Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	
Sam Williams, Jr., M.D.,	DATE: September 24, 1993
Petitioner,	Docket No. C-93-014
- v. -	Decision No. CR287
The Inspector General.	

DECISION

By letter (Notice) of August 19, 1992,[1] the Inspector General (I.G.) notified Petitioner that he was being excluded from participation in the Medicare, Medicaid, and Maternal and Child Health Services Block Grant and Block Grants to States for Social Services programs for three years.[2] The I.G. told Petitioner that he was being excluded under section 1128(b)(3) of the Social Security Act (Act), based on Petitioner's conviction of a criminal offense related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Petitioner requested a hearing and the case was assigned to me. I scheduled an in-person hearing in this case to begin on March 16, 1993, in San Diego, California. On February 23, 1993, Petitioner requested a continuance of this hearing. I rescheduled the hearing to begin on March 25, 1993. However, during a telephone conference

---

[1] The only date reflected on the Notice is a date-stamped notation that Petitioner received the Notice on August 27, 1992. However, Petitioner has stipulated to the accuracy of the August 19, 1992 date. Petitioner's Objections to the I.G.'s Proposed Findings of Fact and Exhibits at page 1; I.G. Proposed Finding 5.

[2] Unless the context indicates otherwise, I use the term "Medicaid" hereafter to represent all programs other than Medicare from which Petitioner was excluded.

on March 17, 1993, Petitioner requested that his case be heard via the submission of written briefs and affidavits in lieu of an in-person hearing. The I.G. did not object to Petitioner's request. During this conference, Petitioner also: 1) waived his right to an in-person hearing; 2) stipulated that the I.G. had a basis upon which to exclude him; and 3) asserted that mitigating circumstances exist requiring that his period of exclusion be shortened. Specifically, Petitioner asserted that, pursuant to 42 C.F.R. § 1001.401(c)(3)(ii), no alternative sources of the type of health care items or services Petitioner furnishes are available.[3]

I have carefully considered the evidence submitted by the parties[4], their arguments, and the applicable laws and

---

[3] I use the following abbreviations when citing the parties' exhibits and briefs and my findings of fact and conclusions of law:

I.G.'s Exhibit	I.G. Ex. (number at page)
Petitioner's Exhibit	P. Ex. (number at page)
Petitioner's Brief	P. Br. (page)
I.G.'s Response Brief	I.G. Br. (page)
Petitioner's Reply Brief	P. R. Br. (page)
I.G.'s Reply Brief	I.G. R. Br. (page)
I.G.'s Proposed Findings	I.G. Prop. Find. (number)
Petitioner's Proposed Findings	P. Prop. Find. (number)
Petitioner's Declaration	P. Dec. (page)
My Findings and and Conclusions	Finding (number)

[4] Each party has objected to proposed exhibits submitted by the other party. The I.G. has proposed 18 exhibits in this case (I.G. Ex. 1 - 8, 10, and 12 - 20).

(continued...)

[4] (...continued)
The I.G. initially proposed I.G. Ex. 9 and 11 (I.G. Ex. 9 was a copy of an accusation made by the Medical Board of California (California Board) against Petitioner. I.G. Ex. 11 was a copy of a memorandum of agreement/surrender of registration between Petitioner and the Drug Enforcement Administration (DEA)). In his brief of April 26, 1993, Petitioner objected to these exhibits, arguing that the matters referenced by these documents are collateral to and have no bearing on this case. P. Br. 4. In the brief of June 28, 1993, the I.G. withdrew I.G. Ex. 9 and 11, giving as reasons the new regulations and Petitioner's stipulation conceding the I.G.'s authority to exclude Petitioner. I.G. Br. 3. However, with his reply brief, Petitioner now seeks to have I.G. Ex. 9 and 11 admitted as his P. Ex. 11 (the California Board action) and 12 (the D.E.A. settlement). P. Ex. 11 also includes a stipulation settling Petitioner's dispute with the California Board. Petitioner has submitted these exhibits in order to show the opinions of other "policing agencies" with regard to Petitioner's medical services. P. R. Br. 6. Also with his reply brief, Petitioner submitted P. Ex. 10, a letter in support of Petitioner from the counselor in charge of Petitioner's diversion program for impaired physicians. See P. R. Br. 6.

Petitioner has objected to the admission of I.G. Ex. 4, 5, 6, and 8 as irrelevant. Petitioner has objected to the admission of I.G. Ex. 12, because it does not provide a reference date or any self-authenticating information. Petitioner has objected to the admission of I.G. Ex. 14, because it does not provide the names of physicians who participated in Medi-Cal (the California Medicaid program) after the last quarter of 1992. Petitioner has objected to the admission of I.G. Ex. 17, because he believes the I.G.'s survey is distorted.

