Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	
Thomas P. Whitfield, D.P.M.,	Date: June 24, 1998
Petitioner,	
- v. -	Docket No. C-98-010 Decision No. CR539
The Inspector General.	

DECISION

I conclude that the ten-year exclusion imposed and directed against Petitioner, Thomas P. Whitfield, D.P.M., from participating as a provider in Medicare and other federally financed health care programs is reasonable.

PROCEDURAL HISTORY

By letter dated August 18, 1997, Thomas P. Whitfield, D.P.M., the Petitioner herein, was notified by the Inspector General (I.G.), United States Department of Health and Human Services (HHS), that it had been decided to exclude him for a period of ten years from participation in the Medicare, Medicaid, Maternal and Child Health Services Block Grant, and Block Grants to States for Social Services programs.[1] The I.G. explained that the exclusion was mandated under section 1128(a)(1) of the Social Security Act (Act) because Petitioner had been convicted of a criminal offense related to the delivery of an item or service under the Medicaid program; that a five-year minimum period of exclusion is required by section 1128(c)(3)(B) of the Act; and that Petitioner's ten-year period of exclusion took into consideration the amount of restitution that Petitioner was ordered to pay.

Petitioner filed a request for hearing.

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[1] In this decision, I use the term "Medicaid" to refer to these State health care programs.

Both parties submitted briefs in this matter. The I.G. submitted eight proposed exhibits (I.G. Exs. 1-8). Petitioner did not object to the admission into evidence of the I.G.'s exhibits, and I admit into evidence I.G. Exs. 1 through 8. Petitioner submitted three proposed exhibits (P. Exs. 1-3). As part of his submission, Petitioner submitted two different exhibits designated as P. Ex. 1. Specifically, Petitioner submitted into evidence a letter dated December 16, 1996, which he designated as P. Ex. 1, as well as another letter dated January 20, 1997, which he also designated as P. Ex. 1. I have re-marked the letter dated January 20, 1997 as P. Ex. 4. The I.G. did not object to the admission into evidence of Petitioner's exhibits, and I admit into evidence P. Exs. 1 through 4. Because I have determined that the case can be decided on the basis of undisputed facts, I have decided the case on the basis of the parties' written submissions in lieu of an in-person hearing.

Based on the law, the evidence before me, and the parties' written arguments, I conclude that Petitioner's ten-year period of exclusion comports with the remedial purposes of the Act and is reasonable. Accordingly, I affirm the I.G.'s determination to exclude Petitioner from participating in the Medicare and Medicaid programs for a period of ten years.

APPLICABLE LAW

Sections 1128(a)(1) and 1128(c)(3)(B) of the Act make it mandatory for any individual who has been convicted of a criminal offense related to the delivery of an item or service under Medicare or Medicaid to be excluded from participation in such programs for a period of at least five years.

Aggravating factors specified in the regulations may justify a lengthening of the period of exclusion. The reasonableness of the length of any exclusion imposed for a period of more than five years will be decided based on the presence of, and the weight assigned to, certain aggravating and offsetting mitigating factors, if any, which the regulations identify. The regulation codified at 42 C.F.R. § 1001.102(b) provides that the following factors may be considered to be aggravating and a basis for lengthening the period of exclusion: (1) the acts resulting in the conviction, or similar acts, resulted in financial loss to Medicare and the State health care programs of $1,500 or more (the entire amount of financial loss to such programs will be considered, including any amounts resulting from similar acts not adjudicated, regardless of whether full or partial restitution has been made to the programs); (2) the acts that resulted in the conviction, or similar acts, were committed over a period of one year or more; (3) the acts that resulted in the conviction, or similar acts, had a significant adverse physical, mental, or financial impact on one or more program beneficiaries or other

individuals; (4) the sentence imposed by the court included incarceration; (5) the convicted individual or entity has a prior criminal, civil, or administrative sanction record; or (6) the individual or entity has at any time been overpaid a total of $1,500 or more by Medicare or State health care programs as a result of improper billings. 42 C.F.R. § 1001.102(b)(1)-(6).

The regulations further provide that, only if any of the aggravating factors justifies an exclusion longer than five years, may mitigating factors be considered as a basis for reducing the exclusion to no less than five years. The regulation codified at 42 C.F.R. § 1001.102(c) provides that only the following factors may be considered mitigating: (1) the individual or entity was convicted of three or fewer misdemeanor offenses, and the entire amount of financial loss to Medicare and the State health care programs due to the acts that resulted in the conviction, and similar acts, is less than $1,500; (2) the record in the criminal proceedings, including sentencing documents, demonstrates that the court determined that the individual had a mental, emotional, or physical condition before or during the commission of the offense that reduced the individual's culpability; or (3) the individual's or entity's cooperation with federal or State officials resulted in (i) others being convicted or excluded from Medicare or any of the State health care programs or (ii) the imposition against anyone of a civil monetary penalty or assessment under 42 C.F.R. Part 1003. 42 C.F.R. § 1001.102(c)(1)-(3).

