DEPARTMENT OF HEALTH AND HUMAN SERVICES

Departmental Grant Appeals Board

Office of Hearings for Civil Money Penalties

In the Case of:	DATE: **May 29, 1987**
The Inspector General,	Docket No. C-23
- v. -	**DECISION CR 9**
Dean B. Massey, D.D.S.,	
Respondent.	

DECISION AND ORDER

In this case, the Inspector General (I.G.) of the United States Department of Health and Human Services (DHHS) issued a Notice of Determination (Notice) informing Dean B. Massey, D.D.S. (the Respondent), that the I.G. sought $41,010.60 in civil monetary penalties (a penalty of $35,000 and an assessment of $6,010.60) from the Respondent and a five year suspension of the Respondent from participating as a dental provider in the Medicare and Medicaid programs. In the Notice, the I.G. alleged that the Respondent had violated the Civil Monetary Penalties Law (CMPL) and its implementing federal regulations (Regulations) by presenting 147 requests for payment to Medicaid recipients, during the period August 20, 1981 through October 7, 1983, in violation of the Respondent's provider agreement with the Maryland Medicaid Program. 1/ 2/ 3/ The I.G.

1/ The CMPL, consisting of sections 1128A and 1128(c) of the Social Security Act (Act), is codified in Title 42 U.S.C., sections 1320a-7a and 1320a-7(c). The Regulations are codified in 42 C.F.R. §§1003.100 through 1003.133. See, 48 Fed. Reg. 38827 (August 26, 1983); 51 Fed. Reg. 34764 et seq. (September 30, 1986); and 51 Fed. Reg. 37577 and 39528 (October 23 and 29, 1986).

2/ The terms "civil monetary penalties" and "civil money penalties" are used interchangeably in the CMPL, the Regulations and this Decision and Order.

3/ A person eligible for Medicaid benefits is defined at 42 C.F.R. §430.1 and in the Maryland Medicaid regulations as a "recipient." The Medicaid recipients in issue are also referred to in this Decision and Order as Medicaid beneficiaries or Medicaid patients.

later amended the Notice by withdrawing the proposed assessment and now seeks a $35,000 civil monetary penalty and a five year suspension. The Respondent, pro se, challenges the I.G.'s proposed imposition of a penalty and refutes the allegations, but does not contest the proposed suspension.

JURISDICTIONAL AND PROCEDURAL BACKGROUND

The Respondent is a dentist practicing in Crisfield, Maryland. For the period in issue, he was a Medicaid dental provider and was required to comply with the terms of his Medicaid provider agreement.

The I.G.'s February 28, 1986 Notice to the Respondent alleges that the Respondent improperly made a request for payment to Medicaid patients on 147 occasions, and that these actions violated the terms of the Respondent's provider agreement with the Medicaid program, which required that the Respondent not "charge a person for an item or service in excess of the amount permitted to be charged." CMPL §1320a-7a (B)(2); Regulations §1003.102(b)(1)(ii); COMAR 10.09.05 - Dental services 4/ The I.G. argued that while Medicaid paid the Respondent a total of $3,005.30 for dental services, the Respondent also made a request for payment from the patients of an additional $845.00 for these same visits (including $5.00 charged 143 times, and $10.00, $12.00, $18.00, and $90.00 each charged once) and that the Respondent designated each of these 147 requests for payment as an "exam" or an "office visit". 5/ See, FFCL/22, infra.

The I.G. argues, in effect, that the Respondent's actions give rise to liability under the CMPL and Regulations because the 147 requests for payment to the Medicaid recipients were prohibited. The I.G. argues that the American Dental Association (ADA) standards of practice specify that dentists should not bill for an "office visit" when other services are performed, and that the State Medicaid policy and regulations in effect during the period at issue (August 20, 1981 through October 7, 1983) prohibited the billing of Medicaid recipients for an "exam" or an "office visit" when Medicaid was billed for dental services. The I.G. argues further that: (1) the Respondent did not perform any additional services for the "exam" or "office visit" charge, and (2) even if he did perform additional services, the State regulations made it clear

4/ The Maryland Medicaid program's regulations governing dentists is published at Code of Maryland Annotated Regulations (COMAR) 10.09.05 - Dental Services. IG Ex 152/Attachments A&B.

5/ The I.G. attached a list of alleged improper violations ("Appendix") to the February 28, 1986 Notice. See, FFCL/7, infra. Only 146 of the 147 listed violations are at issue. See also, footnote 23, infra.

that the Respondent could not properly bill Medicaid recipients personally for an "exam" or an "office visit" if he also billed Medicaid for other dental services performed during the same visit, because the "exam" or "office visit" fee was included in the Medicaid payment to the Respondent for any other dental services rendered.

In addition, the I.G. argues that the Respondent's prior guilty plea to a misdemeanor count of Medicaid fraud (and the Maryland Circuit Court's determination) in Criminal No. 4063 is a "final determination" (for purposes of §1003.114(c) of the Regulations) and operates to establish both the liability and the degree of culpability of the Respondent in this case. The I.G. also argues that all alleged aggravating circumstances were proven by a preponderance of the evidence and that a penalty of $35,000 and a five year suspension are appropriate. Finally, the I.G. argues that the Respondent is potentially liable for a penalty of $2,000 for each of the 147 improper requests for payment, for a total of $294,000.00.

The Respondent filed an answer and a request for a hearing on March 14, 1986. The Respondent does not contest the proposed suspension, but argues that the proposed penalty is inappropriate. 6/ While the Respondent admits that he charged the Medicaid recipients personally and also charged Medicaid for services performed on the same day, as alleged by the I.G., he denies knowledge of wrongdoing and alleges that he thought he was only charging the Medicaid patients for "non-covered" services rendered at the same time "covered" services were rendered. He argues that he was legally authorized (in accordance with materials supplied by the Maryland Medicaid Program) to bill these Medicaid patients as he did. The Respondent argues, in effect, that while he designated the services performed for the Medicaid recipients as an "office visit" or for an "initial exam," he actually performed "non-covered" services. Next, the Respondent argues that liability is not established by reason of section 1003.114(c) of the Regulations because there is no "final determination," in that there is no judgment of conviction on State criminal charges, only a plea of guilty before judgment.

With regard to mitigating factors outlined in section 1003.106 of the Regulations, the Respondent argues that the proposed civil monetary penalty should be reduced because: (1) he already reimbursed

6/ The Respondent stated in the preamble to his proposed Findings of Fact that he "consents to being excluded as a provider." The Respondent also made significant concessions in his brief, his proposed findings of fact and conclusion of law, his reply brief, and in the September 15, 1986 "Stipulations." These concessions included his acceptance of many of the I.G.'s proposed findings of fact and conclusions of law.

the State of Maryland pursuant to his plea agreement; (2) he made no money on the Medicaid patients in question (he alleged that he suffered a 22% loss); (3) his financial condition is very grave (he alleged that he could not afford an attorney in this case); (4) he cooperated fully in the investigation of this case; (5) he has no prior offenses and has a good reputation in the community for voluntarily contributing his time to indigent care and community activities; (6) he had no premeditated fraudulent plan (i.e., he made an unintentional error because the Maryland Medicaid regulations were unclear, contradictory, and confusing); and (7) the penalty proposed by the I.G. is disproportionate to the offense alleged.

A prehearing meeting was held on April 21, 1986 and a prehearing conference was held on July 23, 1986, both in Washington, D.C. A Prehearing Order was issued on July 30, 1986 and a Supplemental Order was issued on August 12, 1986. Prehearing and hearing procedures, opportunities for discovery, and rights under the CMPL and Regulations were discussed at the meeting, at the conference, and were discussed in the two Prehearing Orders. A schedule was set forth regarding hearing preparations, including discovery, exchanges of proposed exhibits and lists, and the submission of prehearing motions. Extensive discovery was conducted. Also, many telephone conferences were held to assist the parties during the prehearing process. 7/

The parties filed Stipulations, dated September 15, 1986. Based on the Stipulations, Maryland State Court documents, and the parties' briefs on the question of the effect of the Respondent's prior guilty plea in his criminal case, I issued a Prehearing Ruling on September 19, 1986. In the Ruling, I held that the I.G. had established liability in this case by proving that the Respondent's prior plea of guilty and the State Court's disposition of the plea are binding on the Respondent, pursuant to Section 1003.114(c) of the Regulations.

A formal hearing was held in Snow Hill, Maryland on November 18 and 19, 1986 and in Princess Anne, Maryland on November 20, 1986. At the hearing, the parties were afforded a full opportunity to present and have relevant evidence entered into the record, to present and cross-examine witnesses, and to present statements, motions, and argument. One witness testified on behalf of the I.G. and ten witnesses testified on behalf of the Respondent. The I.G. was represented by Thomas Herrmann, an attorney with the Office of General Counsel, Inspector General Division; the Respondent was pro se. 8/

7/ In addition, the Senior Staff Attorney for this Office (Gerald P. Choppin, Esq.) spent many hours explaining prehearing and hearing procedures to the Respondent.

8/ The Respondent conducted his own defense in this case.

The parties were given the maximum time allowed under the Regulations to submit post-hearing written briefs and proposed findings of fact and conclusions of law. The I.G. and the Respondent presented post-hearing briefs, proposed findings of fact and conclusions of law, and reply briefs.

THE GOVERNING LAW AND REGULATIONS

I. General Provisions of The Civil Monetary Penalties Law (CMPL) and Regulations 9/ 10/

Section 1320a-7a of the CMPL (§1128A of the Act) grants authority for the I.G. to issue a Notice to impose civil money penalties and assessments against a medical provider who the I.G. determines: (1) has presented or caused to be presented any false or improper claims for payment under the Medicare, Medicaid, or the Maternal and Child Health Services Block Grant Programs; or (2) presented or caused to be presented a request for payment to a Medicaid recipient or Medicare beneficiary in violation of the terms of a respondent's Medicaid or Medicare provider agreement. See, Regulations §1003.102. Once a respondent is subject to a penalty or an assessment, section 1320a-7(c) of the CMPL (§1128(c) of the Act) grants authority for the I.G. to include a proposal to suspend the medical provider from participation in the above named public assistance programs. See, Regulations §§1003.105, 1003.107.

The intended purpose of imposing a civil money penalty is to deter persons from presenting false or improper Medicare or Medicaid claims (or from making requests for payments to Medicaid recipients or Medicare beneficiaries in violation of a provider

9/ The CMPL was added to the Act by section 2105 of the Omnibus Budget Reconciliation Act of 1981 (Pub. L. No. 97-35; 95 Stat. 357, 789-92 effective August 13, 1981), amended in 1982 (Pub. L. No. 97-248; 96 Stat. 380), amended in 1984 (Pub. L. No. 98-369; 98 Stat. 1073, 1089, 1100), and amended in 1986 (Pub. L. No. 99-50; October 21, 1986). The 1986 Amendments are not applicable to this case. All references to the CMPL in this Decision and Order are to the codified sections; see 42 U.S.C.A. §§1320a-7a and 1320a-7(c) (1983 and 1985 Supp.).