I reject as irrelevant I.G. Ex. 4, 5, 6, and 8. I admit I.G. Ex. 12 as authenticated by I.G. Ex. 13 and 19. I admit I.G. Ex. 14 as I find that the absence of physician data after the last quarter of 1992 does not render the prior data invalid. The subsequent data would be cumulative only. I admit I.G. Ex. 17 as I do not find the I.G.'s survey to be distorted. Further, I find that I.G. Ex. 12, 14, and 17 relate to my decision regarding the alleged existence of alternative sources of health care.

(continued...)

regulations. I conclude that, pursuant to the criteria specified in 42 C.F.R. § 1001.401, the three-year exclusion is reasonable.

ADMISSION

Petitioner does not dispute that he was convicted of a criminal offense within the meaning of section 1128(b)(3) of the Act. He admits that this is a proper basis for the I.G. to exclude him from participating in Medicare and Medicaid. March 23, 1993 Order (memorializing Petitioner's admissions at the March 17, 1993 telephone conference); P. Br. 3 - 4; P. Prop. Find. 3.

ISSUE

The only issue in this case is whether or not the length of Petitioner's exclusion should be shortened pursuant to 42 C.F.R. § 1001.401(c)(3)(ii).[5]

---

[4] (...continued)
The I.G. has objected to the admission of P. Ex. 1, 2, 3, 4, 7, 8, 10, 11, and 12 as irrelevant. The I.G. has objected to several paragraphs of P. Ex. 9 as the declarant's unsupported opinion, which is unreliable, relies on statistics not in evidence, covers matters on which the declarant is not qualified to testify as an expert, and is hearsay. I admit P. Ex. 1. I reject as irrelevant P. Ex. 2, 3, 4, 7, 8, 10, 11, 12, and pages 1, 2, 4, 5, and 6 of P. Ex. 9.

[5] Petitioner recognizes that, under the Act and regulations, I am unable to consider the circumstances surrounding his conviction as a mitigating factor shortening the length of his exclusion. However, Petitioner has requested that to the extent I can consider the circumstances of his conviction in addressing the reasonableness of his exclusion, I consider that he was isolated and targeted for prosecution while functioning as an impaired physician. P. Br. 3 - 4; P. Dec. 9 - 11. Petitioner contends that, by making this request, he is not seeking to challenge his criminal conviction or to revisit legal defenses raised pursuant to his conviction. Petitioner asserts that the mitigating factor in his case is 42 C.F.R. § 1001.401(c)(3)(ii). P. Br. 4. The only mitigating factors I can consider are those set out at section 1001.401(c)(3). Thus, I am unable to consider the
(continued...)

FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. Findings of Fact and Conclusions of Law by Agreement of the Parties[6]

1. On December 3, 1990, Petitioner, a physician, was charged in the San Diego Municipal Court with 12 felony counts of violating section 11153 of the California Health and Safety Code, based on his allegedly prescribing, without a legitimate medical purpose, the controlled substances Fastin, Prelu-2, and Tylenol with Codeine 3. I.G. Prop. Find. 1; I.G. Ex. 3.

2. On June 14, 1991, Petitioner pleaded guilty to Count 2 of the felony complaint, prescribing the controlled substance Fastin without a legitimate medical purpose. I.G. Prop. Find. 2; P. Prop. Find. 7; I.G. Ex. 2.[7]

---

[5] (...continued)
circumstances surrounding Petitioner's conviction as a mitigating factor shortening the length of his exclusion. To the extent that there are irregularities associated with his conviction, they must be raised in another forum. See my discussion of the regulations, infra.

[6] The findings of fact and conclusions of law in this section are based on I.G. Prop. Find. 1 - 15, 17 - 19, 23, 25, and 28, and on P. Prop. Find. 1 - 6, and 8. Neither party agreed with all of the other's proposed findings, but did agree with these specific findings of fact and conclusions of law. Petitioner's Objections to the I.G.'s Proposed Findings of Fact and Exhibits 1 - 2; I.G. Br. 26. Therefore, I have adopted these findings of fact and conclusions of law without substantive changes. I have, however, conformed the I.G.'s findings with Petitioner's, sequentially numbered them, deleted some that are not material to my Decision (i.e., P. Prop. Find. 1 and 2, which relate to the I.G.'s attempt to exclude Petitioner pursuant to other sections of the Act prior to his exclusion under section 1128(b)(3), and P. Prop. Find. 3, 5, and 6, which refer to procedural matters), and conformed their style with the style I use in other parts of this Decision.

[7] Petitioner asserts that he entered his plea of guilty on June 14, 1991, but that, under State law, a conviction does not result until the date of sentencing. Petitioner asserts further that his sentencing was delayed until August 27, 1991. Thus, Petitioner asserts
(continued...)