PETITIONER'S ARGUMENTS

Petitioner concedes that he has been convicted of an offense which can form the basis for exclusion. Petitioner argues only that the length of his exclusion is excessive and asks that his exclusion be reduced to five years. Petitioner's Brief, at 3. In this regard, he states that he pled no contest to only one count of an Indictment, and that this count involved charges of $296 and did not result in his collection of any reimbursement. Petitioner contends that while he agreed to pay a substantial sum in restitution, such amount was a negotiated amount with no bearing on the claims he submitted. He states further that he tried to comply with the applicable regulations during the period at issue, but maintains that such regulations were inconsistent and subject to changing interpretation by administrative authorities. Petitioner also contends that while he was under investigation for a number of years, the investigation "ended with no resolution." Id. at 2. He alleges further that the authorities delayed in prosecuting his case, as the investigation commenced in 1987, but he was not charged until 1993. Petitioner asserts also that he is the only Medicaid provider in his field in the area where he practices and for this reason also his exclusion period should be mitigated.

FINDINGS OF FACT AND CONCLUSIONS OF LAW (FFCL)

1. During the period relevant to this case, Petitioner was a podiatrist licensed by the State of North Carolina to provide medical services to patients.

2. On April 15, 1996, in Superior Court Division, State of North Carolina, Petitioner was indicted by a Grand Jury on 38 counts of "Obtaining Property by False Pretenses" from the Medicare and Medicaid programs. I.G. Ex. 3.

3. In that Indictment, it was alleged that, beginning on or about December 12, 1987, and continuing until on or about January 12, 1996, Petitioner filed claims with the Medicare and Medicaid programs for reimbursement for services which he never provided. I.G. Ex. 3; see I.G. Ex. 4.

4. Petitioner pled no contest to one count of obtaining property by false pretenses from the Medicaid program (count 32 of the Indictment) and agreed to pay restitution in the amount of $79,831.35 to the Medicare program, $29,377.06 to the North Carolina Medicaid program, and $28.43 to the Railroad Medicare program. I.G. Exs. 5, 6.

5. On January 31, 1997, the Superior Court of the State of North Carolina, Mecklenburg County, accepted Petitioner's no contest plea; entered a "Judgment Suspending Sentence - Felony," finding Petitioner pled no contest to one count of obtaining property by false pretenses from the Medicaid program; and ordered that Petitioner be imprisoned for a period between eight and ten months (suspended), be placed on supervised probation for 48 months, and pay restitution to the Medicare, Medicaid, and Railroad Medicare programs in the amounts of $79,831.35, $29,377.06, and $28.43, respectively. I.G. Exs. 5-7.

6. Petitioner's criminal conviction constitutes a conviction within the meaning of section 1128(i)(3) of the Act.

7. Petitioner's conviction for obtaining property by false pretenses is related to the delivery of an item or service under the Medicare and Medicaid programs within the meaning of section 1128(a)(1) of the Act.

8. Once an individual has been convicted of a program-related criminal offense under section 1128(a)(1) of the Act, exclusion for at least five years is mandatory under section 1128(c)(3)(B) of the Act.

9. The I.G. proved the presence of an aggravating factor, in that the acts resulting in Petitioner's conviction, or similar acts, resulted in financial loss to Medicare and Medicaid of $1,500 or more. 42 C.F.R. § 1001.201(b)(1).

10. The I.G. proved the presence of an aggravating factor, in that Petitioner was overpaid a total of $1,500 or more by Medicare and Medicaid as a result of improper billings. 42 C.F.R. § 1001.201(b)(6).

11. The I.G. proved the presence of an aggravating factor, in that the acts which resulted in Petitioner's conviction, or similar acts, were committed over a period of one year or more. 42 C.F.R. § 1001.201(b)(2).

12. Petitioner did not prove the presence of any mitigating factors.

13. The evidence relevant to the aggravating factors proves Petitioner to be untrustworthy to the extent that a ten-year exclusion is reasonably necessary to protect the integrity of federally financed health care programs, and to protect program beneficiaries and recipients.

14. The ten-year exclusion imposed and directed against Petitioner by the I.G. comports with the remedial purposes of the Act and, consequently, is reasonable. FFCL 1-13.

