Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
Carey A. Washington, Ph.D.,	)	Date: March 19, 2009
Petitioner,	)	
-v.-	)	Docket No. C-08-516
	)	Decision No. CR1922
The Inspector General.	)	

DECISION

Petitioner, Carey A. Washington, Ph.D., is excluded from participation in Medicare, Medicaid, and all other federal health care programs pursuant to section 1128(b)(5)(B) of the Social Security Act (the Act) (42 U.S.C. § 1320a-7(b)(5)(B)), effective April 20, 2008, based upon having been terminated and permanently excluded from participation in the South Carolina Medicaid program for reasons bearing upon his professional competence, professional performance, or financial integrity. There is a proper basis for exclusion. Petitioner's exclusion from participation in Medicare for the period during which he is excluded from participation in the South Carolina Medicaid program is mandatory pursuant to section 1128(c)(3)(E) of the Act (42 U.S.C. § 1320a-7(c)(3)(E)) and 42 C.F.R. § 1001.601(b)(1).

I. Background

The Inspector General for the Department of Health and Human Services (the I.G.) notified Petitioner by letter dated March 31, 2008, that he was being excluded from participation in Medicare, Medicaid, and all federal health care programs until such time as he is reinstated by the South Carolina Department of Labor, Licensing and Regulation, pursuant to section 1128(b)(5) of the Act. The basis cited for Petitioner's exclusion was his exclusion from the South Carolina Medicaid program for reasons bearing on his professional competence, professional performance, or financial integrity. Act § 1128(b)(5); 42 U.S.C. § 1320a-7(b)(5); and 42 C.F.R. § 1001.601(a)(1)(ii).

Petitioner timely requested a hearing by letter dated June 3, 2008. The case was assigned to me for hearing and decision on July 8, 2008. On August 4, 2008, I convened a prehearing telephone conference, the substance of which is memorialized in my Order dated August 5, 2008.

The I.G. filed a motion for summary judgment and a supporting brief on August 28, 2008 (I.G. Brief), with I.G. Exhibits (I.G. Exs.) 1 through 8. Petitioner failed to timely file his response to the I.G. motion for summary judgment and on October 15, 2008, I ordered that he show cause for why his case should not be dismissed for abandonment. Petitioner filed his statement of cause and his opposition to the motion for summary judgment on October 28, 2008. No reply was filed by the I.G. and, upon inquiry by my office, it was determined that counsel for the I.G. did not receive a copy of Petitioner's opposition. A copy of Petitioner's opposition was provided to the I.G. On January 29, 2009, the I.G. advised me that he did not intend to file a reply to Petitioner's opposition. No objection has been made to the admissibility of any of the proposed exhibits and I.G. Exs. 1 through 8 are admitted.

II. Discussion

A. Findings of Fact

The following findings of fact are based upon the uncontested and undisputed assertions of fact in the pleadings and the exhibits admitted. Citations may be found in the analysis section of this decision if not included here.

1. The South Carolina Department of Health and Human Services (state agency) notified Petitioner by letter dated January 28, 2005, that a post-payment review of his Medicaid records revealed that claims to Medicaid were made using his billing number during the period June 2002 through May 2004, for counseling services rendered by unlicensed non-doctoral supervisees without the supervising psychologist – Petitioner – present, without prior approval of the South Carolina LLR Board of Examiners in Psychology, and contrary to the Board's prior disapproval of Petitioner's supervising in that manner, as well as many additional errors the agency attributed to lack of supervision. I.G. Ex. 6.

2. The state agency notified Petitioner by letter dated March 10, 2005, that it had disallowed $276,755 in claims made with his billing number on grounds that supervision requirements were not met and criteria for providing psychological services were not met and advising Petitioner that he must pay or appeal the determination. I.G. Ex. 7.

3. The state agency notified Petitioner by letter dated January 17, 2007, that no appeal and no payment of $276,755, had been received, and that he was permanently excluded from participation in the South Carolina Medicaid program effective immediately. I.G. Ex. 8.