3. Petitioner was convicted of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance within the meaning of section 1128(b)(3) of the Act. I.G. Prop. Find. 3.

4. The Secretary of the Department of Health and Human Services (Secretary) delegated to the I.G. the authority to determine, impose, and direct exclusions pursuant to sections 1128(a) and (b) of the Act. I.G. Prop. Find. 4, 6; 48 Fed. Reg. 21,662 (1983).

5. By letter dated August 19, 1992, the I.G. excluded Petitioner for three years pursuant to section 1128(b)(3) of the Act. I.G. Prop. Find. 5; P. Prop. Find. 4.

6. Regulations published on January 29, 1992 establish criteria to be employed by the I.G. in determining to impose and direct exclusions pursuant to section 1128 of the Act. I.G. Prop. Find. 7, 8; 42 C.F.R. Part 1001 (1992).

7. On January 22, 1993, the Secretary published a regulation directing that the criteria to be employed by the I.G. in determining to impose and direct exclusions pursuant to sections 1128(a) and 1128(b) of the Act is binding on administrative law judges (ALJs), appellate panels of the Departmental Appeals Board (DAB), and federal courts in reviewing the imposition of exclusions by the I.G. I.G. Prop. Find. 9; 42 C.F.R. § 1001.1(b); 58 Fed. Reg. 5617, 5618 (1993).

8. My adjudication of the length of the exclusion in this case is governed by the criteria contained in 42 C.F.R. § 1001.401. I.G. Prop. Find. 10.

---

[7] (...continued)
that his date of conviction was August 27, 1991, not June 14, 1991. P. Prop. Find. 7. The I.G. asserts that Petitioner was convicted on June 14, 1991. I.G. Br. 1, 21. On Petitioner's plea of guilty (I.G. Ex. 2), the presiding Judge noted, "[t]he Court accepts defendant's plea, and the defendant is hereby convicted on his plea." This note was dated June 14, 1991. Therefore, from the record before me, it appears that Petitioner was convicted as of June 14, 1991. However, whether or not Petitioner was convicted as of June 14, 1991 or August 27, 1991, is immaterial to my Decision in this case. What is material to my decision is that Petitioner has, in fact, been convicted.

9. An exclusion imposed pursuant to section 1128(b)(3) must be for a period of three years, unless the aggravating or mitigating factors specified in the regulations form a basis for lengthening or shortening that period. I.G. Prop. Find. 11; 42 C.F.R. § 1001.401(c).

10. The I.G. has the burden of proving that aggravating factors as specified in the regulations are present in this case. I.G. Prop. Find. 12; 42 C.F.R. § 1005.15(c).

11. The I.G. did not allege that any aggravating factors were present in this case. I.G. Prop. Find. 13.

12. Petitioner has the burden of proving that mitigating factors exist to justify reducing an exclusion in a section 1128(b)(3) case to a period less than the three-year bench mark established by regulation. I.G. Prop. Find. 14; 42 C.F.R. § 1005.15(c).

13. Petitioner's office is located in southeast San Diego, California. I.G. Prop. Find. 17.

14. Petitioner practices internal medicine. I.G. Prop. Find. 18.

15. Prior to Petitioner's exclusion, more than 75 percent of Petitioner's patients were Medicare beneficiaries or Medi-Cal (the California Medicaid program) recipients. I.G. Prop. Find. 19; I.G. Ex. 15 at 1.

16. The offices of 11 Medi-Cal providers who practice internal medicine within 1.5 miles or less of Petitioner's office are located on streets served by public transportation. I.G. Prop. Find. 23.

17. There is an emergency care facility which treats Medicare and Medi-Cal patients located within 1.5 miles of Petitioner's office which is available to treat medical conditions requiring immediate attention at a time that a patient is unable to obtain medical care from a personal physician. I.G. Prop. Find. 25.

18. The Secretary did not intend that an otherwise reasonable exclusion be reduced because a provider's patients might be forced to obtain medical care from other comparable sources. I.G. Prop. Find. 28.

II. Other Findings of Fact and Conclusions of Law

19. Internists were once exclusively engaged in the practice of medicine related to cardiology, nephrology, gastroenterology, and allergy. They have now developed into a core of diagnosticians for the subspecialists of medicine. Internists generally practice medicine related to certain illnesses which afflict the elderly: arthritis, heart, kidney or liver dysfunction, high blood pressure, and diabetes. P. Dec. 6 - 7.

20. There are at least 11 physicians who practice internal medicine within 1.5 miles or less of Petitioner's office at 286 Euclid Avenue, San Diego, who are willing to accept new Medicare and Medi-Cal patients. I.G. Ex. 17 at 1 - 2; Finding 16.

