Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Cully Richard White, D.O.
(OI File No. H-16-41620-9),

Petitioner

v.

The Inspector General.

Docket No. C-17-7

Decision No. CR4827

Date: April 19, 2017

DECISION

The Inspector General (IG) of the United States Department of Health and Human Services excluded Petitioner, Cully Richard White, D.O., from participation in Medicare, Medicaid, and all federal health care programs based on Petitioner's conviction for wire fraud that was in connection with the delivery of a health care item or service. For the reasons discussed below, I conclude that the IG has a basis for excluding Petitioner. I affirm the mandatory five-year exclusion, and I also affirm that the effective date of Petitioner's exclusion is August 18, 2016.

I. Background

By letter dated July 29, 2016, the IG notified Petitioner that, pursuant to section 1128(a)(3) of the Social Security Act (Act), 42 U.S.C. § 1320a-7(a)(3), he was being excluded from participation in Medicare, Medicaid, and all federal health care programs for a minimum period of five years, effective 20 days from the date of the letter. IG Exhibit (Ex.) 1 at 1. In the letter, the IG informed Petitioner of the factual basis for the exclusion, stating:

> This exclusion is due to your felony conviction as defined in section 1128(i) (42 U.S.C. 1320a-7(i)), in the United States District Court, Eastern District of Wisconsin, of a criminal offense related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care item or service, including the performance of management or administrative services relating to the delivery of such items or services, or with respect to any act or omission in a health care program (other than Medicare and a State health care program) operated or financed by, or financed in whole or in part, by any Federal, State, or local Government agency.

IG Ex. 1 at 1. The IG informed Petitioner that the exclusion period would be for the statutory minimum period of five years. IG Ex. 1 at 1.

Petitioner, through counsel, timely filed a request for hearing before an administrative law judge (ALJ) on September 30, 2016. On November 2, 2016, I convened a prehearing conference by telephone pursuant to 42 C.F.R. § 1005.6, during which I clarified the issues of the case and established a schedule for the submission of pre-hearing briefs and exhibits. I memorialized the schedule and summary of the pre-hearing conference in my Order and Schedule for Filing Briefs and Documentary Evidence (Order), issued on November 3, 2016.

Pursuant to the Order, the IG filed an informal brief (IG Br.) along with five proposed exhibits (IG Exs. 1-5). Petitioner thereafter filed his informal brief (P. Br.). The IG then filed a reply brief (IG Reply). In the absence of any objections, I admit the parties' submissions and exhibits into the record.

Neither party asserts that an in-person hearing is necessary. I will decide this case on the written submissions and documentary evidence. *See* Order, § 5(b).

II. Issue

The issue in this case is whether there is a basis for exclusion; if so, I must uphold the five-year minimum period of exclusion. 42 U.S.C. § 1320a-7(c)(3)(B); 42 C.F.R. § 1001.2007(a)(1).

III. Jurisdiction

I have jurisdiction to decide this case. 42 U.S.C. § 1320a-7(f)(1); 42 C.F.R. § 1005.2.

IV. Findings of Fact, Conclusions of Law, and Analysis[1]

1. Petitioner's conviction for wire fraud requires his exclusion from Medicare, Medicaid, and all federal health care programs for a minimum of five years.

The Act requires the exclusion of any individual or entity from participation in Medicare, Medicaid, and all federal health programs based on four types of criminal convictions. 42 U.S.C. § 1320a-7(a). In this case, the IG relied on section 1320a-7(a)(3) as the legal basis to exclude Petitioner, which states:

> (a) Mandatory exclusion
>
> The Secretary shall exclude the following individuals and entities from participation in any Federal health care program (as defined in section 1320a–7b(f) of this title):
>
> * * *
>
> (3) Felony conviction relating to health care fraud
>
> Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

42 U.S.C. § 1320a-7(a)(3).[2]

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[1] My findings of fact and conclusions of law are set forth in italics and bold font.