10/ The Regulations (currently found at 42 CFR §§1003.100 to 1003.133) became effective on September 26, 1983 (48 Fed. Reg. 38827 et seq., August 26, 1983). They have been amended a few times since 1983 to make minor changes and additions and were moved from 45 CFR to 42 CFR in 1986 (See 50 Fed. Reg. 37371 et seq., Sept. 13, 1985; 51 Fed. Reg. 18790 et seq., May 22, 1986; 51 Fed. Reg. 34764 et seq., Sept. 30, 1986; 51 Fed. Reg. 37577 and 39528, Oct. 23 and 29, 1986).

agreement); the purpose of imposing an assessment is to make the government whole for its costs and any damages resulting from such improper acts; the purpose of a suspension is to protect program integrity. See, H.R. Rep. No. 97-158, 97th Cong., 1st Sess. Vol III, 329; Preamble to the Regulations (48 Fed. Reg. 38827 to 38836, August 26, 1983).

The Regulations implement the provisions of the CMPL, delegate authority from the Secretary to the I.G. to make determinations regarding civil monetary penalties, and provide a respondent the right to a hearing before a federal Administrative Law Judge (ALJ).

The I.G. has the burden of producing and proving by a preponderance of the evidence (1) liability under the CMPL and Regulations, and (2) aggravating circumstances. A respondent has the burden of producing and proving by a preponderance of the evidence any mitigating circumstances that would justify reducing the amount of the penalty, assessment, and suspension. Regulations §1003.114.

The CMPL and Regulations provide for a civil money penalty of "not more than $2,000" for each improper request for payment made to a Medicaid recipient or Medicare beneficiary. Regulations §1003.103.

The Regulations require that a full and fair trial-type hearing be conducted by an ALJ. Regulations §1003.115. Either party may seek review by the Secretary of DHHS, within 60 days, of an ALJ's decision and order; judicial review of any final decision and order may also be sought. Regulations §§1003.125, 1003.127. Judicial review of penalties and assessments is in the appropriate United States Court of Appeals, and judicial review of a suspension is in the appropriate United States District Court.

II. Liability Under the CMPL and Regulations

A. Requisite Proof to Establish Liability

Liability will not attach under the CMPL and the Regulations unless the I.G. establishes liability by a preponderance of the evidence adduced during the proceedings in a case. The Regulations allow the I.G. to establish liability in either of two distinct ways. The first requires the I.G. to prove the merits of the case by a preponderance of the evidence. To do this, the I.G. must prove each of the requisite elements of liability set forth in the CMPL and Regulations for each "item or service," "claim,"

or "request for payment" that the I.G. alleges to be false or improper. See CMPL §1320a-7a; Regulations §§1003.102, 1003.114(a). 11/ 12/ 13/

The second manner of establishing liability is akin to collateral estoppel. In order for liability to be established in this manner, the I.G. must prove that a "final determination" has been rendered against a respondent in a prior proceeding (within the meaning of §1003.114(c) of the Regulations), that the "final determination" involved the same subject matter in issue, and that the key elements of liability under the CMPL and Regulations were either synonymous with, or encompassed within, a standard of liability found in the statute governing the prior proceeding.

B. The Two Primary Bases for Liability and Their Elements

There are two primary bases upon which a person can be subject to liability under the CMPL and Regulations. See, Regulations §1003.102(a)(1) and (b)(1). 14/ Each has its own elements (or standards) which must be proven in order for liability to attach. The first basis for liability requires the I.G. to establish that false or improper claims were presented or caused to be presented by a respondent and that the claims contained items or services

11/ Section 1320a-7a(h)(2) of the CMPL and §1003.101 of the Regulations define a "claim" as an application for payment submitted for one or more items or services for which payment may be made under the Medicare (Title XVIII), Medicaid (Title XIX), or Maternal and Child Health Services Block Grant (Title V) programs.

12/ Section 1320a-7a(h)(3) of the CMPL and §1003.101 of the Regulations define an "item or service" to include any item, device, medical supply or service claimed to have been provided to a patient and listed in an itemized claim for payment.

13/ Section 1003.101 of the Regulations defines "request for payment" as an application for payment by a medical provider to a Medicaid recipient or Medicare beneficiary for an "item or service" which is covered under Medicaid or Medicare. The terms "bill," "charge," and "request for payment" are used interchangeably in this Decision and Order.

14/ The CMPL and Regulations also set forth other lesser known bases for liability which are not relevant to this case and which have not yet been tested under the CMPL and Regulations. See, e.g., Regulations §1003.102(a)(2) and (b)(2).

which the respondent "knew or had reason to know" were "not provided as claimed" (emphasis added). CMPL §1320a-7a(1)(A); Regulations §1003.102(a)(1). 15/

The second basis for liability under the CMPL and Regulations requires the I.G. to establish that a request for payment was presented or caused to be presented to a Medicaid recipient or Medicare beneficiary by a respondent, and that such action violated a provider agreement or other agreement. CMPL §1320a-7a(B)(2); Regulations §1003.102(b)(1). This is the basis in issue in this case. This is the first case of its type to be heard under the CMPL and Regulations. In order for liability to attach, the I.G. must prove that a respondent: "(1) has presented or caused to be presented a request for payment in violation of the terms of: . . . (ii) an agreement with a State agency not to charge a person for an item or service in excess of the amount permitted to be charged." Regulations §1003.102(b) (1)(ii). 16/ 17/

The most significant difference between these two bases of liability is that for a person to be held liable under the first he must "know or have reason to know;" scienter is required. There is no such requirement under the second; strict liability

15/ Under §1320a-7a (a)(1)(A) of the CMPL and §1003.102(a)(1) of the Regulations, penalties and assessments may be imposed against (1) any "person" (medical provider) who (2) "presented or caused to be presented" (3) one or more Medicaid (or Medicare) "claims" (4) containing one or more medical "items or services" (5) to the Medicaid (or Medicare) "agency" for payment (6) that a Respondent "knew or had reason to know" (7) "were not provided as claimed" (emphasis added).

16/ Since the Respondent in this case has admitted he made the 146 requests for payment to the Medicaid recipients and filed claims with Medicaid for dental services performed on the same day, the only element of liability left for the I.G. to prove is that the actions of the Respondent violated his provider agreement with Medicaid (i.e., that the Respondent was prohibited from making the 146 requests for payment to the Medicaid recipients).

17/ It is noted that the CMPL calls for imposition of both a penalty and an assessment when liability attaches in either of the two primary fact categories outlined above. The Regulations, however, provide for the imposition of a penalty and an assessment in the first, but only for the imposition of a penalty in the second (the situation presented in this case). See, Regulations §1003.104. The I.G. withdrew the proposed imposition of an assessment in this case to comport with the Regulations.

attaches when it is proven that a respondent's provider agreement has been violated by the presentation of improper requests for payment to Medicaid recipients or Medicare beneficiaries. 18/

III. The Medicaid Law and Program in Maryland

The Medicaid program (Title XIX of the Act; 42 U.S.C. §1396 et seq.) was created by Congress to assist states in providing medical care to needy persons. If a state chooses to have a Medicaid program, it must submit, for approval by the Secretary of DHHS, a State Plan which meets federal statutory and regulatory requirements.

The Maryland Medicaid program is administered by the Maryland Department of Health and Mental Hygiene (MDHMH). MDHMH is responsible for determining eligibility for services, establishing standards for the services provided, establishing standards and requirements for the submission of claims for reimbursement, setting payment levels for providers of services, processing claims, paying claims, and providing regulations and guidance concerning what acts constitute a violation of a provider agreement. MDHMH issues regulations and transmittals which notify providers and beneficiaries about the Medicaid rules, regulations, and practices. Reimbursable dental services may be provided to Medicaid beneficiaries by either a facility or an individual who has voluntarily chosen to participate in Maryland's Medicaid program. See 42 C.F.R. §440.100. These providers must qualify for participation by meeting certain criteria and must enter into a provider agreement with the State. I.G. Ex 151 B/1 to 2.

There is no dispute that a dental provider is prohibited by the Maryland Medicaid regulations from personally charging a Medicaid recipient for "covered" services or for services "not covered as separate procedure." "Covered services" are those services Medicaid pays for. Services "not covered as separate procedure" are those services that are included in the Medicaid payment to the provider for the other "covered" services rendered. "Non-covered" services are generally those services that Medicaid does not pay for. In some instances, a Medicaid dental provider can charge a

18/ The CMPL and the Regulations provide relief for those who might accidentally fall within these strict liability provisions. For example, the Regulations specify that an ALJ should find it a "mitigating circumstance" where the facts prove that a medical provider made improper requests for payment to Medicaid recipients as a "result of an unintentional and unrecognized error" and "corrective steps were taken promptly after the error was discovered." Regulations §1003.106(b)(2). Additionally, the Regulations specify that other circumstances of a mitigating nature should be taken into account when "the interests of justice" so require. Regulations, §1003.106(b)(2), (5).

Medicaid recipient for "non-covered" services rendered even when "covered" services are also rendered during the same visit, and in other instances he cannot. See, IG Ex 152/Attachment A&B; IG Ex 154; and R Ex 9A.

ISSUES

Since liability has been established by reason of a prior "final determination," since the I.G. withdrew the proposed assessment, and since the Respondent does not contest the I.G.'s proposed suspension, the only remaining issues are:

1) whether the amount of the proposed penalty of $35,000 is reasonable and appropriate under the circumstances of this case;

2) whether the I.G. proved by a preponderance of the evidence the aggravating circumstances alleged in the I.G.'s Notice; and

3) whether the Respondent proved by a preponderance of the evidence any mitigating circumstances that would justify reducing the amount of the penalty.

FINDINGS OF FACT AND CONCLUSIONS OF LAW 19/ 20/ 21/

Having considered the entire record, the arguments, objections, motions, and submissions of the parties, and being advised fully herein, I make the following Findings of Fact and Conclusions of Law:

1. For the purposes of this case, I have taken judicial notice of the statutes of the United States, the regulations of the Secretary of DHHS, all other pertinent regulations of the United States, the statutes of the State of Maryland, the regulations and transmittals of the Maryland Medicaid Program, and all other pertinent regulations of the State of Maryland as they existed during the time at issue in this case. Stip/A.1, 2.

2. This proceeding is governed by the CMPL and the Regulations. Stip/A.3.

3. The Secretary has delegated his authority to take action under the CMPL and the Regulations to the I.G. and to the I.G.'s delegates. Stip /A.4 to 7.

19/ References to the briefs, the transcript, the stipulations, hearing exhibits, and to these Findings of Fact and Conclusion of Law are as follows:

I.G.'s Brief	=	IG Br/page number
I.G.'s Reply Brief	=	IG Rep Br/page number
Respondent's Brief	=	R Br/page number
Respondent's Reply Brief	=	R Rep Br/page number
Transcript	=	TR volume number/page number
Stipulations	=	Stip/number
I.G. Exhibit	=	IG Ex number/page number
Respondent's Exhibit	=	R Ex number/page number
ALJ Findings of Fact and Conclusions of Law	=	FFCL/number

20/ Some of the findings and conclusions proposed by the parties were rejected or modified because they were not supported by the evidence in the record and some have been incorporated elsewhere in this Decision.

21/ Any part of this Decision and Order preceding or following the Findings of Fact and Conclusions of Law which is obviously a finding of fact or conclusion of law is hereby incorporated as a finding of fact or conclusion of law; I refer primarily to the facts and conclusions that were not disputed.

4. On February 28, 1986, Eileen Boyd, the Deputy Assistant I.G., Civil Fraud Division, DHHS, issued a Notice informing the Respondent of the I.G.'s intent to impose penalties of $35,000 and assessments of $6,010.60, pursuant to §1320a-7a of the CMPL (§1128 of the Act), and a five year suspension from participation in Medicare and Medicaid pursuant to §1320a-7(c) of the CMPL (§1128(c) of the Act). Stip/B.12.

