp. 838 (E.D. Tenn. 1990); Manocchio v. Kusserow, 961 F.2d 1539 (11th Cir. 1992).

The remedial purpose of section 1128 of the Act, including section 1128(b)(6)(B), mandates that I evaluate the record in this case, including the exclusion imposed against Petitioner, with an eye toward the protection of Medicare beneficiaries and Medicaid recipients from incompetent practitioners and from inappropriate or inadequate care. Paul G. Klein, D.P.M., DAB CR317, at 10 (1994); S. Rep. No. 109, 100th Cong., 1st Sess. 1 (1987),

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the Secretary's acknowledgement that the Judge should formulate the length of exclusion consistent with the remedial purposes of the Act. The permanent exclusion that I have imposed is a result of a careful analysis of the record which persuaded me that a permanent exclusion was needed to protect program participants and the program itself from the threat of a continuation of Petitioner's conduct should he be reinstated into the program. In my Findings and in my Discussion, I set forth in more detail the extent of my analysis.

reprinted in 1987 U.S.C.C.A.N. 682; Teri L. Gregory, DAB CR336, at 16 (1994); Scott Gladstone, M.D., DAB CR331, at 26 - 27 (1994); George Iturralde, M.D., DAB CR218, at 9 (1992). An additional remedial purpose of the Act is to protect federally-financed health care programs from unscrupulous providers who, through their conduct, have demonstrated that they pose a threat to the financial integrity of these programs. David L. Gordon, M.D., DAB CR327, at 11, 13 - 14 (1994); Scott Gladstone, M.D., DAB CR331, at 26 - 27 (1994); George Iturralde, M.D., DAB CR218, at 9 (1992). Even a slight threat to beneficiaries and recipients will warrant a lengthy exclusion. Myron R. Wilson, Jr., M.D., DAB CR146 (1991); Norman C. Barber, D.D.S., DAB CR123 (1991); Thieu Lenh Nghiem, M.D., DAB CR248 (1992). Even though a permanent exclusion arguably will have an adverse economic impact upon Petitioner, the need to provide protection to program beneficiaries and recipients from an untrustworthy provider is the paramount interest. Sam Williams, Jr., M.D., DAB CR287, at 19 (1993).[27]

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[27] I note that in the case of Robert L. Alexander, M.D., DAB CR244, at 14 (1992), Administrative Law Judge Charles Stratton intimated that an exclusion should not be permanent because the remedial purposes of the Act contemplate rehabilitation of the excluded Petitioner. This general prohibition is premised on the principle that an exclusion "may not be so extreme and disproportionate that it bears no rational relation to the remedial goals." Alexander at 24. While I concur with this principle, I do not agree that valid circumstances can never exist to warrant a permanent exclusion where rehabilitation is unlikely. This case is unlike Alexander, where Judge Statton found compelling reasons in the record to conclude that the Petitioner was undertaking steps to remedy his misconduct, the risk of repetition of such conduct was minimal, and the imposition of a 10-year exclusion was warranted rather than the more lengthy exclusion imposed by the I.G. Here, my findings of fact and conclusions of law establish the presence of extreme and extensive evidence of Petitioner's violations of section 1128(b)(6)(B). Consequently, I cannot find any compelling basis in this record to impose anything less than a permanent exclusion. Therefore, since Petitioner has demonstrated no remorse or likelihood of rehabilitation, his conduct is so abhorrent and is dangerous to the health, safety, and welfare of program recipients and beneficiaries and presents a clear risk to the financial integrity of such programs, a permanent exclusion is supportable as the only remedy which will satisfy the remedial purposes of

The regulations specify that the following factors be considered aggravating and a basis for lengthening the period of exclusion for more than three years: 1) the violations were serious in nature, and occurred over a period of one year or more; 2) the violations had a significant adverse physical, mental, or financial impact on program beneficiaries or other individuals; 3) the individual or entity has a prior criminal, civil, or administrative sanction record; or 4) the violation resulted in financial loss to Medicare or the State health care programs of $1500 or more. Petitioner has not contended, nor does the record support, that any of the mitigating factors at 42 C.F.R. § 1001.701(d)(3)(i) and (ii) are present. Findings 945 - 948.