21. There are at least six board-certified internists in southeast San Diego. I.G. Ex. 17 at 2, 18 at 3; I.G. R. Br. 8.

22. There are at least five board-eligible internists in southeast San Diego. I.G. Ex. 17 at 2, 18 at 3.

23. There are at least seven black internists and at least six black physicians engaged in general practice or family medicine in southeast San Diego. P. Dec. 5.

24. Petitioner began referring his Medi-Cal patients to other physicians by February 1992 and referred all his Medicare patients to other physicians by September 1992. P. Dec. 8.

25. Following Petitioner's exclusion, Malbour Watson, M.D., assumed the responsibility for almost all of Petitioner's patients covered under Medicare and Medi-Cal. P. Ex. 5 at 1; see also P. Dec. 12.

26. Richard Butcher, M.D., a colleague of Petitioner's in family practice, has provided alternative medical services to Petitioner's former Medicare patients. P. Dec. 12.

27. Petitioner did not prove that his former Medicare and Medi-Cal patients have been unable to establish a long term treatment relationship with another physician. See Findings 24 - 26.

28. Petitioner did not prove that obtaining access to alternative sources of medical care would create an unreasonable hardship for his former patients. See Findings 16 - 17, 20 - 27.

29. Petitioner did not prove that his racial identity is an essential component of the type of medical services he delivers.

30. Petitioner did not prove that the health care services provided by family or general practice physicians are not comparable or equivalent to the health care services that practitioners of internal medicine provide.

31. Petitioner did not prove that alternative sources of the type of health care items or services that he furnishes are not available.

32. Petitioner did not prove the presence of any mitigating factor under 42 C.F.R. § 1001.401(c)(3).

33. There is no basis in the regulations to modify Petitioner's three-year exclusion.

34. The three-year exclusion imposed by the I.G. is reasonable. Findings 1 - 33.

RATIONALE

Petitioner does not dispute that he was convicted of a criminal offense within the meaning of section 1128(b)(3) of the Act and that this gives the I.G. a basis to exclude him from participating in Medicare and Medicaid. Petitioner has stipulated that my adjudication of this case is governed by the criteria contained in 42 C.F.R. § 1001.401. The I.G. has imposed a three-year bench mark exclusion and contends that none of the factors for either lengthening or shortening an exclusion (identified by regulation as either aggravating or mitigating factors) are present in this case. Petitioner contends that there are circumstances defined by the regulations as mitigating which justify reducing his exclusion. Petitioner asserts that the weight of the evidence establishes that alternative sources of the type of health care items or services he provides are not available, and he cites the mitigating circumstance identified in 42 C.F.R. § 1001.401(c)(3)(ii). Thus, the only issue in this case is whether the length of Petitioner's exclusion should be shortened pursuant to 42 C.F.R. § 1001.401(c)(3)(ii); i.e., whether alternative sources of the type of health care items or services Petitioner furnishes are not available.

I. For the mitigating factor at 42 C.F.R. § 1001.401(c)(3)(ii) to apply, there must be evidence

proving that the consequence of a provider's exclusion is that health care services be reduced to a point where obtaining alternative health care would impose unreasonable hardships on Medicare and Medi-Cal beneficiaries and recipients.

A purpose of the exclusion law is to protect Medicare and Medicaid beneficiaries and recipients from providers who render inappropriate or inadequate care. The regulation at 42 C.F.R. § 1001.401(c)(3)(ii) contemplates that, in determining the appropriate duration of an exclusion, the fact finder will consider Congress' interest in ensuring the protection of Medicare and Medicaid beneficiaries and recipients and will balance that interest against the competing interest of ensuring that beneficiaries and recipients will not be deprived of needed health care as a result of a provider's exclusion. James H. Holmes, M.D., DAB CR270, at 15 - 16 (1993).[8]

As I observed in Holmes, the mitigating factor identified at 42 C.F.R. § 1001.401(c)(3)(ii) (that alternative sources of the type of health care items or services furnished by the individual or entity are not available) is not defined by statute. I found, however, that to qualify as an "alternative source" within the meaning of the regulations, the alternative source must provide health care items or services that are comparable or equivalent in quality to the type of items or services provided by the excluded provider. The alternative source must substitute for the items or services furnished by the excluded provider without jeopardizing the health of the recipients of those items or services. Id. at 13. The alternative source must also be "available." An alternative source is not available within the meaning of the regulation if beneficiaries and recipients cannot reasonably obtain the alternative health care. Id. at 14. Therefore, alternative sources of health care items or services of the type furnished by an excluded provider are not reasonably available if the beneficiary or recipient cannot use that source, such as

---

[8] In this Decision, I rely heavily on my decision in Holmes. In Holmes, I set forth the legal standard which I am following in this case, as the legal issues in both cases are identical. The petitioner in Holmes, as Petitioner here, was excluded for three years pursuant to section 1128(b)(3) of the Act. Both the petitioner in Holmes and Petitioner were excluded after January 29, 1992 (and before January 22, 1993). Both the petitioner in Holmes and Petitioner raised 42 C.F.R. § 1001.401(c)(3)(ii) as the sole mitigating factor.

if the alternative health care provider does not participate in Medicare or Medicaid. Id. at 14 - 15.