[2] While there are slight differences in the wording of Section 1128 of the Act and its codification at 42 U.S.C. § 1320a-7, the two authorities are substantively identical and I refer to them interchangeably. I further note that the Secretary of the Department of Health and Human Services (Secretary) has delegated to the IG the authority "to suspend or exclude certain health care practitioners and providers of health care services from participation in these programs." 48 Fed. Reg. 21,662 (May 13, 1983); *see also* 42 C.F.R. § 1005.1.

The IG argues that Petitioner's exclusion is required based on his conviction for wire fraud because it is a felony conviction related to fraud that was committed in connection with the delivery of health care items or services. IG Br. at 4-8; IG Reply at 1-3. Petitioner does not dispute that, for purposes of the Act, he has a "conviction" for wire fraud. P. Br. at 1-2; 42 U.S.C. § 1320a-7(i)(3), (4). However, Petitioner argues, as relevant to the discussion herein, that his felony conviction does not mandate exclusion because it is not related to a government health care program, did not involve the delivery of a health care item or service, and is not related to health care fraud. P. Br. at 3-10. As explained below, I reject Petitioner's arguments and I conclude that Petitioner's conviction for wire fraud mandates his exclusion.

On May 14, 2013, a grand jury in the Eastern District of Wisconsin returned a true bill of indictment charging that Petitioner committed 13 counts of health care fraud, in violation of 18 U.S.C. §§ 2 and 1347. IG Ex. 3 at 2. The indictment charged the following, with respect to the 13 offenses:

CULLY R. WHITE

> In connection with the delivery and payment for health care benefits, items, and services, did knowingly and willfully execute and attempt to execute a scheme to defraud health care benefit programs, and to obtain money from health care benefit programs by means of material false and fraudulent pretenses and representations (hereinafter the "scheme"), which is more fully described below.

IG Ex. 3 at 2. The indictment charged that Petitioner "knowingly and willfully executed and attempted to execute his scheme to defraud health care benefit programs, including private companies providing health insurance, and to obtain money from health care benefit programs by means of material false and fraudulent pretenses and representations . . . by submitting and causing to be submitted a claim in the indicated amount to the indicated insurance company seeking payment for intra-operative nerve monitoring and related services, which White falsely reported had been provided . . . ." IG Ex. 3 at 4. In explaining the offense conduct, the indictment provided the following details:

> White's scheme was essentially as follows:
>
> a. In approximately October 2010, White recruited K.B., a doctor of osteopathic medicine licensed to practice in the State of Wisconsin, to prepare reports reflecting that K.B. had conducted intra-operative nerve monitoring during surgical procedures performed by White. White agreed to pay K.B. $150 for each report K.B. prepared.

b. White provided K.B. with examples of reports reflecting intra-operative nerve monitoring and agreed to provide K.B. with the necessary information to prepare such reports.

c. K.B. had no training or experience in performing intra-operative nerve monitoring and never performed monitoring of White's surgical procedures. Instead, after White completed surgical procedures, White provided K.B. with the necessary information to prepare monitoring reports.

d. Based on the information provided by White, K.B. prepared reports falsely representing that K.B. had performed intra-operative nerve monitoring during surgical procedures performed by White. In fact, K.B. was not present, did not monitor, and did not become aware of the procedures until after they were completed and White provided K.B. with the necessary information to prepare the reports.

e. Using the reports prepared by K.B. White submitted claims to health care benefit programs, including private companies providing health insurance, fraudulently seeking payment for services purportedly provided by K.B.

IG Ex. 3 at 3.