In determining an appropriate term of exclusion in this case, I must evaluate the exclusion de novo, in conjunction with the regulatory criteria and in light of the remedial goals of the statute. Sections 205(b) and 1128(b)(6)(B) of the Act; 42 C.F.R. § 1001.701.

The number and severity of the aggravating factors that are present in this case and the total lack of any mitigating factors demonstrates that Petitioner is such an unscrupulous, untrustworthy individual that he cannot possibly be considered anything but a significant, serious, and continual threat to program beneficiaries and recipients. Initially, the record demonstrates that Petitioner has received prior administrative sanctions from the California Board of Medical Quality Assurance (CBMQA). Finding 8. The record further demonstrates that, from 1983 through 1989, well in excess of the one year regulatory requirement, Petitioner engaged in providing care to these seven patients that is substantially in excess of their needs or of a quality which fails to meet professionally recognized standards. Findings 1 - 833. Petitioner's improper billing for these seven patients caused him to receive approximately $172,000 in overpayments. Findings 834 - 936; Tr. at 1234 - 1235.

During much of this period, Petitioner was under the scrutiny of the CBMQA or CA Blue Cross, where most of his treatment and billings practices at issue here were subject to review. Despite such action, Petitioner continued with treatment procedures and billing practices that were grossly below professional standards of

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the Act.

practice.[28] Moreover, even considering the wealth of expert testimony presented in this case, Petitioner has yet to recognize that his treatment of these seven patients was completely outside of recognized bounds of propriety and safety. Findings 1 - 996.

The record amply demonstrates that Petitioner jeopardized the health and safety of these seven patients and demonstrates that he will, when given any opportunity to do so, subject program recipients and beneficiaries to treatment and testing that is medically inappropriate, ineffective, or unnecessary. Petitioner has further demonstrated that he will 1) submit claims for reimbursement that are not supported by documentation, and, when questioned on his conduct, will attempt to blame others for his mistakes; 2) rationalize that the absence of documentation to support his purported treatment is due to allegedly missing patient files; and 3) cite studies or treatises for support of his treatment protocols which, upon review, support the opposite conclusions. Moreover, Petitioner has demonstrated a highly contemptuous attitude toward the Medicare program and those persons responsible for policing the program, as well as the integrity of this administrative process.

Most of the arguments and statements made by Petitioner in response to the I.G.'s allegations were, at best, unsupported and, at worst, deliberately misleading. Findings 76 - 833 (especially 165, 181, 189 - 217, 326 - 353, 433 - 454, 544 - 567, 619 - 625, 696 - 719, 822 - 833). Several of the more egregious examples of this type of conduct involved Petitioner's insistence that he was instructed to throw away a large portion of the chemotherapy drugs after only one usage, despite the fact that these chemotherapy drugs were available in multi-use vials. Notwithstanding the testimony of two credible witnesses and the record as a whole, Petitioner constantly maintained that he was explicitly informed by CA Blue Shield to bill for an entire vial of chemotherapy drugs even though he administered only a portion of the vial to the patient. Findings 834 - 936. Another example of this type of conduct is Petitioner's tendency to blame his staff for both for billing discrepancies and for Petitioner's own failure to accurately record critical information in a patient's flow sheet. Findings

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[28] The three million dollars Petitioner was paid in the years in question, utilizing more than one provider number, shows the extent to which he used his oncology practice as a means to obtain payment from the Medicare and Medicaid programs. Findings 890 - 892.

1 - 936 (especially 165, 181, 189 - 217, 326 - 353, 433 - 454, 544 - 567, 619 - 625, 696 - 719, 822 - 833).