Regarding the geographic area that should be considered in determining whether a lack of alternative health care sources is a mitigating factor for purposes of 42 C.F.R. § 1001.401(c)(3)(ii), a provider must show that there are no available alternative sources of public transportation reasonably accessible for patients. Id. at 23. Moreover, where a provider demonstrates the lack of available alternative sources through the inadequacy of public transportation, the provider must go further and demonstrate that the use of other means of transportation would result in unreasonable hardship to that provider's former Medicare and Medicaid patients. Id. Mere inconvenience resulting from the use of other means of transportation will not suffice. Id. In short, the use of such other transportation must be so impractical that its use would be a bar to using alternative sources of health care. Id.

Thus here, as in Holmes, I conclude that, in order for the mitigating factor at 42 C.F.R. § 1001.401(c)(3)(ii) to apply, there must be evidence proving that the consequence of a provider's exclusion is that health care services would be reduced to a point where obtaining alternative sources of health care would impose unreasonable hardships on beneficiaries and recipients. Id. at 14. This is a far more stringent test to meet than showing merely a reduction in the availability of health care, since health care services are necessarily reduced when a provider is excluded. Id.

II. The burden of proving mitigating circumstances is on Petitioner.

It is both logical and consistent with the regulations at 42 C.F.R. § 1001.401 to place the burden of proving mitigating circumstances on Petitioner. This includes placing on Petitioner the burden of proving that alternative sources of the type of health care he furnishes are not available. The mitigating circumstances identified in the regulations are in the nature of affirmative defenses and the burden should fall on the excluded party to prove the existence of affirmative reasons for imposing less than the minimum exclusion set forth in the regulations. Furthermore, my decision is consistent with the burdens established in exclusions imposed under section 1128 of the Act prior to the promulgation of the current regulations and is consistent also with burdens that have been established in other kinds of cases in which the remedy is exclusion.

Holmes at 16 - 17; Bernardo G. Bilang, M.D., DAB 1295, at 10 (1992); 42 C.F.R. § 1005.15(b).

III. Petitioner has not met his burden of proof.

Based on my review of the evidence of record, I conclude that Petitioner has failed to sustain his burden of proving that alternative sources of the type of health care he provides are not available.

Petitioner practices internal medicine in southeast San Diego, California.[9] Findings 13, 14. On June 14, 1991, Petitioner was convicted of prescribing the controlled substance Fastin without a legitimate medical purpose. Finding 2. By letter dated August 19, 1992, the I.G. excluded Petitioner from Medicare and Medicaid for three years, pursuant to section 1128(b)(3) of the Act. Prior to his exclusion, more than 75 percent of Petitioner's patients were Medicare beneficiaries or Medi-Cal recipients. Finding 15. Petitioner's argument in mitigation of this three-year term is that alternative sources of the type of health care he provides (internal medicine) cannot be readily substituted for his medical services without jeopardizing the health of his Medicare and Medi-Cal patients. P. R. Br. 2.

A. Alternative sources of health care exist in southeast San Diego.

In support of this argument, Petitioner contends that the community (demographic area) within which I should consider whether alternative health care services are available is southeast San Diego, the location of Petitioner's practice. P. Br. 5.

Petitioner asserts that southeast San Diego is a community with significant Medicare, Medi-Cal, and other funded health care demands. P. Br. 5. Specifically, Petitioner states that: 1) the population served is 26 percent black, 31 percent Hispanic, 20 percent Asian, and less than 22 percent white non-Hispanic; 2) approximately 250,000 minorities reside in southeast San Diego; and 3) rendering services to this southeast San Diego community are seven black internists and six black physicians in general or family practice (not certified in internal

---

[9] Petitioner has not specifically defined what he means by southeast San Diego. The I.G. has defined it as the area within a two-mile radius of Petitioner's office. I.G. Br. 9. Petitioner has not objected to this definition. P. R. Br. 1 - 8.

medicine). P. Dec. 5; Finding 23.[10] Petitioner asserts that my consideration should be limited to this community due to the lack of available public transportation within southeast San Diego and the inability of residents of that community to travel to other areas of San Diego for treatment. P. R. Br. 2. He asserts further that such areas outside of southeast San Diego are: 1) "white and upper middle class;" 2) not "inviting" to Petitioner's minority patients; and 3) not available to Medicare and Medi-Cal patients since less than 10 percent "have their own means of private transportation." P. R. Br. 3.