5. On October 28, 1986, the I.G. withdrew the proposed assessments. The I.G. did so because section 1003.102(b)(2) of the Regulations does not provide for an assessment in this type of case.

6. The I.G.'s Notice was based on a determination that the Respondent presented or caused to be presented to Medicaid recipients 147 requests for payment in violation of his agreement with the Maryland Medicaid Program "not to charge for an item or service in excess of the amount permitted to be charged." Regulations §1003.102 (b)(1)(ii).

7. One of the alleged violations cited in the Notice occurred prior to August 14, 1981. IG Ex 144. The Respondent is not liable for violations prior to August 13, 1981, the effective date of the CMPL. See, Griffon v. United States Department of Health, 802 F.2d 146 (5th Cir. 1986). Thus, only 146 of the alleged violations are at issue here.

8. On March 14, 1986, the Respondent requested a hearing before an Administrative Law Judge; the hearing was held from November 18 to 20, 1986.

9. The Respondent no longer contests the suspension; he contests only the penalty.

10. The CMPL and Regulations authorize the Secretary to impose civil monetary penalties against any person who presents or causes to be presented a request for payment which is in violation of the terms of an agreement with a State Medicaid agency "not to charge a person for an item or service in excess of the amount permitted to be charged." CMPL §1320a-7a (B)(2); Regulations §1003.102(b)(2).

11. Any person subject to a penalty may be suspended from participating in the Medicare and Medicaid programs. CMPL §1320a-7(c).

12. The I.G. has the burden of producing and proving liability by a preponderance of the evidence. Regulations §1003.114.

13. The maximum penalty that could be imposed against the Respondent in this proceeding is $292,000.00.

14. The purpose of a penalty is to deter persons from presenting false or improper Medicaid or Medicare claims or from making requests for payment to Medicaid recipients or Medicare beneficiaries in violation of a provider agreement. H.R. Rep. No. 97-158, 97th Cong., 1st Sess. Vol. III, 329.

15. Civil money penalties substantially in excess of the amount actually collected may be imposed against a respondent; Mayers v. U.S. Department of Health and Human Services, 806 F.2d 995 (11th Cir. 1986). In Mayers the provider claimed $145,550 and was reimbursed $24,697.73 by Medicare; the penalties and assessments upheld totalled $1,791,000 (approximately 12 times the amount claimed and 70 times the amount collected).

16. In making the determination on the appropriate amount of a penalty to be imposed, the statute and implementing regulations direct an Administrative Law Judge to consider aggravating and mitigating factors. CMPL §1320a-7a; Regulations §1003.106.

17. The I.G. has the burden of proving the existence of aggravating factors, and the Respondent bears the burden of proving the existence of any mitigating factors. Each party must meet his burden by a preponderance of the evidence. Regulations §1003.114.

18. Aggravating and mitigating factors include the nature and circumstances under which the claims or requests for payment were made, the degree of a respondent's culpability, prior offenses, financial condition of a respondent, and any other matters that justice might require be considered. CMPL §§1320a-7a(c), 1003.106(a)(b).

19. The Maryland Department of Health and Mental Hygiene (MDHMH) is the authorized State Medicaid Agency for the State of Maryland. MDHMH administers the Medicaid program in Maryland. Stip/B.1, 2. See, 42 U.S.C. §1396 et seq.

20. The Respondent, a practicing dentist, opened an office in Crisfield, Maryland in 1979 (TR III/532).

21. On August 10, 1979, the Respondent, Dean B. Massey, D.D.S., filed an application to participate in the Maryland Medicaid program. He was enrolled in the program, entered into a provider agreement with MDHMH, treated Medicaid recipients, and submitted claims for reimbursement to MDHMH using provider number 4-97810. Stip/B.3, B.4.

22. The Respondent admits, and I find, that: (A) he presented or caused to be presented 146 requests for payment from Medicaid recipients (from August 20, 1981 to October 7, 1983) and designated these charges as an "office visit" or "exam"; and (B) he presented or caused to be submitted 146 claims for Medicaid reimbursement and received payment, as specified in the Appendix to the I.G.'s February 28, 1986 Notice. Stip/B.5, Stip/B.7A. See also, TR I/30, 165, 178, 183, 184; TR III/556.

23. The MDHMH promulgated regulations, guidelines and transmittals governing the participation of dental providers in the Medicaid program during the relevant period. See, COMAR 10.09.05 - Dental Services.

24. Dental providers participating in the Medicaid program are obligated to know about and to comply with the governing Medicaid regulations and requirements. IG Ex 151B/1-2; TR II/339. See also, Decision and Order in Inspector General v. Scott, OHCMP/DGAB Docket No. C-15, at 27-28.

25. At all times in issue, the Maryland Medicaid regulations governing dentists participating in the Maryland Medicaid Program provided that a dentist must "[a]ccept payment by the Department as payment in full for services rendered and make no additional charge to any person for covered services" (emphasis added). COMAR 10.09.05.03; IG Ex 152/Attachment A/560, Attachment B/561. From July 1, 1982 through the end of the period in issue, this also applied to services "not covered as separate procedure."

26. In 1983, the Dental Consultant for the Medical Assistance Compliance Administration of the Maryland Medical Assistance Program told the Respondent that a dentist could contract with a Medicaid recipient for non-covered services paid for by the recipient. IG Ex 154.

27. MDHMH regulations specified which "dentally necessary" services were "covered services," which were "not covered as separate procedure," and which were "non-covered" services. Based on the record, I interpret the regulations to mean that Medicaid pays for "covered" services, that a dental provider is prohibited from charging a Medicaid recipient separately for "covered" services or for services "not covered as separate procedure" (NCASP), and Medicaid did not pay for non-covered services. Based on the record, I also interpret these regulations to mean that a dental provider could charge a Medicaid recipient personally for "non-covered" services in certain instances and that in certain other instances a dental provider was prohibited from doing so. COMAR 10.09.05.04, 05; IG Ex 152/Attachment A/561, Attachment B/562; 154.

28. The MDHMH regulation in effect on January 1, 1981 listed "covered" and "non-covered" services; neither "exam" nor "office visit" were listed as either "covered" services or "non-covered" services. Non-emergency services for recipients 21 years of age or older were listed as "non-covered" services. COMAR 10.09.04, 05; IG Ex 152/Attachment A/561-562.

29. On March 22, 1982, the MDHMH sent dental providers a new list of covered, NCASP, non-covered services, and a fee schedule, all effective July 1, 1982. Initial, periodic, and emergency oral examinations were listed as NCASP. Office visits were listed as "not covered." R Ex 9B/Appendices A, C.

30. None of the Respondent's "exam" charges to Medicaid recipients occurred after March 1982; the Respondent testified that he understood the March 1982 MDHMH issuance to prohibit such charges. TR III/55, 569, 658.

31. The Respondent testified that after March 1982 he continued to provide the same services (for which he had been charging Medicaid recipients $5.00 as an "exam" and an "office visit"), but listed the charge solely as an "office visit." TR III/659. He testified that part of the services were oral hygiene instruction (listed in the MDHMH March 1982 issuance separately as a non-covered service), and the presentation of a $1.50 toothbrush and an oral hygiene kit. Id. He testified that he was told by MDHMH that examination "fees" (services) were "subsumed" under prophylaxis, a covered procedure. TR III/658; R Ex 9 B/ Appendix A, C.

32. In December 1982, MDHMH revised the regulations governing dentists participating in the Maryland Medicaid Program, effective January 1, 1983, and sent all dentists MDHMH Dental Transmittal No. 7 notifying them of the revision. The listing of office visits as "not covered" was not changed. IG Ex 152/2; 152/Attachments B and C.

33. MDHMH Dental Transmittal No. 7 stated that program recipients would be notified of the revised regulations. Attached to Transmittal No. 7 was a copy of the recipient notice. The notice summarized the changes, and stated in part, that MDHMH would "den[y] separate payment for office visits and house calls, as payment for these visits is included in the program payment for actual services rendered" (emphasis added). IG Ex 152/Attachment C/2, 10. See also, IG Ex 152/Attachments A, B, C/10; R Ex 7; R Ex 11/2. In each instance, the Respondent was absolutely prohibited from charging Medicaid recipients for an "office visit," a "non-covered" service.

34. At all times in issue here, MDHMH regulations prohibited dentists from billing recipients for "covered" services. Prior to January 1, 1983, MDHMH regulations did not specifically prohibit a dentist from billing a recipient for an "office visit." After January 1, 1983, a dentist could not bill a recipient for an "office visit." IG Ex 152/Attachments A, B, C.

35. General Medicaid policy is that program reimbursement is intended to cover provider charges in full; providers are not allowed to bill Medicaid patients personally for any of the covered or NCASP services provided during a visit. TR II/330.

36. MDHMH regulations governing dentists specify that a "provider shall submit a request for payment" on a claim form. The form contained a certification statement which read (until July 1, 1982):

> I certify that I have rendered the professional care shown on this report, and have made no charge, and will accept no payment from the patient or patient's family. . .

(and after July 1, 1982):

> I certify that the services shown on this report were rendered and that no charge has been or will be made for payment from the patient, the patient's family or other source, except as authorized by the program.

IG Ex. 151/B; Stip/B9; See IG Ex 1A to 143A and 145A to 147A.

37. The Respondent employed his wife, Gail Massey, as a "receptionist, assistant, business manager and hygienist." TR I/29-30.

38. Gail Massey and Melinda Sterling (hired in March 1982), were responsible for billing patients, insurance companies, and the Medicaid program for services rendered by the Respondent. Ms. Massey and Ms. Sterling did the billing in accordance with instructions given directly by the Respondent. TR I/36, 164.

39. During the period in issue, all services rendered by the Respondent were recorded on office ledger cards by either the Respondent or his staff. TR I/36, 41, 54, 183, 186. With respect to Medicaid recipients, the office ledger card showed the services rendered and amount claimed from the Medicaid program, and also any charge to the recipient. TR I/41. See, e.g., IG Ex 1B.

40. A Medicaid claim form would be prepared from the information recorded on a patient's ledger card. TR I/186. The claim form was subsequently signed by the Respondent and submitted to MDHMH for payment. Stip/6.

41. When a patient was charged, a copy of the office ledger card was sent to the patient as a bill. TR I/36; IG Ex 86C.

42. All billing instructions, charges made, bills presented and claims presented were generated by the Respondent. TR I/165, 178, 186. The Respondent "read the [Medicaid] Manual completely," and would either write on a patient's ledger card after rendering treatment or instruct personnel what to write. TR I/37, 42, 54.

43. There are 23 instances in which the Respondent billed a Medicaid recipient $5.00 for "exam" or "emerg. exam" in conjunction with an "office visit," and one instance in which the Respondent billed a Medicaid recipient $5.00 for an "oral exam." All 24 of these instances occurred between August 17, 1981 and March 25, 1982. The Respondent added the words "office visit" to nine of these records some time after September 1983. FFCL/76; IG Notice/Appendix.

44. The Respondent admits that the charges in issue ranged from $5.00 (e.g., IG Ex/1B) to $90.00 (IG Ex/72B); and that he submitted claims to the Maryland Medicaid program for services rendered on the same dates as these charges for "exam" or "office visit" were made. See, IG Ex/1A, B to 143A, B and 145A, B to 147A, B; Stips/B6, B7.