Moreover, Petitioner has demonstrated that he has no remorse for his actions, because he remains sincere in his belief that, in all but the most minor instances, his treatment of these seven patients was within professionally recognized standards and not substantially in excess of their needs.[29] Findings 189 - 217, 326 - 353, 433 - 454, 544 - 567, 619 - 625, 696 - 719, 822 - 833. Petitioner takes this position despite overwhelming evidence to the contrary. Findings 76 - 833. In steadfastly defending treatment regimes that were so below professionally recognized standards as to endanger his patients' health and degrade their quality of life, and in attempting to justify services that he provided that were substantially in excess of his patients' needs where the record amply demonstrates that Petitioner provided excessive and unnecessary services, Petitioner has demonstrated a disturbing tendency to deny reality and trivialize the severity, seriousness, and magnitude of his unlawful conduct. Findings 165, 181, 189 - 217, 326 - 353, 433 - 454, 544 - 567, 619 - 625, 696 - 719, 822 - 833. Through his testimony at the hearing, Petitioner has further demonstrated that, when questioned about issues regarding his inappropriate treatment of these seven patients, he misstated the record and invented scenarios that were entirely unsupported. Findings 189 - 217, 326 - 353, 433 - 454, 544 - 567, 619 - 625, 696 - 719, 827 - 833.

Review of Petitioner's educational background and work experience leads to the conclusion that he should have the intellect to understand the complexity of the issues presented by this case. I.G. Ex. 3E; P. Ex. 1; Findings 1 - 2. When confronted with overwhelming evidence that

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[29] For instance, after repeated denials in both direct and cross-examination, Petitioner finally admitted that he should have documented B.G.'s refusal of potentially curative treatment. Again, only after repeated questioning, Petitioner admitted also that, in several instances, he should have documented the amount of chemotherapy the patient actually received. However, examining the record as a whole, it is apparent that, in the vast majority of instances, Petitioner either denies that the treatment he provided was in any way deficient, or blames his mistakes on his office staff (for whom he is responsible) or on what he contends were inadequate billing instructions by CA Blue Shield. Findings 1 - 966.

his treatment and billing practices were grossly deficient, Petitioner steadfastly chose to maintain his position and provided surprisingly weak rationalizations. Particularly in light of evidence that he was repeatedly informed and shown that such was the case, as well as Petitioner's failure to accept any responsibility or blame for his conduct or its consequences at any point in this proceeding, Petitioner's failure to recognize that his treatment of patients was grossly below professionally recognized standards strongly suggests that he can never be trusted to be a program provider again.

Some of the most egregious examples of this conduct occurred when Petitioner maintained that, despite the fact patients' flow charts did not accurately reflect the amounts of various chemotherapy drugs these seven patients actually received, his office could nonetheless keep track of the amounts because only a few patients were receiving chemotherapy. Findings 189 - 217, 326 - 353, 433 - 454, 544 - 567, 619 - 625, 696 - 719, 827 - 833. Petitioner did, however, acknowledge that proper documentation in a patient's flow sheet was important to assure continuity of care. Finding 27. Petitioner's assertion that it is appropriate to stake the safety and care of his patients on his ability to recall, without documentation, the precise dosages of chemotherapy received by his patients raises serious concern about his ability to safely treat patients in the future.[30] Such a statement also is a feeble attempt by Petitioner to rationalize obvious and potentially dangerous errors, as well as to diminish the impact of care that was not rendered in accordance with professionally recognized standards.

The fact that Petitioner is cognizant of the purpose for accurate and precise documentation of the chemotherapy a patient receives only serves to make his repeated lapse in documentation and subsequent post hoc rationalizations more egregious. Findings 1 - 966.

Petitioner has exhibited an arrogant disdain for both the Medicare review process and that of the peer review organization by continuing to treat patients in ways that

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[30] This is shown by testimony that, when given the opportunity to state how much chemotherapy he administered to patients, Petitioner could not recall and referred to the flow sheet. Findings 334, 344 - 345, 700 - 701, 823; see Findings 326 - 329, 446 - 450, 551 - 552, 624, 716.

are below professionally recognized standards and substantially in excess of patients' needs, even while being subject to prepayment and postpayment review. Findings 834 - 936. Petitioner has further shown his disdain for Medicare and its regulations by submitting billings in ways designed to minimize detection of his substandard and excessive treatment of these seven patients. Findings 834 - 936.