4. The I.G. notified Petitioner by letter dated March 31, 2008, that he was being excluded from participation in Medicare, Medicaid, and all federal health care programs pursuant to section 1128(b)(5) of the Act, based upon having been suspended, excluded, or otherwise sanctioned by the South Carolina Medicaid program for reasons bearing upon his professional competence, professional performance, or financial integrity. I.G. Ex. 1.

5. Petitioner timely requested a hearing by letter dated June 3, 2008. I.G. Ex. 2.

B. Conclusions of Law

1. Petitioner's request for hearing was timely and I have jurisdiction.

2. Summary judgment is appropriate.

3. Petitioner was permanently excluded from participation in a state health care program for reasons bearing upon his financial integrity, thus, there is a basis for his exclusion from participation in Medicare pursuant to section 1128(b)(5)(B) of the Act.

4. Pursuant to section 1128(c)(3)(E) of the Act and 42 C.F.R. § 1001.601(b)(1) the period of Petitioner's exclusion from participation in Medicare shall not be less than the period of his exclusion from the state health care program.

5. Petitioner's exclusion was effective 20 days after the date of the I.G. notice of exclusion. 42 C.F.R. § 1001.2002(b).

C. Issues

The Secretary of the Department of Health and Human Services (the Secretary) has by regulation limited my scope of review to two issues:

> Whether there is a basis for the imposition of the exclusion; and,
> Whether the length of the exclusion is unreasonable.

42 C.F.R. § 1001.2007(a)(1).

In this case there is no issue as to the reasonableness of the period of exclusion as the Act requires that the period of Petitioner's exclusion from participation in Medicare shall not be less than the period of his exclusion from the state health care program. Act, § 1128(c)(3)(E).

D. Applicable Law

The law generally applicable to this case includes that set forth in my Conclusions of Law and the following statements of the law.

Petitioner's right to a hearing by an ALJ and judicial review of the final action of the Secretary is provided by section 1128(f) of the Act (42 U.S.C. § 1320a-7(f)). The standard of proof is by a preponderance of the evidence. 42 C.F.R. § 1001.2007(c). Petitioner bears the burden of proof and persuasion on any affirmative defenses or mitigating factors and the I.G. bears the burden on all other issues. 42 C.F.R. §1005.15(b) and (c). When an exclusion is based on a determination by another government agency "or any other prior determination where the facts were adjudicated and a final decision was made," the prior determination is not subject to review or collateral attack on substantive or procedural grounds. 42 C.F.R. § 1001.2007(d).

E. Analysis

1. Summary judgment is appropriate in this case.

Pursuant to section 1128(f) of the Act, a person subject to exclusion has a right to reasonable notice and an opportunity for a hearing. The right to hearing before an ALJ is accorded to a sanctioned party by 42 C.F.R. § 1005.2 and the rights of both the sanctioned party and the I.G. to participate in a hearing are specified in 42 C.F.R. § 1005.3. Either or both parties may choose to waive appearance at an oral hearing and to submit only documentary evidence and written argument for my consideration. 42 C.F.R. § 1005.6(b)(5). The ALJ may also resolve a case, in whole or in part, by summary judgment. 42 C.F.R. § 1005.4(b)(12). Summary judgment is appropriate and no hearing is required where either: there are no disputed issues of material fact and the only questions that must be decided involve application of law to the undisputed facts; or, the moving party must prevail as a matter of law even if all disputed facts are resolved in favor of the party against whom the motion is made. A party opposing summary judgment must allege facts which, if true, would refute the facts relied upon by the

moving party. *See e.g.*, Fed. R. Civ. P. 56(c); *Garden City Medical Clinic*, DAB No. 1763 (2001); *Everett Rehabilitation and Medical Center*, DAB No. 1628, at 3 (1997) (in-person hearing required where non-movant shows there are material facts in dispute that require testimony); *Thelma Walley*, DAB No. 1367 (1992); *see also, New Millennium CMHC*, DAB CR672 (2000); *New Life Plus Center*, DAB CR700 (2000).