DISCUSSION

The first statutory requirement for the imposition of mandatory exclusion pursuant to section 1128(a)(1) of the Act is that the individual or entity in question have been convicted of a criminal offense under federal or State law. I find that Petitioner has been so convicted. Section 1128(i)(3) of the Act provides, inter alia, that when an individual enters a guilty plea or a plea of nolo contendere to a criminal charge and the court accepts such plea, the individual will be regarded as having been convicted within the meaning of section 1128 of the Act. A plea is "accepted" within the meaning of section 1128(i)(3) whenever a party offers a plea and the court consents to receive the plea in disposing of the pending criminal matter. Lila V. Nevrekar, M.D., DAB CR319 (1994). In the present case, the record reflects and Petitioner concedes, that he entered a plea of no contest to obtaining property by false pretenses involving his submission of false Medicaid claims and that the court accepted his plea. I.G. Exs. 5-7. Petitioner was thus convicted within the meaning of section 1128(i)(3) of the Act.

Next, it is required under section 1128(a)(1) of the Act that the crime at issue be related to the delivery of an item or service under Medicare or Medicaid. The record establishes that Petitioner submitted claims to Medicaid for services he allegedly provided, when he did not, in fact, provide such services.

The record establishes further that Petitioner, by pleading no contest to the offense charged in count 32 of the Indictment, was convicted of having filed, or causing to be filed, claims against Medicaid that charged for items or services which were never provided by Petitioner. I.G. Ex. 3, at 45-46. The filing of fraudulent Medicare and Medicaid claims consistently has been held to constitute clear program-related misconduct. Alan J. Chernick, D.D.S., DAB CR434 (1996) (I.G.'s five-year minimum mandatory exclusion of dentist who was convicted in State court of filing a false claim upheld); see also Barbara Johnson, D.D.S., DAB CR78 (1990) (I.G.'s five-year minimum mandatory exclusion of dentist convicted of filing false claims upheld).

In his defense, Petitioner claims that he did not engage in any fraudulent misconduct, that he attempted to comply with the applicable regulations regarding the submission of the claims in question, and that he did not receive any money concerning the charge to which he pled no contest. By such claims, Petitioner appears to attack the merits of his criminal conviction. It is well-established, however, that such collateral attacks on a petitioner's underlying criminal conviction are not permitted in the context of an exclusion appeal. Paul R. Scollo, D.P.M., DAB No. 1498 (1994); Ernest Valle, DAB CR309 (1994); Peter J. Edmonson, DAB No. 1330 (1992).

I therefore conclude that the I.G. properly excluded Petitioner under section 1128(a)(1) of the Act. As a matter of law, a minimum five-year exclusion is mandated by the Act. I further find, however, that a ten-year exclusion is reasonable and warranted due to the presence of aggravating factors within the scope of 42 C.F.R. § 1001.102(b). In this regard, a basis for lengthening the period of exclusion exists where "[t]he acts resulting in the conviction, or similar acts, resulted in financial loss to Medicare and the State health care programs of $1,500 or more." 42 C.F.R. § 1001.102(b)(1). In Buford Gibson, Jr., M.D., DAB CR499 (1997), the administrative law judge (ALJ) found that the financial loss to Medicaid was the most weighty aggravating factor. In that case, the financial loss to Medicaid was at least $500,000 and the ALJ found that this amount demonstrated the magnitude of Petitioner's untrustworthiness. Id. at 5-6.

In the case at hand, I find that the Medicare and Medicaid programs lost in excess of $1500 as a result of Petitioner's criminal acts, thus satisfying the aggravating factor found at 42 C.F.R. § 1001.102(b)(1). The record reflects that Petitioner

agreed and was ordered to pay restitution in the amount of $79,831.35 to Medicare and $29,377.06 to Medicaid. Petitioner claims that such amount was merely a "negotiated figure" bearing no relation to the actual amount misappropriated, but I reject such argument. Restitution of this magnitude to the Medicare and Medicaid programs shows that Petitioner's theft from these programs far exceeds the $1,500 threshold. Clearly Petitioner would not have consented to pay such amount if he truly believed it bore no relation to the amount he unlawfully billed over the years and if he believed that investigating officials could not prove that was the amount of his fraud. I find further that the great specificity of the Indictment and related documents, which detail names of patients, places of treatment, claimed treatment, billing codes, and claim numbers for hundreds of instances of improper billing, indicate that the restitution amount reflects the amount of loss to the Medicare and Medicaid programs. I.G. Exs. 3, 4.