At the hearing, Petitioner demonstrated a contempt for these proceedings by testifying that his treatment of patients was supported by medical research and then offering the researchers' published studies as exhibits. Findings 189 - 217, 326 - 353, 433 - 454, 544 - 567, 619 - 625, 696 - 719, 827 - 833. Upon examination, not only did the exhibits fail to support Petitioner's contentions, the exhibits refuted the very principles Petitioner asserted the studies conclusively proved. Findings 76 - 833. The exhibits, when examined in their entirety, undermine Petitioner's position and support the testimony given by the I.G.'s expert witnesses that Petitioner's care was below professionally recognized standards and substantially in excess of the needs of these seven patients. Findings 76 - 833. In his zealous attempts to justify his care of these patients, Petitioner undermined his credibility as, while under oath, he attempted to twist the meanings of the studies to justify his treatment of these seven patients. Findings 189 - 217, 326 - 353, 433 - 454, 544 - 567, 619 - 625, 696 - 719, 822 - 833. Petitioner further demonstrated his contempt for these proceedings by using every means at his disposal to delay and prolong the ultimate resolution of this case. Background at pages 3 - 6; Tr. at 1960 - 1977.

Most serious, Petitioner demonstrated a total disregard for the health and well being of the seven patients. Findings 76 - 833. Petitioner repeatedly and consistently administered unnecessary and useless CEA and blood tests. Findings 76 - 833. In doing so, Petitioner inflicted useless and unnecessary venipunctures. On several occasions, Petitioner administered unnecessary and useless vitamin injections. Findings 76 - 833.

Petitioner's disregard for the health and quality of life of his patients, and Petitioner's willingness to jeopardize the health and well-being of his patients, was amply shown by his failing to document accurately the amounts and types of chemotherapy he administered. Findings 76 - 833. It is illustrated also by Petitioner's insistence on administering chemotherapy via infusion which, in all but one instance, was useless as

far as helping the patient, but seems to have been instrumental in allowing him to charge more for treatments.[31] Despite Petitioner's statements to the contrary, his administration of infusion treatments of one to eight hours unnecessarily prolonged the amount of time his patients spent in his office. Findings 76 - 833. Had Petitioner administered chemotherapy in accordance with professionally recognized standards and not substantially in excess of the patients' needs, he would have administered virtually all of the treatments by bolus, which would have been less time consuming and caused the patients to spend less time in Petitioner's office. Findings 76 - 833.

The seriousness of Petitioner's conduct is further demonstrated in the decreased quality of life that his excessive and substandard services caused these seven patients, as well as the adverse mental and financial impact his conduct had on these seven patients. Findings 1 - 936. Petitioner's provision of services in excess of patients' needs resulted in many of these seven patients coming to his office at an excessive frequency, such that it calls into question whether some of these individuals were even examined or treated by Petitioner on all of the occasions Petitioner claimed to have examined or treated them. Findings 76 - 833. Petitioner's records reflect that several of these seven patient were compelled to make staggering numbers of office visits over the course of their treatments, at probably great inconvenience. Findings 76 - 833. This is especially true where treatment within professionally recognized standards would have resulted in fewer office visits. Findings 76 - 833.

Petitioner consistently documented that he was administering supralethal doses of chemotherapy to these patients, but the lack of documented side effects and the fact that these individuals did not die from the excessive doses Petitioner claimed to have administered shows that Petitioner failed to administer the chemotherapy in the amount claimed. Findings 76 - 833. Indeed, the record reflects that, in many instances, when Petitioner claimed to have provided supralethal doses of various chemotherapy drugs, the patient actually received

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[31] With one minor exception, the I.G.'s experts testified that Petitioner's infusions of between one to eight hours served no medical purpose except to allow Petitioner to bill Medicare more. Findings 1 - 966; I.G. Ex. 3E; see Tr. at 68 - 752, 764 - 957, 966 - 1081, 1302 - 1654.

doses that were insufficient to have any effect on the patient's cancer. Findings 76 - 833.

Petitioner's administration of doses of chemotherapy that were insufficient to have any effect on the patient's cancer was below professionally recognized standards and jeopardized the health, safety, and well-being of these individuals. Findings 1 - 833. Moreover, in administering ineffective treatments and unknown doses, Petitioner robbed patients of any hope for cure of their cancer or palliation of their symptoms. Findings 1 - 833. In several instances, Petitioner administered prolonged, expensive chemotherapy treatments when other more effective treatments were available. Findings 1 - 833. In other instances, Petitioner misdiagnosed patients' conditions, and insisted in providing chemotherapy treatment to one patient who did not even have cancer. Findings 1 - 833.