Several months later, Petitioner, with the benefit and advice of counsel, entered into a plea agreement, at which time the United States contemporaneously filed an information, on September 26, 2013, charging the single count of wire fraud to which Petitioner would plead guilty pursuant to the plea agreement. IG Ex. 4. The information charging wire fraud provided a nearly verbatim description of Petitioner's scheme as was contained in the indictment for health care fraud, stating:

a. In approximately October 2010, White recruited K.B., a doctor of osteopathic medicine licensed to practice in the State of Wisconsin, to prepare reports falsely reflecting that K.B. had conducted intra-operative nerve monitoring during surgical procedures performed by White. White agreed to pay K.B. $150 for each report K.B. prepared.

b. White provided K.B. with examples of reports reflecting intra-operative nerve monitoring and agreed to provide K.B. with the necessary information to prepare such reports.

c. K.B. had no training or experience in performing intra-operative nerve monitoring and never performed monitoring of White's surgical procedures. Instead, after he completed surgical procedures, White provided K.B. with the necessary information to prepare monitoring reports.

d. Based on the information provided by White, K.B. prepared reports falsely representing that K.B. had performed intra-operative nerve monitoring during surgical procedures performed by White. In fact, K.B. was not present, did not monitor, and was not aware of the procedures until after they were completed when White provided K.B. with the necessary information to prepare the reports.

e. Using the reports prepared by K.B., White submitted claims totaling approximately $265,000 to insurance companies fraudulently seeking payment for services purportedly provided by K.B.

IG Ex. 4 at 16-17. While the offense conduct was essentially identical, the information charged a violation of 18 U.S.C. §§ 2 and 1343, wire fraud, rather than health care fraud as had been charged in the 13-count indictment. The information charged that Petitioner "knowingly and willfully executed and attempted to execute his scheme to defraud to obtain money by means of material false and fraudulent pretenses and representations, which scheme is more fully described above, by causing a claim in the amount of $3,720 to be submitted electronically from Milwaukee, Wisconsin to Humana, Inc., an insurance company with a billing address located in Lexington, Kentucky, seeking payment for intra-operative nerve monitoring and related services, which White falsely represented had been provided by K.B. to patient K.M.S., on whom White performed surgery on December 13, 2010." IG Ex. 4 at 17-18.

In entering into a plea agreement, Petitioner agreed that he was guilty of the offense charged in the information. IG Ex. 4 at 1-2. The plea agreement stated, in pertinent part:

> During the period from November 2010 through October 2011, and at White's request, K.B. prepared and provided to White approximately 100 reports reflecting that K.B. had conducted intra-operative nerve monitoring during surgical procedures performed by White. White paid K.B. $14,850 for these reports. K.B. was not qualified to and did not perform intra-operative nerve monitoring during White's surgical procedures. In fact, K.B. only became aware that White had performed surgery after the surgery was completed when White provided K.B. with the necessary information to prepare a monitoring report.

> Using the report prepared by K.B., White fraudulently submitted claims totaling approximately $265,000 to various insurance companies, seeking payment for the monitoring services K.B. purportedly provided. Based on these claims, the insurance companies paid White approximately $82,000.
>
> The charge set forth in the information to which White has agreed to plead guilty is based on claims in the amount of $3,270 White caused to be electronically submitted from Milwaukee, Wisconsin to Humana, Inc., in Lexington Kentucky. White initially submitted the claims to Humana on March 24, 2011, and resubmitted the claims on July 4, 2011.
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> In these claims, White sought payment for intra-operative nerve monitoring and related service White falsely represented had been provided by K.B. during a surgical procedure. White performed on patient K.M.S. on December 13, 2010. Based on these claims, Humana ultimately paid White $3,251.50.

IG Ex. 4 at 3-4.

Petitioner pleaded guilty to the count contained in the information, and the 13 counts charged in the indictment were dismissed on the motion of the United States. IG Ex. 5 at 1. On April 23, 2014, a United States District Judge imposed judgment, at which time she adjudicated Petitioner guilty of a single count of wire fraud in violation of 18 U.S.C. § 1343. IG Ex. 5 at 1. The United States District Judge ordered Petitioner be committed to the custody of the United States Bureau of Prisons for a term of six months, and ordered that Petitioner "shall comply with the conditions of home confinement for a period not to exceed 180 days" during the two-year term of supervised release that would follow his release from imprisonment. IG Ex. 5 at 2-4. The United States District Judge also imposed a fine of $60,000, and ordered restitution in the amount of $643.50 payable to United Wisconsin Insurance Co. IG Ex. 5 at 5.