In response to this argument, the I.G. asserts that there are numerous Medicare and Medi-Cal providers practicing internal medicine in the southeast San Diego community and, therefore, consideration of providers outside this limited area of San Diego is unnecessary. I.G. Br. 8. The existence of alternative providers is demonstrated by Petitioner's post-exclusion referral of his Medicare and Medi-Cal patients to Drs. Malbour Watson and Richard Butcher. Findings 25, 26.[11] Moreover, assuming that there were not an adequate number of Medicare and Medi-Cal providers in southeast San Diego -- thereby supporting the conclusion of a lack of alternative sources of health care in that community -- the record does not support Petitioner's assertion of a lack of public transportation and the unwillingness of physicians in other areas to take new Medicare or Medi-Cal patients.

---

[10] Dr. Richard O. Butcher, president of the National Medical Association, indicated that one of his roles is to get physicians to service Medicare and Medi-Cal patients in southeast San Diego; he alleges it is difficult to recruit physicians in that area due to the low reimbursement rate for services covered under Medicare and Medi-Cal. P. Ex. 1 at 1. In apparent contradiction of his own witness, Petitioner asserts that at least 13 physicians provide health care to this community. Finding 23.

[11] Petitioner asserts that these physicians cannot carry the burden of all his former program patients. P. Dec. 12. Considering the other alternative medical sources available to any patient who could not be accommodated by these physicians, there is no hardship arising from any further referrals for medical care.

B. Alternative sources of health care exist outside southeast San Diego also.

The I.G. points out that the public transportation system in San Diego County, including southeast San Diego, provides ample means by which Petitioner's former Medicare and Medi-Cal patients can seek alternative sources of health care.[12] I.G. Br. 9; I.G. Ex. 16. Petitioner's contention that some of his patients are too frail to use public transportation to travel to areas outside southeast San Diego is ill founded; Petitioner has offered no proof to support it. Further, I find Petitioner's contention to be suspect. If I accept Petitioner's claim that only 10 percent of his Medicare and Medi-Cal patients have access to private transportation, then 90 percent would have to either walk or use public transportation to get to his office. Considering their alleged infirmities, Petitioner would have only a minimal number of Medicare or Medi-Cal patients. Such a conclusion is not borne out by this record. Responding to Petitioner's unsupported contention that physicians outside the southeast San Diego community (in communities such as La Jolla, Hillcrest, or the beach areas) would not accept new Medicare and Medi-Cal patients, the I.G. surveyed physicians in these three areas and, contrary to Petitioner's contention, identified two physicians in each area who would accept new Medicare and Medi-Cal patients.[13] Petitioner's unsupported argument that such areas are uninviting to his black patients is unpersuasive and without support in the record. The test for purposes of this mitigating factor is that seeking alternative sources would impose an unreasonable burden on his former Medicare and Medi-Cal patients. In short, travel to such areas would have to impose a bar to their receiving health care. Even assuming there is discomfiture associated with travel to these communities,

---

[12] I.G. Ex. 16 identifies the sources of public transportation in metropolitan San Diego which provide both services within southeast San Diego and from southeast San Diego to other communities in metropolitan San Diego such as La Jolla, Hillcrest or the beach areas.

[13] The I.G. identified Mission Beach (selected as a "beach area") as a community within San Diego approximately 9 - 10 miles from Petitioner's office. La Jolla, also abutting the ocean, was identified as being 17 - 20 miles from Petitioner's office. Finally, Hillcrest, an area within the City of San Diego, was identified as being approximately 6 - 7 miles from Petitioner's office. I.G. Br. 11.

Petitioner has failed to prove that such discomfort rises to the level of being an unreasonable burden.

Petitioner has failed to establish that the geographic area that must be considered in applying the mitigating factor regarding an alternative source of medical care should be limited to southeast San Diego. He has failed to show that there are no other physicians practicing internal medicine who are not accessible to his former Medicare and Medi-Cal patients through the use of public transportation and that use of such public transportation would result unreasonable hardship. Even assuming public transportation was not available, he further has failed to establish that use of other means of transportation would be impractical and would pose a barrier to obtaining access to alternative sources of medical care.

C. Other health care providers can provide health care items or services to Petitioner's Medicare and Medi-Cal patients comparable to those provided by Petitioner.