45. The Respondent stated that he designated certain charges to recipients as "office visits" for various reasons. These included (1) the need to save space on the ledger card; (2) the need to "separat[e] Medicaid charges from private charges," and (3) the need to facilitate the billing process. TR I/41; TR III/596, 622.

46. With regard to why the Respondent charged the Medicaid recipients, the Respondent testified that the terms "examination" and "office visit" are "not synonymous . . ." and that there are differences between the two services. TR III/592-593. He also testified that while he charged $5.00 for an "office visit," the same $5.00 fee at times was for both an "exam" and an "office visit" and that he could have called the fee anything. TR III/618 to 664.

47. On September 25, 1983, the Respondent received from MDHMH the revised Maryland Medical Assistance Program Provider Manual for Dental Services. TR I/188-189, 195; TR III/557.

48. On October 7, 1983, the Respondent received a complaint from a Medicaid recipient questioning his "office visit" charge. The Respondent then stopped billing Medicaid recipients for "office visit." Tr I/171-173, 192; TR III/566.

49. The Respondent had a policy of billing a $2.00 per month "interest" charge on overdue accounts. TR I/203. Interest was assessed on unpaid "exam" or "office visit" charges after a three month period had elapsed. IG Ex/16B, 48B, 49B, 86B, 109B, 134B, 135B. The Respondent stopped assessing interest on unpaid balances of Medicaid recipients after the State began its investigation. TR I/181.

50. In 1984, the Maryland Medicaid Fraud Control Unit (MFCU) conducted an investigation of the Respondent's participation in the Medicaid program. IG Ex 151B/3. The MFCU determined that the Respondent charged and collected $955.00 from Medicaid recipients for 168 "office visits" occurring on the same dates as those appearing on signed claim forms submitted to MDHMH for reimbursement of covered services. IG Ex 151B/4; Stip/B9.

51. The MFCU determined that the Respondent had given various justifications for the "exam" or "office visit" charge: he characterized it as an "office fee" (IG Ex 17C) or "service charge" (IG Ex 26C, 49D, 59C); he stated that Medicaid did not cover all his costs or charges for services rendered (IG Ex 14C, 37C, 81D, 97D, 98D, 137D); and he stated that the program did not pay for specific services rendered to a recipient, such as tooth extraction (IG Ex 20C) or teeth cleaning (IG Ex 103C).

52. The Respondent or members of his staff told Medicaid recipients that the "office visit" fee was charged because Medicaid would not cover the entire cost of services rendered (IG Ex 15C, 15D, 37C, 38C, 49D, 71E, 81D, 82D, 93D, 93E, 94D, 94E, 95D, 95E, 98F, 99F, 135E) or would not cover specific services rendered (e.g., teeth extractions (IG Ex 20C, 20D, 20E, 21C, 21D, 21E, 22C, 22D, 22E) (e.g., cleaning of teeth - IG Ex 103F, 104F, 105F) (e.g., x-rays - IG Ex 150A).

53. The MFCU determined, and the I.G. proved, that on one occasion the Respondent refused to treat a Medicaid recipient until the requested "office visit" fee had been paid. IG Ex 72C, 72E.

54. The MCFU determined, and the I.G. proved, that during the period in issue, the Respondent charged Medicaid patients, but not private patients, an "office visit" fee. IG Ex 34 C, 47C. Patients who were not using a Medicaid card were not charged a separate amount for an "office visit" because the Respondent incorporated that fee into his charge for specified services rendered. TR I/110-121, 122-123; IG Ex 34B, 34C, 34C, 47B, 47C.

55. The MFCU determined, and the I.G. proved, that the Respondent had charged Medicaid recipients monthly interest of $2.00 on their outstanding "office visit" charges. IG Ex 16B, 48B, 49B, 86B, 109B, 134B, 135B. One recipient was billed interest for seven months until she paid the $5.00 "office visit" fee in addition to $14.00 interest. See, IG Ex 86B; IG Ex 151B/4; Stip/B9. See, also, IG Ex 50C, 130C, 131C, 132C, 137C, 137D, 147D, 153B/8.

56. Based on the MFCU investigation, the Respondent was charged by the Maryland Attorney General in Criminal Information No. 4063 on June 14, 1984 with one count of Medicaid Fraud (State of Maryland v. Dean B. Massey) in violation of MD. ANN. Code Art. 27, §§230B(b)(1), 230C. Stip/B.8A. The conclusions in Criminal Information No. 4063 are incorporated herein by reference.

57. The Respondent agreed and stipulated to a Statement of Facts in Maryland Criminal No. 4063. IG Ex 151B; Stip/B.9. These facts are incorporated herein by reference.

58. The Respondent admits, and I find, that on November 28, 1984, the Respondent pled guilty in the Circuit Court for Somerset County to one misdemeanor count of Medicaid Fraud in Criminal No. 4063 (Art. 27, §§230B(b)(1), 230c), encompassing the 146 requests for payment in issue in this case, as set forth in the Appendix to the I.G.'s Notice. Stip/B.10A., B.11A.; IG Ex 151E.

59. Based on the Respondent's guilty plea in Maryland Criminal No. 4063, the Office of Inspector General conducted an investigation of the Respondent's participation in the Maryland Medicaid Program. TR I/89-93.

60. On September 19, 1986, I issued a prehearing Ruling which held that the I.G. had established liability in this case by proving that the Respondent was bound by a prior "final determination" in Criminal Case No. 4063, pursuant to section 1003.114(c) of the Regulations. The September 19, 1986 Ruling in this case is reconfirmed.

61. Dr. Massey was represented by counsel at his trial in Maryland Criminal No. 4063. The trial was held on November 28, 1984 before the Honorable Alfred T. Truitt, Jr., Associate Judge, First Judicial Circuit Court for Somerset County, Maryland. Dr. Massey pled guilty at that time to the charge as set forth in "Criminal Information No. 4063." The State court had his plea agreement and a signed "Statement of Facts" before it when the Court accepted the Respondent's guilty plea and made its determination of guilt.

62. Appended to the stipulated "Statement of Facts" (IG Ex 151B) was a listing of those Medicaid recipients who were charged an "office visit" or "exam" fee for services allegedly rendered on the same day as covered services for which Dr. Massey submitted a claim to the State Medicaid program.

70. The Respondent's practice of billing Medicaid recipients for an "exam" or an "office visit" was a deviation from accepted dental practices; Medicaid recipients were never charged such fees by other doctors and dentists. IG Ex 118C, 118D, 118E, 154, 155, 156; TR I/149, 154. This is an aggravating factor. TR I/149, 154; IG Ex 118C, D, E.

71. A random sample of the changes which the Respondent made to non-Medicaid patients during the period at issue in this case shows that the Respondent billed non-Medicaid patients only for specified services and that he did not bill non-Medicaid patients additional amounts for "office visits." IG Ex 158/6, 14, 31, 35, 50, 57, 58, 59, 71; TR I/113, 114, 117, 118, 120-122. The Respondent billed Medicaid recipients $5.00 and more for an "office visit," in addition to the amounts billed the Medicaid program for various dental services which he rendered to the recipients on the same dates as the requests for payment for "office visits. IG Ex 1A to I/143B and 145A to 147D. The Respondent billed the Medicaid program approximately the same amount as he billed private patients for the same or similar dental services. See, TR 113-122; and compare, IG Ex 158/6, 14, 57, and 58, with IG Ex 3A, 3B, 6B, 29B, 49B; and compare, IG Ex 158/31 with IG Ex 10A. Under these circumstances, justice requires that the Respondent's act of billing Medicaid recipients an additional $5.00 for an "office visit" be considered an aggravating circumstance.

72. In one instance, the Respondent refused to treat a Medicaid recipient until she had paid a $90 "office visit" charge. IG Ex 72C, 72E. Justice requires that this be considered a major aggravating circumstance.

73. The Respondent assessed a $2.00 per month "interest" charge against Medicaid recipients for unpaid balances of three months or less. FFCL 49; IG Ex 158/9, 34, 62. This is an aggravating circumstance.

74. The I.G. alleged that, in addition to the violations set out in the Notice, the Respondent had billed the Medicaid program for services which he had not provided as claimed, and that this was an aggravating circumstance. I find that the I.G. has not proven these allegations as an aggravating circumstance.

75. The I.G. based his proposed penalties of $35,000 in part on one alleged violation that occurred prior to August 13, 1981, the effective date of the CMPL. FFCL/7. This is a mitigating circumstance.

63. Based on the evidence in this record, I find and conclude that the State Court's determination was a judgment of guilt, that the Court's judgment of guilt was a "final determination," and that the Court's judgment of guilt is conclusive and binding on the Respondent by reason of section 1003.114(c) of the Regulations.

64. The facts distinctly put at issue and directly determined by the trial judge in Criminal No. 4063 are those stipulated to by the Respondent in the November 26, 1984 "Statement of Facts" and those set forth in the November 28, 1984 transcript of proceedings in Criminal No. 4063. The questions of law put at issue and directly determined by Judge Truitt in Criminal No. 4063 are set forth in the "Criminal Information" and subsequent plea agreement, as evidenced by the November 28, 1984 transcript of proceedings and the docket sheet in Criminal No. 4063. These documents establish that the Respondent admitted that: (1) he made the 146 requests for payment from Medicaid recipients at issue in this case; and (2) he falsely certified on Medicaid claims (for dental services provided at the same time as the alleged services for which he billed the recipients) that he had not charged or accepted payment for "covered" dental services rendered to Medicaid recipients when, in fact, he had done so with actual knowledge in willful violation of his Medicaid provider agreement.

65. By virtue of the prior "final determination" (i.e., the determination of guilt of Medicaid fraud in Criminal No. 4063 made by the Court), the issue of the Respondent's liability and degree of culpability with respect to the CMPL violations alleged by the I.G. has been established pursuant to section 1003.114(c) of the Regulations. See, Ruling and Order of September 19, 1986 in this case.

66. The degree of the Respondent's culpability is determined by the Maryland Circuit Court's judgment in Criminal No. 4063 that he "knowingly and willfully" engaged in Medicaid Fraud (IG Ex 151). This is an aggravating circumstance.

67. The 146 instances at issue are a large number of violations; and the two year period over which the violations occurred is a long period of time; these are aggravating circumstnces.

68. The Respondent made 146 requests for payment for a total of $840; this is a large amount given that it was taken from Medicaid recipients. This is an aggravating circumstance.

69. The Respondent's "office visit" charges during the period January 1, 1983 - October 7, 1983 are indicative of an established pattern of billing Medicaid recipients for covered services in violation of his provider agreement. This is an aggravating factor.

76. The Respondent admits that he altered the patient billing ledgers in nine of the violations alleged in the Notice, to add the words "office visit" to the word "exam." IG Ex 164, 34B, 73B, 76B, 84B, 86B, 103B, 106B, 129B, 137B. The original "exam" entries were made between January 4 and March 5, 1982. Id. The Respondent personally added "office visit" to each of the nine entries some time between September 1983 and January 31, 1984. TR III/681. The Respondent learned of the State investigation on January 4, 1984; the State served the Respondent with a subpoena on January 28, 1984, and the Respondent turned the records over to the State on January 31, 1984. Id. The I.G. proved that the Respondent's alteration of the records of his requests for payment made to Medicaid recipients was an attempt to hide a possible violation of his provider agreement and, as such, an aggravating circumstance.