Petitioner further claims that he pled no contest to only one count of the Indictment, involving $296, which he asserts resulted in no payment to him. I reject this argument also. The regulation states that an aggravating factor includes acts similar to those resulting in the conviction. 42 C.F.R. § 1001.102(b)(2). In Petitioner's case, the count to which he pled guilty was part of a 38-count indictment involving hundreds of such claims over a period of eight years. I again note in this regard the specificity of the Indictment and other related documents which detail numerous instances of improper billing. I.G. Exs. 3, 4. Under the regulations, I must consider "similar acts" to those which resulted in his conviction. Thus, with respect to Petitioner's case, I therefore can correctly consider the other instances of alleged misconduct, which are set forth in the detailed Indictment offered into evidence by the I.G. It is fair to conclude that Petitioner's amount of restitution, which is far in excess of the amount to which he pled no contest, took into consideration the other counts of alleged misconduct contained in the Indictment.

The I.G. alleges also the existence of the aggravating factor found at 42 C.F.R. § 1001.102(b)(6), which is satisfied where "[t]he individual or entity has at any time been overpaid a total of $1,500 or more by Medicare or State health care programs as a result of improper billings." 42 C.F.R. § 1001.102(b)(6). The ALJ in Buford Gibson, Jr., M.D., supra, found that the amount of the petitioner's illegal gain was confirmed by the $500,000 restitution payment he was required to pay. Id. at 6. I find that such determination, that the restitution amount confirms in a general way the overpayment amount, is reasonable. In the present case, Petitioner was ordered to pay restitution of $109,236.84. It strains credibility that Petitioner would pay such a large sum in restitution if his illegal gain did not, in fact, approximate that sum. In fact, the State court document

setting forth the terms and conditions of Petitioner's plea states "[t]he above described restitution represents full settlement of all restitution due from the defendant to the Medicare Program, Medicaid Program, and Railroad Medicare Program for claims submitted by the defendant on or before January 12, 1996." I.G. Ex. 5, at 1. Accordingly, Petitioner's restitution amount establishes that, as a result of his improper billings, he was overpaid by Medicare and Medicaid far in excess of the $1,500 threshold amount needed to trigger the aggravating factor found at 42 C.F.R. § 1001.102(b)(6).

The I.G. also asserts that the acts resulting in Petitioner's conviction, or similar acts, were committed over a period of one year or more, thus satisfying the aggravating factor at 42 C.F.R. § 1001.102(b)(2). I find that such assertion is supported in the record before me. Although Count 32 of the Indictment to which Petitioner pled no contest specifies a period of three months, from April 1995 until July 1995, the evidence of record satisfies me that Petitioner's misconduct occurred over an eight-year period. I base this conclusion on the specificity of the instances of alleged misconduct charged in the Indictment and other related documents. I.G. Exs. 3, 4. In this regard, the Indictment lists numerous instances of alleged misconduct and details specifically for each instance cited the patient's name, the facility where the alleged treatment occurred, dates of treatment, claimed treatment and billing codes, claim numbers of the alleged claims, and what treatment, if any, in fact occurred. I.G. Ex. 3. From this high degree of specificity in the Indictment, I find that I am able to glean reliable specifics of "similar acts" within the scope of 42 C.F.R. § 1001.102(b)(2) to substantiate the allegation that Petitioner's pattern of repeated similar acts occurred over a period of one year or more. In fact, I find that such acts occurred over an eight-year period. Accordingly, the aggravating factor at 42 C.F.R. § 1001.102(b)(2) is present in this case.

In mitigation of the length of the exclusion, Petitioner claims that he tried in good faith to comply with the applicable regulations, that he pled no contest to only one count of the Indictment, that allegedly no fraud was found on his part by Medicare and Medicaid investigators, and that he is the only podiatrist available to treat indigent patients in the area where he practices. I can only consider the mitigating factors identified by the regulations. 42 C.F.R. § 1001.102(c)(1)-(3); Buford Gibson, Jr., M.D., supra, at 8. None of the factors cited by Petitioner are encompassed by the regulations.

Based upon the evidence of record, I find that Petitioner has generally demonstrated that he is not a trustworthy individual. A Grand Jury indicted him on 38 counts of "Obtaining Property by False Pretenses" from the Medicare and Medicaid programs. I.G. Ex. 3. The highly specific Indictment details numerous instances

where Petitioner billed the programs for podiatry services to amputees, services to patients who were not present, and for non-reimbursable routine foot care. These actions are indicative of a high level of culpability and a high degree of untrustworthiness. I find that such actions indicate that Petitioner's participation in federal and State health care programs would place public funds and program beneficiaries at risk.

CONCLUSION

The I.G.'s determination to exclude Petitioner for ten years from participating in Medicare and Medicaid comports with the remedial purposes of the Act and is reasonable. Accordingly, I affirm the ten-year exclusion.

/s/

Joseph K. Riotto
Administrative Law Judge