There are no genuine issues of material fact in dispute in this case. Petitioner does not deny that he was permanently excluded from participation in the South Carolina Medicaid program. Petitioner also does not deny the facts that were the basis for the state agency determination to permanently exclude him from participation in the South Carolina Medicaid program. This case must be resolved against Petitioner as a matter of law and summary judgment is appropriate.

2. There is a basis for Petitioner's exclusion pursuant to section 1128(b)(5)(B) of the Act.

The I.G. cites section 1128(b)(5)(B) of the Act as the basis for Petitioner's exclusion. The statute provides:

> (b) Permissive Exclusion.—The Secretary may exclude the following individuals and entities from participation in any Federal health care program (as defined in section 1128B(f)):
>
> * * * *
>
> (5) Exclusion or suspension under federal or state health care program.—Any individual or entity which has been suspended or excluded from participation, or otherwise sanctioned, under—
>
> > (A) any Federal program, including programs of the Department of Defense or the Department of Veterans Affairs, involving the provision of health care, or
> >
> > (B) a State health care program,
>
> for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity.

The statute permits the Secretary to exclude from participation any individual or entity: (1) excluded from participation in a state health care program; (2) for reasons bearing upon the individual's or entity's financial integrity. Petitioner does not dispute that the South Carolina Medicaid program is a state health care program within the meaning of section 1128(h) of the Act. Petitioner does not dispute that he was permanently excluded from the South Carolina Medicaid program. Petitioner also does not dispute that he was

excluded for failure to repay the overpayment determined by the state agency or that the overpayment resulted from the submission of claims for payment from the program using his billing privileges. I conclude that there is a nexus between Petitioner's financial integrity and his failure to repay the overpayment and the fact that he permitted his billing number to be used for the submission of unauthorized claims for payment.

Petitioner argues in his request for hearing that he has been in practice as a psychologist licensed by the State of South Carolina since 1997. In 2003, the administrator of We Care Enrichment Center (We Care) asked that he provide services to foster care parents and their children in their homes and schools. The administrator had staff to deliver services but he needed a licensed psychologist to provide supervision and consultation. Petitioner agreed to provide services for 20 percent of total billing. Petitioner provided group and individual supervision in his office for approximately 18 months. We Care was audited by the state agency, several violations were identified related to case notes and billing, and it was concluded that Petitioner should have been providing his services at the We Care site rather than at his office. The administrator was notified of the overpayment of $276,000 but failed to respond or repay the overpayment. Petitioner states that because his Medicaid number was used by the administrator to file claims for reimbursement from Medicaid, the state agency pursued him and that he is currently paying the overpayment amount. Petitioner states that he has provided quality services in a professional manner and will continue to do so. He asserts that he provided the supervision required but the administrator failed to administer the program correctly. Petitioner states that he has never falsified any aspect of treatment; that he entered the agreement with the administrator of We Care in good faith; that he followed all guidelines of the state "Psychological Board" in providing supervision of the We Care staff; that the state agency did nothing for 18 months and the administrator did not reveal the results of the audit to him or take any action; that his only mistake was trusting the administrator as services were provided with appropriate supervision; that he would have made corrections immediately had he know of the issue; and that he was the victim of the irresponsibility and dishonesty of the administrator. I.G. Ex. 2.