77. Character witnesses, Philomena Bradford (TR I/141), William E. Dykes, Jr. (TR II/293), Wade D. Ward (TR II/347), Kim Lawson (TR II/449), and Tony Bruce (TR/461) all indicate that the intentional filing of false, misleading or unauthorized claims with the willful intention to secure funds to which the Respondent was not entitled was out of character and that the Respondent voluntarily contributed much time and effort to indigent care and community endeavors. The Respondent's contributions to his fellow citizens and the community is a mitigating factor.

78. The Respondent has no history of prior offenses. This is neither a mitigating nor an aggravating circumstance.

79. It is not a mitigating circumstance that the Respondent allegedly suffered a monetary loss as a Medicaid dental provider.

80. It is a mitigating circumstance that the Respondent cooperated in the investigation of this case.

81. It is a mitigating circumstance that the Respondent has paid $973 in restitution, most of which pertained to the 146 violations at issue in this case, and has performed 250 hours of community service. R Ex 18B.

82. The available figures and the testimony indicate that the Respondent has a net worth of approximately $27,000. R Ex 16B; IG Ex 159, 160; TR II 260-280, 397-444. The Respondent's financial condition is a mitigating circumstance.

83. After weighing all of the aggravating and mitigating circumstances, alleged and proven, it is appropriate, based on the evidence adduced in this case, to impose a penalty of $13,500 on the Respondent and to suspend him from participating in the program for a period of 5 years.

DISCUSSION

I. Liability is Established in this Case by a "Final Determination" in a Prior Proceeding

On September 19, 1986, I issued a prehearing Ruling which held that the I.G. had established liability in this case by proving that the Respondent was bound by a prior "final determination" in a criminal case, pursuant to section 1003.114(c) of the Regulations. For reasons discussed below, the September 19, 1986 Ruling in this case is reconfirmed.

Section 1003.114(c) of the Regulations provides that:

> (c) Where a final determination that the Respondent presented or caused to be presented a claim and/or request for payment falling within the scope of §1003.102 has been rendered in any proceeding in which the Respondent was a party and had an opportunity to be heard, the Respondent shall be bound by such determination in any proceeding under this part [emphasis added].

In 1984, the Maryland Medicaid Fraud Control Unit (MFCU) of the Office of the State Attorney General investigated the Respondent's participation in the State Medicaid program. The investigation revealed that on 168 occasions, from early 1981 to October 7, 1983, the Respondent billed Medicaid patients personally for an "exam" or an "office visit" while also billing Medicaid for dental services rendered to these patients during the same visit; in most instances the "office visit" or "exam" fee was $5.00. See, IG Ex/1A, B to 147A, B; 151B/4; 153; Stip/B9. Also during the period at issue, the Respondent assessed interest against Medicaid patients at the rate of $2.00 per month on the $5.00 "office visit" or "exam" charge. See, IG Ex 86B, 151B-4; Stip/B9. FFCL/49 and 55. The Respondent never charged private patients a separate "exam" or "office visit" fee. Id.

Based on the MFCU investigation, on June 14, 1984, the Respondent was charged with one count of Medicaid fraud, in violation of MD. ANN. CODE, art. 27, §§230B(b)(1); 230(C). FFCL/56 through 58. Criminal Information No. 4063 alleged that the Respondent:

> did knowingly and willfully make and cause to be made false statements and representations of material facts in certain applications for payment for services submitted to the Medical Assistance Program [Medicaid] . . . in that the said Dean B. Massey did falsely represent in connection with the applications for payment that no charge had been made or would be made for payment from the patients, the patients' families or other sources, except as authorized

> by the Program, when in truth and in fact the said Dean B. Massey did in fact impose charges for payment upon the patients and the patients' families, which ["office visit"] charges were not authorized by the Program . . . .

IG Ex 151A.

Dr. Massey was represented by counsel and "had an opportunity to be heard" at his trial on November 28, 1984 before the Honorable Alfred T. Truitt, Jr., Associate Judge, First Judicial Circuit Court for Somerset County, Maryland. Dr. Massey pled guilty to the charge as set forth in "Criminal Information No. 4063." The State Court had his plea agreement and a signed "Statement of Facts" when the Court accepted the Respondent's guilty plea and made its determination of guilt. The Judge asked Dr. Massey if he wished to plead guilty "because in fact you are guilty" and if he wished to give up his rights; Dr. Massey stated: "yes, sir." The Court then stated "the finding is guilty." FFCL 58 and 61. See, transcript of proceedings in Criminal No. 4063, November 28, 1984, p. 12, line 11. 22/ Appended to the stipulated "Statement of Facts" (IG Ex 151B) was a listing of Medicaid recipients whom Dr. Massey charged for an "office visit" or "exam" while also billing the State Medicaid program for dental services rendered during the same visit. Stip/B10; FFCL/62. The Statement of Facts provided that:

> Dr. Massey charged and collected a total of $955.00 from [Medicaid] patients for 168 office visits on the same date that he submitted signed invoices to the Department for reimbursement of covered services rendered, and was reimbursed by the Department for those covered services.

IG Ex 151B/4. See IG Ex 151B/7-12. The Appendix to the I.G.'s Notice to the Respondent in this case lists 147 of the same Medicaid recipients, 147 requests for payment, and 147 claims presented to Medicaid, which were at issue in the State Criminal proceeding. Those charges occurring prior to August 13, 1981 were purposely not included in the I.G.'s Notice in this case. 23/ Thus, the 146 requests for payment at issue in this case are the identical requests for payment that were in issue in the State criminal

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22/ The transcript of proceedings in Criminal No. 4063 is found in the record in this case as Attachment A to the I.G.'s brief in support of the I.G.'s Motion for a Prehearing Ruling.

23/ The I.G. indicated in this case that he is not pursuing matters occuring prior to the effective date of the CMPL, August 13, 1981. There is, however, one request for payment, of the 147 listed, that was made prior to August 13, 1981. Apparently, the inclusion of this one request for payment in the I.G.'s Notice was an oversight. Accordingly, it is dismissed from this case and there remain 146 requests for payment at issue. FFCL/7.

proceeding. In that case, Dr. Massey stated that he made these requests for payment "knowingly and willfully" in violation of his provider agreement.

In the criminal case, the Respondent received a suspended sentence and was placed on probation, pursuant to MD. ANN. CODE, art. 27, §641. On November 28, 1984, the Circuit Court for Somerset County filed its "Order For Probation," ordering the Respondent to pay court costs and restitution of $955 plus $18.00 interest, and to perform 250 hours of community service. The controversy between the State of Maryland and the Respondent was then concluded, except for administrative execution of the terms of probation.

The Maryland Annotated Code, Art. 27, §641 provided (at the time in issue) that:

> Whenever a person accused of a crime pleads guilty or nolo contendere or is found guilty of an offense, a court exercising criminal jurisdiction, if satisfied that the best interests of the person and the welfare of the people of the State would be served thereby, and with the written consent of the person after a determination of guilty or acceptance of a nolo contendere plea, may stay the entering of judgment, defer further proceedings, and place the person on probation . . . .
>
> * * *
>
> (3) By consenting to and receiving a stay of entering of judgment as provided by this subsection, the person waives the right to appeal from the judgment of guilt by the court at any time. Prior to the person consenting to stay of entering of the judgment, the court shall notify the person that by consenting to and receiving a stay of entry of judgment, the person waives the right to appeal from the judgment of guilt by the court at any time.

(Emphasis added.) 1982, ch. 98; 1983, chs. 8, 291.

Based on the evidence in this record, I find and conclude that the State Court's determination was a judgment of guilt, that the Court's judgment of guilt was a "final determination," and that the Court's judgment of guilt is conclusive and binding on the Respondent by reason of section 1003.114(c) of the Regulations. This estops the Respondent from contesting in this proceeding any finding of fact or conclusion of law necessarily established by reason of the "final determination" in Criminal No. 4063. The facts directly determined by the trial judge in Criminal No. 4063 are those stipulated to by the Respondent in the November 26, 1984 "Statement of Facts" and admitted to in the November 28,

1984 transcript of proceedings in Criminal No. 4063. The questions of law put at issue and directly determined by the trial judge in Criminal No. 4063 are set forth in the "Criminal Information" and subsequent plea agreement, as evidenced by the November 28, 1984 transcript of proceedings and the docket sheet in Criminal No. 4063. These documents establish that the Respondent admitted that he made the 146 requests for payment at issue here with actual knowledge and in willful violation of his Medicaid provider agreement. I conclude: (1) that the issues of fact and law determined in Criminal No. 4063 are sufficient to establish liability in fact and in law under the CMPL and its implementing Regulations in this case, and (2) that section 1003.114(c) requires that the Respondent be bound by those issues of fact and law already determined. FFCL/63 through 65. See, "The Two Primary Bases For Liability", supra. Accordingly, the liability of the Respondent is established here.

II. The Appropriate Amount of the Penalty Must Be Based On the Entire Record In This Case

In order to decide the appropriate amount of the penalty that should be imposed in any case where the I.G. has established liability, the CMPL and Regulations require the ALJ to consider aggravating and mitigating circumstances. Specifically, Section 1003.106(a) and (b) of the Regulations and Section 1320a-7a(c) of the CMPL require the ALJ to examine the following circumstances: (1) the nature of the claims or requests for payment and the circumstances under which they were presented, (2) the degree of culpability of the Respondent, (3) the history of prior offenses of the Respondent (as an aggravating factor only), (4) the financial condition of the Respondent, and (5) such other matters as justice may require.

While the CMPL and Regulations require consideration of aggravating and mitigating factors to determine the appropriate amount of the penalty to be imposed in a given case, there is no formula for computing the penalty and there is little guidance to be found in the CMPL and its legislative history. The preamble to the Regulations states that "fixed numbers" have been "eliminated" as "triggering devices," emphasizing that discretion is preferable to a mechanical formula. 48 Fed. Reg. 38827 (August 26, 1983). Section 1003.106(b) of the Regulations contains some general guidelines for the interpretation and application of the aggravating and mitigating factors set forth in section 1003.106(a).

The parties briefed their respective views regarding the aggravating and mitigating factors and how those factors should be applied to the facts in this case. Neither side, however, suggests any formulas for computing the appropriate amount of the penalty, gives insight into a quantum weight ascribed to each aggravating or mitigating

factor alleged, or points to any analogous cases or situations that might illustrate a method for arriving at the appropriate amount of the penalty. The lack of information is not surprising, given that there is little or no guidance available, other than the general guidelines in section 1003.106(b) of the Regulations.

The I.G. argues, in effect, that the amount of the penalty proposed by the I.G. should be imposed by the ALJ, so long as the I.G. sustains the burden of proof with regard to each of the alleged aggravating circumstances (and indicates that he has already considered any mitigating circumstances that he contemplates can be proven by the Respondent). In other words, the I.G. argues that if the I.G. proved all elements of the case as alleged, the ALJ should uphold the proposed amount. The I.G. does not argue what should be done if one or more alleged aggravating circumstances are not proven (as is the case here), or if a mitigating circumstance deserves more consideration than that given by the I.G. (as is also the case here). On the other hand, the Respondent argues that the ALJ has complete discretion and argues that the facts here justify a penalty of one dollar.