Petitioner argues that I should consider his services against the services of other internists only, not against the services of other family or general practice physicians in his community. Petitioner asserts "that the minority physicians available within the [southeast San Diego] community are lacking board-certification and training as internists and are therefore unable to render the type of medical services" that Petitioner provided his former Medicare and Medi-Cal patients. P. Br. 6. Implicit in this contention is that Petitioner's racial status makes him unique and that the provision of health care to his former patients by non-black physicians will result in hardship for his former patients. P. Br. 6 - 7.

Petitioner argues further that, to the extent there are licensed internists in the southeast San Diego community, they are not accepting referrals, as their caseload is at maximum capacity. He contends that referral of his former patients to family or general practice physicians would result in their receiving care of a lesser quality since such practitioners are limited in the medical services that they can render to patients. Id. at 6 - 7.

The I.G. responds by arguing that there is no support for Petitioner's assertion that black physicians in southeast San Diego are lacking board certification and training as internists and therefore cannot render equivalent service to his former Medicare and Medi-Cal patients. I.G. Br. 12. Further, the I.G. has identified 11 Medicare and

Medi-Cal providers located within 1.5 miles of Petitioner's office who are practicing internal medicine and who are willing to accept new Medicare and Medi-Cal patients. Id. at 12 - 15; I.G. R. Br. 3; Finding 20.[14] These results were based on a recent I.G. survey of the offices of such physicians, which determined their specialization through the use of: 1) the American Board of Medical Specialties' Compendium of Certified Medical Specialists, Vol. 2, Internal Medicine 717 (2nd ed. 1988-89); and 2) the 1991 San Diego County Medical Society Membership Directory. I.G. Br. 12 - 14; I.G. R. Br. 15 - 16.[15]

Among the physicians identified by the I.G. survey were two internists, Drs. Rodney Hood and Camille Henry, whose offices are in the same building in which Petitioner's office is located. I.G. Ex. 17 at 2. In addition, at locations in the immediate vicinity of Paradise Valley Hospital (which is approximately 1.5 miles south of Petitioner's office (Id. at 3; see Finding 17)) are the offices of internists Terrance W. Crouch, James Kyle, Matthew Williams, Ben Medina, Genaro Fernandez, Jasmine Chow, Jerome Robinson, Lennie de la Paz, and David Chang. I.G. Ex. 17 at 1 - 3. All of these physicians are located on streets where public transportation is available. Id. at 3; Finding 16. Finally, these physicians have all indicated to the I.G. that they will accept new Medicare and Medi-Cal patients. I.G. Ex. 17 at 1 - 2; Finding 20.

Petitioner challenges the qualifications of a number of the physicians identified by the I.G. He claims that Drs. Chang, de la Paz, and Robinson are specializing in family practice or general medicine and are not board-certified internists. He concludes that they "are not qualified as to their training, years of practice, certification or areas of specialization." P. R. Br. 3.

---

[14] In addition to these providers, there is an emergency care facility which treats Medicare and Medicaid patients located within 1.5 miles of Petitioner's office which is available to treat medical conditions requiring immediate attention at a time that a patient is unable to obtain medical care from a personal physician. Finding 17.

[15] The I.G. requested that I take judicial notice of these publications, as they are public documents. I.G. Br. 13. In his reply brief, Petitioner could have, but did not, object to my taking such notice.

He also questions the manner in which the I.G's survey was conducted and points out that the results are in contrast with information Petitioner obtained when he was first excluded. Id. at 4.

Such arguments have no merit. Petitioner offers no evidence to support his assertions concerning the deficiencies in the survey conducted by the I.G. In contrast, by referencing these physicians' status with regard to board-certification or eligibility as described in the Compendium of Certified Medical Specialists and in the I.G. survey, the I.G. has reaffirmed that the physicians referenced by Petitioner are either board certified or eligible. I.G. R. Br. 7 - 9; I.G. Ex. 17, 18. By relying on the same sources, the I.G. has established that, of the 11 southeast San Diego physicians surveyed, six are board-certified internists and five are board-eligible. I.G. R. Br. 8 - 9. Of equal significance, Petitioner has failed to establish that the health care services provided by either board-eligible internists or family or general practice physicians are not comparable or equivalent to the health care services provided by Petitioner. To establish this, Petitioner would have had to show some clear diminution in the quality of health care by these alternative providers. Petitioner has provided no evidence to show such diminution in this case.

Finally, Petitioner asserts that his status as a black physician makes his provision of medical services to the minority community unique, and his exclusion (as a black physician who now has to refer his patients to other primary care physicians) has imposed a hardship on his former patients. P. Br. 6. I find this argument unpersuasive. Specifically, I find that for race to be a relevant factor with regard to whether alternative sources of health care are available, I would have to find that a petitioner's race "is an essential component of the medical items or services he delivers." Holmes at 25. Petitioner has not made such a showing in this case. Furthermore, Petitioner has not proved that he is the only available black internist who can serve Medicare and Medi-Cal patients in the southeast San Diego community.