Finally, Petitioner has demonstrated that, in many instances, he does not understand why his treatment was not in accordance with professionally recognized standards or substantially in excess of the patients' needs. Petitioner's treatment of these seven patients, and the record as a whole, indicate that he is not able to practice oncology in accordance with professionally recognized standards. Findings 1 - 996. This fact is borne out by Petitioner's censure from the CBMQA, which has banned Petitioner from practicing oncology, and limited his practice of medicine generally to situations where his treatment of patients is overseen by another physician. Finding 8.

Petitioner has further demonstrated a complete lack of remorse for his conduct and is unwilling to recognize or concede that his treatment of these seven patients was inappropriate, excessive, or not in accordance with professionally recognized standards. Findings 1 - 936. Petitioner's lack of remorse is further demonstrated by Petitioner's tendency to blame others for billing errors or for the submission of claims to CA Blue Shield for drugs that were not received by his patients. Findings 165, 181, 189 - 217, 326 - 353, 433 - 454, 544 - 567, 619 - 625, 696 - 719, 827 - 833, 834 - 936.

In providing care below professionally recognized standards or substantially in excess of the needs of these seven patients, Petitioner caused financial loss to the Medicare and State health care programs in an amount well in excess of the $1500 regulatory threshold. Findings 944. More important, the record demonstrates that Petitioner used CA Blue Shield's review process, and

CA Blue Shield's failure to initially take a vigorous enforcement posture against him, to extend the period of time over during which he excessively and improperly billed for program services and thereby threatened the financial integrity of the programs. Findings 834 - 936. Petitioner has displayed a willingness to attempt to secure payment for improper or excessive billings even while he was on notice of the problems associated with his practices and even while he was being denied reimbursement for a substantial percentage of his claims. Findings 834 - 936.

Petitioner contends that Medicare's continuing to authorize payment of his treatment of these patients serves to legitimize the treatment he provided. Petitioner asserts that CA Blue Shield, and the I.G., are now precluded from challenging the treatment he provided to these patients because CA Blue Shield initially approved the claims he submitted for reimbursement for the treatment he provided to these patients. Petitioner contends that, in monitoring him for twelve years and continuing to reimburse him for the vast majority of the claims he submitted, CA Blue Shield ratified his treatment of these patients.

However, as the CA Blue Shield representative testified, that is not the case. While, admittedly, it would have been preferable had CA Blue Shield denied more of Petitioner's claims for excessive or substandard services in the review process, the fact that CA Blue Shield paid many of the claims submitted by Petitioner in no way precludes them from challenging these claims at a later date. Nor can Petitioner can point to any authority to establish that, once a claim manages to survive the prepayment or postpayment review process, it somehow becomes immune to any future challenges. As the CA Blue Shield representatives testified, Petitioner fragmented his claims in such a way as to elude detection of his excessive and substandard services. Findings 834 - 936.

Petitioner places mistaken reliance on his having managed to emerge unscathed from the review process for many years. He escaped detection through a combination of his own manipulations and a lack of vigorous enforcement by CA Blue Shield, and the mere fact of his having escaped detection does not support that the treatment he provided to these seven patients was in accordance with professionally recognized standards and not in excess of these patients' needs. Findings 834 - 936. Unfortunately, as CA Blue Shield officials noted, routinely claims are questioned only after the provider has received reimbursement. Findings 834 - 936.

Moreover, the peer review process which brought these problems to litigation in this case is a more thorough, intensive review than either the prepayment or postpayment review process. Findings 834 - 936.

Petitioner contends that the I.G.'s experts are not persuasive in this case because they did not examine the patients in question and because they did not agree unanimously on every aspect of what were the professionally recognized standards regarding the treatment of these seven patients. I take this argument also to mean that Petitioner calls into question whether the I.G.'s experts were able to agree on whether Petitioner provided services substantially in excess of the needs of these seven patients.

While it is true that none of the I.G.'s experts examined any of these seven patients, Petitioner has offered nothing that would lead me to conclude that any of the testimony that was given by the I.G.'s experts was flawed by their not having examined these patients. All of the problems associated with Petitioner's care and treatment of these patients are readily apparent from the record presented by the I.G. There was no need for any of these experts to have examined these patients to be able to discern the substandard, excessive care that Petitioner provided.