I conclude that it is both Congress' and the Secretary's intent for the ALJ to decide each case on its own merits, using discretion rather than a formula. While the ALJ has much discretion to fix the amount of the penalty on the relative merits of each case, the ALJ must attempt to craft a rational approach designed to reconcile the facts of each case with the intent of Congress. See, generally, DAVIS, Administrative Law Treatise, 2d Ed. 1978 and 1982 Supplement, Chapters 8, to 13, 29. The process is somewhat like sailing on uncharted waters. As the preamble to the Regulations states: "as we gain more experience in imposing sanctions under the statute, we may further refine the guidelines, but at this early stage we believe that increased flexibility is preferable."

Congress intended the penalty to be a deterrent rather than to be retribution or punishment. See, Mayers v. U.S. Department of Health and Human Services, 806 F. 2d 995 (11th Cir. 1986). A deterrent is meant both to encourage others to comply with the law and to discourage a respondent from committing the wrong again. Retribution or punishment goes well beyond this point and might raise constitutional questions. To arrive at an appropriate penalty that would be a deterrent, rather than retribution, the ALJ should consider the factors outlined in the Regulations, weigh the gravity of the wrong done by a respondent, and consider what it would take to prevent the wrong from being committed again by a respondent and others.

Accordingly, taking into consideration the aggravating and mitigating factors, the penalty I deem appropriate in this case is meant to be proportionate to the offense committed by the Respondent, as fashioned by the facts in the record, and is meant to be a deterrent rather than punishment.

III. The Degree of Culpability of the Respondent

One of the most complex of the factors to be considered by the ALJ in determining the amount of the penalty is the "degree of culpability." The guidelines in the Regulations indicate that this factor relates to the degree of the Respondent's knowledge and intent. As stated earlier, it is not a prerequisite that a respondent "knew or had reason to know" that any of his requests for payment were improper in order for liability to attach in this type of case, because strict liability attaches under section 1320a-7a(B)(2) of the CMPL and section 1003.102(b)(1) (ii) of the Regulations whenever the Respondent presents any request for payment which violates his agreement with a State Medicaid agency. See, "The Two Primary Bases For Liability," supra. Knowledge, however, is an aggravating factor, and "unintentional or unrecognized error" is a mitigating factor if the Respondent "took corrective steps promptly after the error was discovered." Regulations, §1003.106(b)(2). The determination of the degree of culpability in this case involves an inquiry into whether the Respondent knew at the time he personally billed Medicaid recipients 146 times from August 20, 1981 to October 7, 1983, that he was violating his Medicaid provider agreement, or whether he simply made a mistake and then corrected his error promptly after he discovered it. See, 48 Fed Reg. 38831.

A. The Degree of Culpability of the Respondent has been Established in this Case by Reason of the Respondent's Prior "Final Determination".

The I.G. argues that the degree of Dr. Massey's culpability is already established in this case by proof of the Respondent's prior "final determination" in Criminal No. 4063. I.G. Br/39, 40. The Respondent disputes this.

The I.G. is correct. The Respondent freely and voluntarily pled and was found guilty of "knowingly and willfully" falsely representing on the Medicaid claims in issue in this case that "no charge had been or would be made for payment from the patients, the patients' families or other sources . . . when in truth and in fact" the Respondent did impose exam and office visit charges directly upon the patients and the patients' families, "which charges were not authorized by the Program . . . ." IG Ex 151A, D, E; FFCL/64 . The Respondent was found to have the requisite criminal intent and knowledge to sustain a determination that he

had engaged in Medicaid fraud, because he agreed at his plea hearing on November 28, 1984 that the "office visit" charges to the Medicaid recipients were not authorized by the Medicaid program and, as a result, "he was not truthful in his statement to the State Medicaid authorities on his claims when he said that he was accepting no other payment from the patient and his family." I.G. Ex 151A, 151D, 151E.

I am convinced that section 1003.114(c) of the Regulations establishes the degree of culpability, because the Respondent is bound by his prior statements in open court that he knew he was violating his Medicaid provider agreement and intended to do so. Thus, for the same reasons that liability has been established (i.e., section 1003.114(c) of the Regulations mandates that the Respondent's "final determination" is binding), the degree of the Respondent's culpability is also established. FFCL 65, 66. Since the I.G. proved by a preponderance of evidence the maximum degree of culpability (i.e., knowledge and intent), the degree of culpability is a major aggravating circumstance. See, Regulations §1003.106(b)(2).

B. The Facts in This Record (Which are in Addition to the Facts Established by The Court's Prior "Final Determination") Do Not Change the Degree of Culpability of the Respondent.

1. Background

The general Medicaid policy is that the amount which the program reimburses a dental provider is payment in full, and the provider is not permitted to request payment from a Medicaid recipient for the difference between the reimbursed amount and the provider's usual and customary charge. A provider is not entitled to any more than the usual and customary charge. See, FFCL 35; R Ex 7; IG Ex 152.

There is no dispute that the Maryland Medicaid regulations provided that a dentist must accept payment by MDHMH "as payment in full for services rendered and make no additional charge to any person for covered services" (emphasis added). COMAR 10.09.05.03. IG Ex 152/Attachment A/560, Attachment B/561. See also, R Ex 2. This provision also applied to services "not covered as separate procedure" (NCASP). The regulations specified which "dentally necessary services" were considered to be "covered services" and "not covered as separate procedure." COMAR 10.09.05.04. IG Ex 152/Attachment A/561, Attachment B/562. See also, R Ex 2. Although it would violate the Maryland Medicaid Regulations for a dentist to charge a Medicaid recipient directly for a "covered service," or for a service "not covered as separate procedure," a dental provider could contract with a Medicaid recipient directly for "non-covered" services (under certain specified circumstances not relevant here). See R Ex 1/2; IG Ex 154/2 (affidavit of Dr. Roosevelt Bush). In listing the services not covered by Medicaid, the Regulations in effect from January 1, 1981 to June 30, 1982 did not specifically include either "exam" or "office visit" as a "non-covered service," or as a "covered service." These regulations did not specifically prohibit a dentist from billing a Medicaid

recipient directly for an "office visit" for this period. See, COMAR 10.09.05.05, IG Ex 152/Attachment A/561. See, R Ex 1/2, where an attorney for the State Dental Association gives his professional opinion that it was legal for a dental provider to bill Medicaid recipients for "non-covered" services. 25/

A modification of the general policy that Medicaid providers are "not allowed to bill in excess of [the Medicaid reimbursement]" (TR II/330), was stated by Dr. Roosevelt Bush, a consultant to MDHMH. Dr. Bush informed Dr. Massey in 1983 that Dr. Massey could "set up a private contract with any patient, including a Medicaid recipient, for services not covered by the Medicaid program, but that the recipient must agree, preferably in writing, before the services are rendered." (Emphasis added.) IG Ex 154/2. If the Respondent had merely charged the Medicaid program for "covered services" and the recipients paid for "non-covered services," he would not have violated his Medicaid provider agreement and, arguendo, would not be liable under the CMPL and Regulations. Dr. Bush, however, attested in an affidavit that at "no time did [he] ever tell Dr. Massey that he could bill Medicaid recipients for "office visits." IG Ex 154/2.

In March 1982, MDHMH updated its list of covered and non-covered services and added a new category designated: "not covered as separate procedure" (NCASP). The latter represented services for which neither the Medicaid program separately nor the recipient individually could be charged. Initial, periodic, and emergency oral examinations were listed as NCASP. See, FFCL 27. The March 1982 update, effective July 1, 1982, listed an "office visit" as a non-covered service. The Respondent admits he received this Medicaid notice. TR III/554.

Effective January 1, 1983, MDHMH revised its regulations governing dentists participating in the Medicaid program. IG Ex 152/2. See, also, IG Ex 152/Attachment B. Just prior to January 1, 1983, all dentists participating in the Maryland Medicaid program were notified, through MDHMH Dental Transmittal No. 7, of the revision of the regulations governing Medicaid dental services. IG Ex 152/2, 152/Attachment C. The evidence in this record indicates that the Respondent had to have known of Transmittal No. 7 on, or shortly before, January 1, 1983. Attached to Transmittal No. 7 was a notice to Medicaid recipients. IG Ex 152/Attachment C/2. The notice explained the new Maryland Medicaid regulations

25/ Shortly after the Respondent informed the I.G. that he proposed as one of his hearing exhibits the opinion of an attorney for the State Dental Association, the I.G. obtained an affidavit in which the attorney stated that he was not familiar with the usual and customary billing procedures of dentists and that the letter opinion which he furnisned to Dr. Massey did not address those issues or the issue of what constitutes a "covered" service. IG Ex 162.

regarding dentists and stated that "separate payment" for office visits and house calls" is denied because "payments for these visits is included in the program payment for actual services rendered." (Emphasis added.) FFCL/32, 33, 34. The regulations regarding dentists, coupled with Transmittal No. 7, make it absolutely clear that a dental provider could not bill a Medicaid recipient for an "office visit" after January 1, 1983 without violating his provider agreement. 27/

2. The Arguments of the Parties

The I.G. argues, in effect, that the facts in the record (in addition to the facts established by Respondent's prior "final determination") establish that the Respondent had the highest degree of culpability. IG Br/39, 40. There is no need to address the I.G.'s argument because, as stated above, the maximum degree of culpability that can be established under section 1003.106(b)(2) of the Regulations (i.e., knowledge and intent) has already been established as a result of the prior "final determination."

In contrast, the Respondent argues that the facts (excluding the facts established by the prior "final determination") evidence that he had no knowledge of wrongdoing and that he thought that the Maryland Medicaid regulations allowed him to do what he did. The finding the Respondent seeks is that the Medicaid regulations were sufficiently ambiguous and confusing so that the combination of services he designated as an "exam" or "office visit" could reasonably be considered separate "non-covered" services and, thus, legally billed separately to Medicaid recipients. In other words, the Respondent argues that I should disregard the prior "final determination" and that the additional facts in this record support a finding that he was not culpable at all; he argues that this is a mitigating factor.

3. Analysis

There are two compelling reasons why I should not make a further determination in this case concerning the degree of the Respondent's culpability. First, as stated above, under section 1003.114(c) of the Regulations the prior "final determination" clearly binds the Respondent. Thus, the issue is foreclosed, and I must base my

27/ Participating dental providers in Maryland, such as the Respondent are obligated to be knowledgable about and to comply with the governing Maryland Medicaid regulations and requirements. Stip/B1; IG 151B/1-2; TR II/339. See also, Decision and Order in Inspector General v. Scott, OHCMP/DGAB Docket No. C-15, at 27-28. The Respondent and his office personnel were aware of their obligation to follow the Maryland Medicaid regulations governing the billing of dental services to Medicaid recipients. The Respondent knew what the regulations said. TR I/37, 42, 185. The Respondent specifically instructed his office personnel on which billing procedures were covered and which were not. TR I/42. There is no dispute that the Respondent was actually responsible for the requests for payment from the Medicaid recipients in issue here.

finding on the facts as determined in the State criminal proceeding. Moreover, while I might sympathize with the Respondent's argument that he could not afford to defend himself properly in his criminal case, he is foreclosed from making any collateral attack here on the prior "final determination" in the criminal case; the Criminal Court was the proper forum for him to make those arguments. The only way in which it would be proper for me to reexamine the Respondent's culpability is if the Respondent established that he had not had an "opportunity to be heard," within the meaning of section 1003.114(c) of the Regulations, in the criminal case. Since the Respondent did not prove this, he is bound by the "final determination."