Petitioner concedes that there are seven black internists and six black physicians engaged in family practice who serve the southeast San Diego community. Finding 23. He admits also that at least one black internal medicine physician is accepting referrals from his practice although he claims this physician cannot accommodate the total demand from Petitioner's former practice. P. Dec. 12. Additional medical care is provided to his former

patients by family practice physicians Drs. Malbour Watson and Richard Butcher.[16] Id. Dr. Watson practices in the same location as Petitioner and is accepting almost all of Petitioner's patients covered under Medicare and Medi-Cal. P. Ex. 5.

Thus, the record supports that there are an ample number of physicians, including a number of black physicians, 1) who practice either internal medicine or family practice; 2) who will accept new Medicare or Medicaid patients; and 3) whose office locations are within 1.5 miles of Petitioner's office. Considering the availability of public transportation within the southeast San Diego community, Petitioner's former Medicare and Medi-Cal patients can receive alternative sources of health care in that community or by travelling to other nearby communities such as La Jolla, Hillcrest, or the beach areas. Thus, there is no showing by Petitioner that having to obtain alternative sources of health care imposes an unreasonable hardship on his former Medicare and Medi-Cal patients.

D. None of Petitioner's other arguments mitigate against the reasonableness of his exclusion.

However, while Petitioner asserts that the only mitigating factor in this case is whether or not alternative health care sources exist, Petitioner has asked me to consider also "objective indicia" of his medical practice. P. R. Br. 5. Petitioner asserts that such indicia include his standing in the community, his reputation among his medical colleagues, and his personal attributes. He asserts that these indicia reflect upon his integrity, medical expertise, humanity, and the quality of the medical services he renders. However, it is not appropriate for me to consider such factors in evaluating the existence of alternative sources of health care. Besides the extreme difficulty of measuring the relative value of such intangible characteristics, such factors are, for the most part, unique to the individual possessing them. Giving weight to such factors in determining whether an exclusion is reasonable would amount to rendering every practitioner a sole source for the purposes of 42 C.F.R. § 1001.401(c)(3)(ii). Such a

---

[16] The I.G. correctly points out that Petitioner's referral of his patients to family practice physicians suggests that Petitioner believes these physicians are competent and seriously undercuts his claim that such physicians provide care which is inferior to that of internists. I.G. Br. 19 - 20.

principle would make this mitigating factor meaningless. Also, assuming that I accepted such criteria as an appropriate formula for measuring Petitioner's qualities for purposes of this mitigating factor, Petitioner has offered no proof that the physicians who have been identified as providing alternative sources of health care are lacking in any of these criteria.

Petitioner asks me to consider the opinions of the "policing agencies" (the Medical Board and the DEA) and how they reflect favorably on Petitioner's rehabilitation. P. R. Br. 5 - 8. However, while evidence as to Petitioner's character, reputation, and medical competence may have been persuasive had I been evaluating this exclusion under the general "trustworthiness" criteria by which I would have judged the reasonableness of the length of Petitioner's exclusion prior to the promulgation of the regulation at 42 C.F.R. § 1001.401, I find that it does not bear directly on whether alternative sources of the type of health care items or services Petitioner furnishes (internal medicine) are available.

Petitioner asks me to consider also the impact of his exclusion on his practice of internal medicine. Petitioner asserts that a large part of his practice over recent years has consisted of Medicare and Medi-Cal patients and that his exclusion may mean the "death knell" of his practice as he cannot sustain an inner-city practice without participating in Medicare and Medi-Cal. P. Br. 5 - 6; P. Dec. 7 - 9, 13. Again, I find that this argument does not directly address whether or not alternative sources of medical care exist. The adverse economic impact of the exclusion on Petitioner's practice is irrelevant to my decision here. See Anesthesiologists Affiliated, et al., DAB CR65, at 65 (1990), aff'd, 941 F.2d 678 (8th Cir. 1991). The only relevant inquiry is, if Petitioner is no longer available to provide his services, whether alternative sources of medical care are reasonably available.

Petitioner states that he defers to my "discretionary powers under the provisions of 42 C.F.R. [§] 1001.401(c)(3)(ii)" to shorten the length of his exclusion. P. R. Br. 8. However, under section 1001.401(c)(3)(ii), I have no discretion to modify a petitioner's three-year minimum exclusion where a petitioner has failed to establish the existence of a mitigating factor. Here, Petitioner has the burden of proof and he has not met it.

CONCLUSION

Petitioner has failed to meet his burden of proving that no alternative sources of the type of health care items or services he provides are available. Consequently, the three-year exclusion imposed and directed against Petitioner is reasonable.

/s/

Edward D. Steinman
Administrative Law Judge