Petitioner primarily argues that because his "conviction is not for fraud involving a public health program, the public health program exclusion of 42 U.S.C. § 1320a-7(a)(3) is not triggered and may not be imposed by the I.G." P. Br. at 2. Petitioner, citing to a District Court decision involving an irrelevant provision of law, 42 U.S.C. § 1320a-7(a)**(1)**, argues that the IG's interpretation of 42 U.S.C. § 1320a-7(a)(3) is "contrary to Congress's intent to exclude providers from public health care programs only in response to a conviction related to such public health care programs . . . ." P. Br. at 2. Petitioner argues that "[t]he I.G. uses a disjunctive 'or' to break up the statute and to ignore the requirement that a felony conviction for fraud must relate to a health care item, service, or program operated of financed by a government agency before a Medicare exclusion may be imposed." P. Br. at 2. Petitioner further contends that the IG's citation to *Ellen L. Morand,* DAB No. 2436 (2012) is flawed, and that the ALJ's reliance on the same case

during the November 2, 2016 pre-hearing conference "suffers from the same infirmities as the I.G.'s approach." P. Br. at 3. Contrary to these allegations, there is no "infirmity" with respect to Petitioner's exclusion based on section 1320a-7(a)(3). Petitioner has not shown that the plain language of 42 U.S.C. § 1320a-7(a)**(3)**, the congressional intent for that statutory authority, or his own interpretation of the provision through creative grammatical analysis and sentence diagraming, supports that a conviction must involve a government health care program to mandate exclusion pursuant to 42 U.S.C. § 1320a-7(a)(3).

The plain language of the statutory provision at issue involving a felony conviction related to health care fraud is clear, and applies to an individual who, after August 21, 1996, has a felony conviction that was "in connection with the delivery of a health care item or service *or* with respect to any act or omission in a health care program [other than those outlined in 42 U.S.C. § 1320a-7(a)(1)] operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct." 42 U.S.C. § 1320a-7(a)(3) (emphasis added). Petitioner argues that the "or" in section 1320a-7(a)(3), when read properly to take into account Congress's "intent to exclude from public health programs persons who have been convicted of felony fraud related to public health care programs," requires that a conviction mandating exclusion under section 1320a-7(a)(3) involve a public health care program.

Even though Petitioner speaks extensively to the purported congressional intent underlying section 1320a-7(a)(3), he does not cite to *any* authority evidencing congressional intent. In fact, the District Court decision he relies upon in support of his argument pertains to a different subsection, 42 U.S.C. § 1320a-7(a)(1).[3] Since the plain language of the statute mandates that exclusion is warranted under section 1320a-7(a)(3) in such a circumstance where Petitioner has a conviction relating to health care fraud after August 21, 1996, and that conviction was "in connection with the delivery of a health care item or service," there is no need to look to the congressional intent. Further, Petitioner has not demonstrated there is any ambiguity in the plain language of the statute at issue. *See, e.g., Estate of Cowart v. Nicklos Drilling Co.*, 505 U.S. 469, 475 (1992) ("In a statutory construction case, the beginning point must be the language of the statute, and when a statute speaks with clarity to an issue judicial inquiry into the statute's meaning, in all but the most extraordinary circumstance, is finished.").

[3] Section 1320a-7(a)(1), the provision discussed in the District Court case cited by Petitioner, specifically pertains to a criminal offense related to the delivery of an item or service under Medicare or a state health care program. That provision is inapplicable to this case, since Petitioner's fraud involved improper billing to insurance companies, rather than Medicare or a state health care program.