Second, even though the Respondent's culpability has already been established, the additional facts in this record (i.e., those exclusive of the prior "final determination") do not prove by a preponderance of the evidence that the Respondent committed an "unintentional or unrecognized error" and then "took corrective steps promptly after the error was discovered." Regulations §1003.106(b)(2). The additional facts in the record tend to support the I.G.'s allegations that the Respondent knew he was charging Medicaid recipients for "covered services;" the facts do not support the Respondent's allegations that he thought he was charging for "non-covered" services and that he was permitted to do so. Thus, the record indicates that the Respondent knew he was charging Medicaid recipients for dental services that were included in the services which Medicaid covered because: (a) the Respondent, in effect, gave the Medicaid recipients no choice but to pay the "office visit" or "exam" fee; (b) the Respondent had a duty to inquire on March 22, 1982; (c) the Respondent was on notice that he was specifically prohibited from doing so after January 1, 1983, and the Respondent did not take "corrective steps promptly" after he knew that he could not do so.

In fairness to the parties, it should be noted that because I issued a pre-hearing Ruling which held that the Respondent was bound by his prior "final determination," the parties were, in effect, diverted from telling the full story concerning liability and the degree of culpability. For example, but for the Ruling the I.G. might have presented testimony from Medicaid recipients or others in an effort to prove that the Respondent was charging Medicaid recipients for "covered services" under the guise of an "office visit" or "exam," as alleged. On the other hand, but for the Ruling the Respondent might have made an effort to demonstrate more effectively that prior to January 1, 1983, the Medicaid regulations per se did not prohibit what he was doing prior to January 1, 1983 or that he had not had notice that he was prohibited from charging Medicaid recipients for an "office visit." Even pro se, the Respondent's effort brought out certain facts which I carefully reviewed.

The additional facts as developed in this record are set out above and in the three points below. These facts illustrate that even

without the facts established by the prior "final determination," the Respondent's degree of culpability would not change so as to make it a mitigating circumstance.

(a) The Respondent, in Effect, Forced Medicaid Recipients to Pay an "Office Visit" or "Exam" Fee Before They Could Receive Medicaid Services.

The first reason why the facts in the record are not a mitigating factor (exclusive of the prior "final determination") is that they indicate that the Respondent made Medicid recipients feel that he would not provide covered Medicaid services unless the Medicaid recipients first agreed to pay a charge which the Respondent labeled as an "exam" or "office visit."

A dental provider interested in the well being of his patient, as Dr. Massey said he was, would have made sure that he told the patient what "non-covered" services were needed and that the quantity and quality of "covered" services was in no way dependent on whether the patient agreed to pay personally for the "non-covered" services. Dr. Massey did not give Medicaid recipients that understanding and, thus, did not allow them the option of rejecting his "office visit" and "exam" services if they wanted only "covered" services. See, FFCL 72 . Thus, his method of operating gave the 146 Medicaid recipients no choice. This illustrates that the Respondent violated both the letter and the spirit of his provider agreement.

(b) On or Shortly After March 22, 1982 The Respondent had a Duty to Inquire Into Whether he was Allowed to Charge Medicaid Recipients for the Services He Called an "Office Visit."

The Respondent testified that when he received information from Medicaid in March 1982 that an examination would be "not covered as separate procedure" after July 1, 1982, he asked Medicaid what those words meant, because that classification was new to him. TR III/554-555. The Respondent admits that he became aware of the regulatory change on or shortly after March 1982. He indicated that he made a telephone inquiry in 1982 to Dr. Roosevelt Bush, a consultant to Medicaid. TR III/556. Although Dr. Bush stated in a sworn affidavit that Dr. Massey actually made the inquiry in 1983, the facts clearly establish that the Respondent recognized he had a duty to inquire whether his practice of charging Medicaid recipients for an "exam" was allowed by Medicaid regulations.

Dr. Massey testified at one point that an "office visit" charge was justified if he gave the patient oral hygiene instructions. TR III/637, 639, 658. This is also what he told one Medicaid recipient, the mother of a Downs Syndrome patient who needed reinforcement in "cleaning his teeth properly." TR I/146, 153, 154, 156. But, at another point, Dr. Massey testified that a "bona fide office visit" . . . "a legitimate office visit" was where he

spent time explaining to a patient how to get treatment which Medicaid did not pay for. TR III/592-593, 622. He also testified, in response to my questioning, that prior to the above described regulatory change, he charged Medicaid recipients $5.00 for a composite of "exam" and "office visit" services, yet continued to charge $5.00 for an "office visit" without an "exam" after that. See, TR III/659. Clearly, under the circumstances, the Respondent had a duty to ask Medicaid whether he could do this.

In his alleged conversation with Medicaid in 1982, the Respondent apparently did not seek to clarify his use of the term "office visit." Given the imprecise nature of the collection of "services" he allegedly provided as an "office visit" and the lack of a clear distinction between his understanding of the terms "office visit" and "exam," Dr. Massey was obliged to make a more thorough inquiry. His failure to do so is a further indication that he already knew -- or did not want to know -- the answer.

(c) The Respondent knew he was Prohibited by the Medicaid Regulations from Charging Medicaid Recipients for an "Office Visit" for the Period After January 1, 1983

The preponderance of the evidence indicates that the MDHMH issued a transmittal which made clear that, after January 1, 1983, the Respondent could not charge Medicaid recipients for an "office visit" or "exam." It is unlikely that the Respondent did not receive this transmittal because he admits that he received other Medicaid notices. At the very least, the Respondent had some degree of knowledge. State Medicaid regulations are published in the Maryland Register. See, R Ex 9A.

The Respondent's knowledge of his wrongdoing in billing for an "office visit" after January 1, 1983 is further evidenced by the Respondent's own testimony during cross-examination. TR III/618 to 664. During cross-examination, the Respondent initially was not forthright in answering questions addressed by the I.G. and although he acknowledged that "we are talking in circles" (TR III/636), he did little to find a way out of the confusion created by his testimony. In fact, he seemed to be attempting to obscure the truth. See e.g., TR III/623, 630. At other times, he seemed uncertain that he had done what was right and genuinely sorry for what he did. He stated that although he intended "to help patients" by giving them oral hygiene instuctions and generally helping them prevent decay and maintain dental hygiene, he agreed: (1) that he could not charge for an exam after mid-1982 (TR III/658); and (2) that it appeared that all he really had done (after MDHMH listed examinations as "not covered as separate procedure" in mid-1982) was change the designation in his records from "exam" to "office visit" while continuing to provide the identical services to the recipients. TR III/659. See also, TR

III/660 to 664. The Respondent stopped his illegal practices only after a Medicaid recipient complained in October 1983. 28/

IV. The Nature and Circumstances of the Claims and Services in Issue

The guidelines at section 1003.106(b)(1) of the Regulations state that the nature and circumstances of the requests for payment should be considered a mitigating factor if requests for payment were all of the same type, occurred within a short period of time, were few in number, and the total amount requested from Medicaid recipients was under $1,000. But, the regulations do not specify what constitutes a "short period of time" or how to evaluate the number of claims. The guidelines at section 1003.106(b)(1) of the Regulations also state that an aggravating circumstance exists where the requests for payment were of several types, occurred over a lengthy period of time, were large in number, indicated a pattern of making such requests for payment, or the amount requested from Medicaid recipients was substantial. Again, however, the guidelines do not indicate what period of time is lengthy, what amount of requests is a large number, or what is a substantial amount. See, 48 Fed. Reg. 38827 (August 26, 1983). These judgments are left to the discretion of the ALJ.

Since the guideline examples of aggravating circumstances are couched in the disjunctive, only one need be proven by the I.G. to establish the nature and circumstances as an aggravating circumstance. Here, the I.G. has established more than one.

On the other hand, the guideline examples of mitigating circumstances are couched in the conjunctive; all must be proven by the Respondent in order to have the nature and circumstances of the claims in issue to be considered mitigating. The Respondent did not prove them.

The Respondent improperly billed Medicaid recipients for an "exam" or an "office visit" in 146 instances during the two year period in question. I find that the 146 instances constitute a "large number of claims" under the guidelines. I find this because the Respondent admitted that he so billed all Medicaid recipients served during the period in issue. Also, given that Dr. Massey admitted knowledge of his wrongdoing in the prior "final determination," I find the two year period to constitute a "lengthy" period of time. See, generally, IG Ex 1A to 143B and 145A to 147D. These are two aggravating circumstances proven by the I.G.

28/ Absent the Respondent's prior "final determination," I might have been persuaded to impose a much lower, or perhaps nominal, penalty (as the Respondent suggested in his brief) if the record had shown that the Respondent had ceased billing Medicaid recipients (who could ill afford a $5.00 "office visit" fee) no later than January 1, 1983 and had not, in effect, forced the Medicaid recipients to pay the "office visit" fee.

The Respondent's "office visit" charges during the period in issue are indicative of an established pattern of billing Medicaid recipients for covered services in violation of his provider agreement, as discussed above. This is an aggravating circumstance proven by the I.G.

The Respondent's practice of billing Medicaid recipients for an "exam" or an "office visit" was a deviation from accepted dental practices; Medicaid recipients were never charged such fees by other doctors and dentists. Dr. Roosevelt Bush, a consultant to the Maryland Medicaid program (a source cited by Dr. Massey), stated in a sworn affidavit that:

> During my professional career and tenure with the Maryland Medical Assistance Program, I have never encountered a dentist, with the exception of Dr. Massey, who billed the patient or a third party for an "office visit" on the same date and time when other billable services were rendered.

IG Ex 154. Dr. Bush's statement was corroborated by the testimony of the mother of one of the Medicaid recipients whose billings were at issue. The witness was called by Dr. Massey. She stated that she "never felt she was injured" by Dr. Massey's charging an "office visit" fee, but affirmed on the I.G.'s cross-examination that no other doctor charged an office visit fee. TR I/145, 149, 154. The mother of another Medicaid recipient whose billings were at issue also furnished information to a State investigator that a dentist in Salisbury, Maryland (near Crisfield), who had treated her child prior to Dr. Massey, had not charged an "office visit" fee. IG Ex 118D. Thus, in addition to the Respondent violating his Medicaid provider agreement, he charged Medicaid recipients for a "service" for which other dentists and doctors did not bill. In addition, a random sample of the amount which the Respondent billed to non-Medicaid patients during the period at issue in this case shows that the Respondent billed non-Medicaid patients only for specific services, rather than the general "exam" or "office visit" fees. FFCL/71. This is an aggravating circumstance proven by the I.G.

The guideline makes it an aggravating circumstance if the total amount taken from Medicaid recipients is "substantial." The charges in issue are less than the $1,000 set forth in the guidelines for a mitigating circumstance. The total of all the charges in issue here is $840, consisting mostly of $5.00 charges. The broad sweep of the guidelines includes claims improperly made to and collected from government agencies as well as charges to Medicaid recipients, as here. I find the amount to be "substantial" within the meaning of the guidelines. Even small amounts taken

from indigent people may reasonably be considered "substantial." This is an aggravating factor. 29/

V. Other Matters to be Considered as Justice Requires

The CMPL and the Regulations also contain an umbrella factor, "other matters as justice may require." The Regulations do not provide further detail, except to indicate that consideration of other matters should be limited to those relating to the purposes of civil money penalties and assessments. Regulations §1003.106(b)(5).