Petitioner argues in his opposition to the I.G. motion for summary judgment that his reputation for professional competence and professional performance is high. He states that it was the We Care administrator's responsibility to administer the program. He denies having received the letter dated February 4, 2004 from the South Carolina Board of Examiners in Psychology responding to his January 30, 2004 letter, which advised him that he was responsible for complying with regulations for the employment and supervision of unlicensed persons providing psychological services, and that the Board of Examiners would not approve off-site supervision for such persons. I.G. Ex. 4. I note that the Board of Examiners' letter reflects Petitioner's correct mailing address at the time and Petitioner offers no explanation for why he did not seek an explanation for why he

received no response to his January 30, 2004 letter if no response was received. Petitioner states that he asked the administrator to address the concerns of the state agency but only later learned that the administrator failed to do so. Petitioner states that he cannot understand why the state agency's purported attempts to contact him were unsuccessful. Petitioner asserts that the administrator misrepresented himself to the state and Petitioner. Petitioner acknowledges that he met with the state agency but no demand for repayment of the overpayment was made to him and he thought the agency was going to pursue the administrator of We Care. Petitioner asserts that he would have terminated his association with We Care had he learned of the issues raised by the state agency. Petitioner states that he has always attempted to achieve the highest standards of professionalism and ethics as a clinical psychologist. He states the process has been complicated and tedious but he acted upon information from the administrator of We Care. Petitioner states that the administrator of We Care failed to take responsibility for his negligence but Petitioner has accepted responsibility and negotiated repayment with the state agency with great financial loss. Petitioner argues that his acts are indicative of his financial and professional integrity. He does desire to be reinstated in both Medicare and Medicaid.

I have carefully considered Petitioner's arguments and conclude that they do not establish grounds for any relief. My authority is limited to determining whether there is a basis for Petitioner's exclusion and I have found that there is a basis. For purposes of summary judgment I accept as true Petitioner's assertions of fact. However, the facts asserted do not affect the outcome. Petitioner permitted the administrator to use his billing privileges to bill Medicaid for Petitioner's services and the services of others. Petitioner cannot avoid his responsibility for the abuse of his billing privileges by the simple expedient of blaming the administrator for the abuse. The fact that Petitioner may not have received the Board of Examiners' letter stating off-site supervision would not be approved also does not affect the outcome. The Board's regulation is clear on its face that an unlicensed employee must work in the same physical location as the supervising psychologist unless the Board has approved other arrangements. I.G. Ex. 5, at 2. Petitioner requested approval from the Board of Examiners of his practice of meeting with unlicensed persons to review their work but not being at the same physical site when they delivered their services. I.G. Ex. 3. Even if Petitioner never received the letter from the Board of Examiners disapproving his practice, the regulation placed him on notice that he could not proceed in the manner he suggested absent specific approval of the Board. Furthermore, Petitioner was not excluded from the South Carolina Medicaid program for violation of the South Carolina regulation that required direct supervision of unlicensed personnel in the same physical location. Petitioner was excluded for failure to promptly

resolve the overpayment. I.G. Ex. 8. Petitioner does not dispute that he was excluded for failure to resolve the overpayment. Petitioner also does not dispute that the evidence shows that he did not begin repayment of the overpayment until he was notified of his exclusion, which was two years after the overpayment was declared. I.G. Ex. 8.

3. Permanent exclusion is not unreasonable.

Pursuant to section 1128(c)(3)(E) of the Act and 42 C.F.R. § 1001.601(b)(1) the period of Petitioner's exclusion from participation in Medicare shall not be less than the period of his exclusion from the state health care program. Petitioner was permanently excluded from the South Carolina Medicaid program. Accordingly, his permanent exclusion from Medicare is not unreasonable as a matter of law.

The period of exclusion is not in issue as the Act requires that Petitioner's exclusion from Medicare be not less than the period of his exclusion from the state Medicaid program. I have no authority to reduce the period of exclusion from permanent to a period of years, even if, I accept Petitioner's equitable arguments.

III. Conclusion

For the foregoing reasons, Petitioner is permanently excluded from participation in Medicare, Medicaid and all federal health care effective April 20, 2008, 20 days after the March 31, 2008, I.G. notice of exclusion.

/s/

Keith W. Sickendick
Administrative Law Judge