Petitioner's assertion that the I.G.'s reliance upon the limited paperwork hampered her experts' ability to render valid opinions is undercut by the fact that most of the documentation regarding these seven patients was from Petitioner's own files. Moreover, Petitioner was given ample opportunity to submit any rebuttal information he wished, including 1) when CA Blue Shield initially questioned the claims; 2) when the PRO requested he submit all rebuttal information; and 3) during the exchange of documents and exhibits in this case. Yet, on all three occasions, Petitioner offered nothing persuasive to support his contentions that the treatment he administered to these seven patients was in accordance with professionally recognized standards and not in excess of the patients' needs.

Petitioner contends that the testimony of the I.G.'s experts must be discounted because all three did not agree unanimously on what treatments and procedures were within professionally recognized standards. While I concede the experts were not unanimous in all of their opinions, there was a consensus in all but the most unimportant points. Findings 1 - 966. In the few areas where the experts did not agree, I either did not use the

testimony in those areas to make adverse findings against Petitioner or made affirmative Findings that the treatment provided by Petitioner was in accordance with professionally recognized standards or not substantially in excess of a patient's needs.[32] See Findings 407, 585 - 588. However, in the overwhelming majority of the testimony, there was almost total uniformity and consensus among the experts such that, in weighing the evidence as a whole, I was able to make the Findings and reach the conclusions as elaborated earlier. Accordingly, Petitioner's contention that the expert testimony in this case should be discounted because of a lack of consensus is without merit.

CONCLUSION

The remedial purposes of the Act guide my Decision in this case. Considering the extensive record before me, Petitioner has provided little or nothing to indicate that he understands, recognizes, or accepts that his treatment of these seven patients was not in accordance with professionally recognized standards or substantially in excess of their needs. Certainly, his competency to treat oncology patients now and in the future has been seriously questioned and his ability or willingness to attain such skills remains in doubt. He has shown a total lack of remorse for his conduct and contempt for the Medicare program and for this proceeding. Of particular importance, Petitioner has demonstrated an outrageous disregard for the welfare of these patients, subjecting them to essentially worthless oncology treatment protocols which neither cured their cancer nor provided palliative measures. Equally of concern is that Petitioner has placed his desire to maximize his Medicare

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[32] One such area of disagreement was where Dr. Hoffman stated that he did not believe that Petitioner's attempt to treat patient J.L. with chemotherapy was below professionally recognized standards. Tr. at 870 - 872; Findings 585 - 588. Accordingly, I made no findings that Petitioner's attempt to treat J.L. with chemotherapy was below professionally recognized standards. However, Dr. Hoffman did agree with the other I.G. experts in stating that he did believe the types, amounts, method of administration and duration of the chemotherapy that Petitioner documented he provided to J.L. was below professionally recognized standards and substantially in excess of J.L.'s needs. Findings 568 - 618. It is that criticism of Petitioner's treatment of J.L. that is reflected in my Findings.

billings over and above the proper treatment of these patients, even going so far as to unmercifully expose them to excessive office visits for unnecessary medical procedures that robbed them of their dignity and quality of life. There is nothing in the record that would allow me to conclude that, at any time in the future, Petitioner has the capacity or willingness to recognize the unlawfulness of his behavior and modify his conduct such that he will no longer pose a tremendous and overwhelming threat to both the health and well being of program beneficiaries and recipients and the financial integrity of Medicare and State health care programs.

I have carefully examined this record to discern any credible evidence that at some point in the future Petitioner will no longer pose a threat to program recipients and beneficiaries. None exists in this record. I am mindful of the significance of the permanent exclusion of this Petitioner. However, I cannot find any evidence in this record to suggest that any shorter exclusion will adequately protect the programs or be consistent with the remedial purposes of the Act. Accordingly, I find that the I.G. has the authority to direct and impose an exclusion against Petitioner, and I further find that a permanent exclusion from participation as a provider in the Medicare and State health care programs is appropriate.

/s/

Edward D. Steinman
Administrative Law Judge