The Respondent billed one of the Medicaid recipients (named in the I.G.'s Notice) $90 for an "office visit" on June 7, 1983. IG Ex 72 B. The Respondent charged the Medicaid program for "outpatient surgery" performed on the same patient on June 8, 1983. IG Ex 72A. In a sworn statement dated September 10, 1985, the recipient stated that the Respondent had told her on June 7 that if "she didn't have the money before the surgery . . . he would not do the surgery." IG Ex 72E. This was consistent with information reported to the State at the time of its investigation in 1984. IG Ex 72C, 72D. This incident occurred six months after MDHMH adopted new regulations and specifically informed providers that a Medicaid recipient could not be charged for an "office visit." By conditioning the provision of covered services on the payment of such a large amount, Dr. Massey seriously jeopardized the quality of care received by the Medicaid recipient. This incident is a major aggravating circumstance. FFCL/72.

The I.G. argues that, in addition to the violations set out in the Notice, the Respondent had billed the Medicaid program for services which he did not provide as claimed, and that this should be considered an aggravating circumstance. The I.G. relied in part on alleged incidents or persons not cited in its Notice. IG Ex 130E, 131E, 132E. In the one instance which might properly have been under the Notice, the statement given to the I.G. was in direct conflict with one previously given to the State. Compare, IG Ex 49F and IG Ex 49E. Accordingly, I find that the I.G. has failed to establish these allegations as an aggravating circumstance. FFC/74.

The I.G. erroneously based his proposed penalty of $35,000, in part, on one alleged violation which occurred prior to the effective date of the CMPL. FFCL/7. This is a mitigating circumstance because an improper claim made prior to the effective date of the CMPL does not constitute a violation of the CMPL.

29/ The guidelines state that a total amount of less than $1,000 is one element necessary for finding the nature and circumstances of payment to be a mitigating factor. The total amount here was less than $1000. Nevertheless, since the other necessary elements specified in the guidelines were not present (and they all must be present to find the nature and circumstances to be a mitigating factor), the nature and circumstances of payment cannot be considered a mitigating factor, and I am not precluded from finding the amount, if less than $1000, to be an aggravating factor.

During the entire period at issue, the Respondent was required by Medicaid to "[m]aintain adequate records for a minimum of 5 years, and make them available" to MDHMH. COMAR 10.09.05.03; IG Ex 152, Attachments/A&B. The I.G. alleged that the Respondent altered patient billing ledgers in this case so as to mislead State investigators. The Respondent admitted that he had altered the records as alleged -- by adding the words "office visit" to records already bearing the word "exam" in 13 instances in which he requested payment from Medicaid recipients for an "exam" (he initially had contended that he added the word "office visit" "to separate out what a patient paid me versus what Medicaid billed"). TR III/684.

The Respondent was shown to have altered at least one record some time after a February 8, 1983 postmark on a bill sent to a recipient. The bill was for "exams" which were provided on June 25, 1981 and January 4, 1982. 30/ The Respondent testified that he altered the records himself some time between September 1983 and January 29, 1984. The latter is the day that he and his wife assembled the 175 records requested by the State investigators; he said: "we didn't alter anything that day . . . we didn't have time." TR III/681, 683.

The Respondent argued that his alteration of Medicaid records was "legal" because the instances in which he added the words "office visit" all occurred prior to the July 1, 1982 regulatory change which prohibited billing a Medicaid recipient for an "exam." TR III/676, 679, 685. The Respondent stated that the "fee remained the same, the person got charged for the same." TR III/676. This contradicted his earlier testimony which explained the differences between an "exam" and an "office visit." There he defined "exam" as "checking for pathology. . . soft and hard tissue . . . [f]illing the forms out . . . ." TR III/592. He defined an "office visit," for example, as "sitting down" with a patient and trying to "work . . . through" how to get treatment when Medicaid would not pay for it. TR III/593. 31/

I find that the Respondent's explanations do not excuse the alteration of records which the Respondent was obliged to maintain and make available to the Medicaid program. The evidence that he made the additions long after the "exam" or "office visit" belies

30/ On each of those dates, the Respondent provided other dental services and billed the Medicaid program for those services. IG Ex 86B, E.

31/ Later in his testimony he described an "office visit" as oral hygiene instruction, giving a patient a toothbrush, and talking about treatment plans. TR III 639, 653-656.

his explanation that he did it to separate patient billings from Medicaid billings. The evidence also strongly suggests that he altered the records during the four weeks between learning of the State investigation (January 4) and delivery of the records to the State investigators (January 31). He admittedly altered the records long after such notations would have been useful to his billing process and only after he became aware that there was some problem with his billing of Medicaid recipients. Under these circumstances, any alteration of records which the Respondent was obliged to maintain for the State, and which were potential evidence, however harmless the alteration, must be considered an aggravating circumstance. FFCL/76.

Character witnesses Philomena Bradford (Transcript TR I/141), William E. Dykes, Jr. (TR II/293), Wade D. Ward (TR II/347), Kim Lawson (TR II/449), and Tony Bruce (TR/461) all indicate that the intentional filing of false, misleading or unauthorized claims with the willful intent to secure funds to which the Respondent was not entitled was out of character for the Respondent. They also indicated that the Respondent voluntarily contributed much time and effort to indigent care and community endeavors. The Respondent's contributions to his fellow citizens and the community is considered a mitigating factor. FFCL/78.

VI. History of Prior Offenses

The next factor discussed in the Regulations is "prior offenses" of the Respondent. The guidelines at section 1003.106(b)(3) state that an aggravating circumstance exists if, prior to the presentation of the improper claims at issue, the Respondent was held liable for criminal, civil or administrative sanctions in connection with one of the programs covered by the CMPL or any other medical services program. This guideline would clearly prevent consideration of mere allegations of past wrongdoing; the Respondent must have been "held liable" and subjected to actual sanctions before committing the acts for which he is found liable here. The preamble makes clear that prior offenses are not an aggravating circumstance, unless there has been a final agency determination or a final adjudication in a court. 48 Fed. Reg. 38832.

The Respondent had not been found guilty of offenses prior to the time he presented the requests for payment and the claims at issue here. Thus, there are no prior offenses which could be considered an aggravating factor in this case. On the other hand, absence of a prior offense is not a mitigating factor under the Regulations. FFCL/77.

VII. Financial Condition

The Regulations state that the financial condition of the Respondent would constitute a mitigating circumstance if the penalty or assessment, without reduction, would jeopardize the ability of a

respondent to continue as a health care provider. Thus, it is clear that the ALJ may consider the Respondent's financial condition (a traditional element evaluated in compromising or settling claims). Furthermore, the guidelines at section 1003.106(b)(4) note that the ALJ must consider the resources available to a respondent. This indicates that financial disclosure by a respondent is a key requirement in evaluating a Respondent's financial condition.

There is testimony in the record regarding the Respondent's net worth. The testimony centered around the Respondent's submission of an unaudited balance sheet dated October 9, 1986. R Ex 16 B. This balance sheet showed the Respondent to have a net worth of minus $11,881.61. The negative balance reflects an alleged excess of liabilities over assets.

The Respondent's accountant testified that although he had not performed an audit in connection with the preparation of the balance sheet, he would not otherwise qualify (condition) the result. TR II/424. The accountant stated that he had considered both personal and business assets, but acknowledged that he had failed to list furnishings and jewelry. TR II/432.

The balance sheet did not include a specific line item for the value of the Respondent's dental practice. Nevertheless, the accountant testified that the practice was worth approximately $18,000. TR II/417. He based this figure on accounts receivable of $14,026.77 and the purchase price of the dental equipment, minus accumulated depreciation ($4,187.64). Id. The I.G.'s witness, who investigated this case for the I.G., and who is also an accountant, testified that the Respondent's practice should be valued at $47,000. TR II/280. This figure was determined for the investigator by a professor who teaches dental management at the University of Maryland. TR II/279. The figure was corroborated by a 1985 Survey of Dental Practice conducted by the American Dental Association. I.G. Ex 159. The investigator testified that he had not revealed the Respondent's name to the professor, who had taught the Respondent. The investigator noted that he had indicated to the professor only the geographic location of the practice and information from the Respondent's 1984 income tax reports showing the Respondent's business income, statement of profit and loss, and depreciation schedule. TR II/288. Those figures disclosed that the Respondent had a $2,000 profit that year on a gross income of $47,000. The Respondent's expenses included a salary of $8,256 paid to the Respondent's wife for assistance in the office. TR II/437.

The I.G.'s witness also indicated that the Respondent's house and lot in Crisfield, Maryland, might have been undervalued, at $29,900, on the balance sheet. TR II/255, 272, 275. The Respondent's accountant used the Somerset County assessment appraisal of $13,450. The accountant said that Somerset County appraisals were usually 40 to 45 percent of the market value. TR II/400, 427. Subsequent to his preparation of the balance sheet, he

obtained an appraisal from a local realtor, who valued the property at $31,000. Id. The testimony of the I.G.'s investigator was based on a visit to the assessor's office and a review of property sales in Crisfield; he indicated that the assessed value of a house in Crisfield ranged from 30 to 60 percent of market value. TR II/273-274. In my view, the testimony of both sides is consistent and persuades me that an estimated value of approximately $30,000 is reasonable.

The I.G. also questioned the accountant's valuation of the Respondent's 1984 Oldsmobile Cutlass at $5,500. The $5,500 figure was obtained by the Respondent from a used car dealer in Crisfield. TR II/399. The I.G. cited the National Automobile Dealer's Association "blue book" average retail price, starting at $6,625 for a four door sedan. I.G. Ex 160; cf. TR II/261. The "blue book" average loan value for a four door sedan was $5,000, and the average trade-in value was $5,550. Id. I find that an estimated value of approximately $5,500 is reasonable.

Thus, the Respondent's net worth is reasonably representd by the figures shown on the balance sheet, except for the value of Respondent's dental practice, furnishings, and jewelry. Considering these factors and other incidental aspects covered in the testimony of both witnesses, I estimate that, based on the figures available to me in this record, the Respondent's net worth is approximately $27,000.

The I.G. considered the Respondent's financial condition to be a significant mitigating factor (TR I/291, 292), and I agree. Although I find the evidence to indicate a more substantial net worth than the Respondent's balance sheet showed, I am not persuaded that it is as substantial as the I.G. argues. Thus, I conclude that the Respondent's financial condition is a more significant mitigating circumstance than the I.G. considered it to be in proposing a penalty of $35,000.

VIII. The Penalty As Modified Here is Supported by the Record

Based on my viewing of the Respondent's financial condition, the fact that the Respondent has already paid $973 in restitution and performed 250 hours of community service, and the other aggravating and mitigating circumstances, I reduce the penalty to $13,500.

The penalty that could have been imposed under the CMPL and Regulations (i.e., $294,000) is much greater than the $35,000 penalty actually proposed by the I.G. As stated earlier, the penalty is intended to serve as a deterrent to future unlawful conduct by both respondents and other providers in the Medicare

or Medicaid programs. In its report on the CMPL, the House Ways and Means Committee found that "civil money penalty proceedings are necessary for the effective prevention of abuses in the Medicare and Medicaid program. . . ." H.R. Rep. No. 97-158, 96th Cong., 1st Sess. Vol. III, 32, 329 (1981). After weighing all of the aggravating and mitigating circumstances, I conclude that a penalty of $13,500 is a sufficient deterrent under the circumstances of this case.

ORDER

Based on the evidence in the record and the CMPL and Regulations, it is hereby Ordered that the Respondent:

(1) pay a penalty of $13,500; and

(2) be suspended from Medicare and Medicaid programs for a period of five (5) years.

/s/

Charles E. Stratton
Administrative Law Judge