Petitioner argues that "[t]he statute is not a model of clarity" (P. Br. at 4), and even presuming Petitioner is correct and the plain language is unclear, the Courts, the Departmental Appeals Board (Board), and Congress have all addressed the intent of section 1128(a)(3). Petitioner has not identified *any* authority showing that Congress did not intend not to mandate exclusion in such an instance unless a government program was involved in the fraud.[4] "It is well-established that section 1128 exclusions are remedial in nature, rather than punitive, and are intended to protect federally-funded health care programs from untrustworthy individuals." *Donald A. Burstein, Ph.D.,* DAB No. 1865 at 12 (2003), *citing Patel v. Thompson*, 319 F.3d 1317 (11th Cir. 2003), *cert. denied*, 123 S. Ct. 2652 (2005); *see Manocchio v. Kusserow*, 961 F.2d. 1539, 1543 (11th Cir. 1992) (discussing legislative history of IG exclusions prior to the enactment of section 1320a-7(a)(3) and that the mandatory exclusionary period "strengthens the ability of the Secretary of [HHS] to exclude from Medicare and Medicaid those health care providers and practitioners who fail to provide quality health services or *who have engaged in fraud involving health care programs*." (citing 133 Cong. Rec. 20,922 (statement of Sen. Bentsen)) (emphasis added). Petitioner executed a scheme in which he claimed that he was utilizing intra-operative nerve monitoring, and he sought reimbursement from insurance companies for such services that were not provided to his patients. Petitioner is exactly the type of untrustworthy individual that Congress contemplated when it added section 1320a-7(a)(3). Congress, in excluding untrustworthy individuals from government health care programs such as Medicare, focused on individuals who have committed specified felony offenses that demonstrate that the individual is untrustworthy and should not have access to Medicare, Medicaid, and other federal health care programs. *See* Testimony of Michael Mangano, Principal Deputy Inspector General of HHS, before the Senate Committee on the Judiciary on May 24, 1994, requesting that Congress add the exclusion authority that was eventually enacted as section 1128(a)(3): "The current permissive exclusion for individuals or entities, in connection with delivery of health care items or services, of fraud or financial misconduct should be mandatory. A criminal conviction related to delivery of an item or service in Medicare or a State health care plan are currently the basis of a mandatory exclusion." 1994 WL 236114.

While Petitioner argues to the contrary, the Act does not require that Petitioner's offense be related to a government health care program. *Ellen L. Morand*, DAB No. 2436 at 9 (2012), citing *Breton Lee Morgan, M.D.*, DAB No. 2264 at 6 (2009) (stating that the use of the disjunctive word "or" in section 1128(a)(3) means that exclusion is mandated "for

[4] Petitioner also urges that pursuant to *Chevron U.S.A. v. Natural Resources Defense Council*, 467 U.S. 837, 824-43 (1984), I must "give effect to Congress's intent by adopting the grammatically correct interpretation" of the statute. P. Br. at 6. Again, Petitioner offers no evidence of Congress's intent. Further, the *Chevron* decision discusses that a federal agency's interpretation of a statute should be afforded deference if the statute is silent or ambiguous with respect to the question in issue.

either a crime committed 'in connection with the delivery of a health care item or service' or a crime that involved an act or omission in a government-funded health care program."). *See also W. Scott Harkonen, M.D.*, DAB No. 2485 at 9 (2012) (Board's discussion, in a wire fraud case that did not involve a loss to government programs, stating: "The Board's application of the phrases 'in connection with the delivery of a health care item or service' and 'related to the delivery of an item or service under title XVIII or under any State care health care program' effectuates the twin purposes of section 1128(a): 1) to protect federal health care programs and their beneficiaries from individuals who have been shown to be untrustworthy; and 2) to deter health care fraud." (citing *Jeremy Robinson*, DAB No. 1905 at 3 (2004), and S. Rep. No. 109, 100th Cong., 1st Sess. (1987), *reprinted in* 1987 U.S.C.C.A.N. 682, 686)); *Harkonen v. Sebelius*, (N.D. Ca. Oct. 22, 2013), 2013 WL 5734918 at 9 (upholding Board decision and stating that "Congress enacted the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), of which 42 U.S.C. § 1320–7(a)(3) is a part, 'to combat waste, fraud, and abuse in health insurance and health care delivery.' Pub. L. No. 104–191, 110 Stat.1936, 1936 (1996). The legislative history regarding the statute as originally enacted indicates that it was intended to protect federal programs from untrustworthy individuals and to 'provide a clear and strong deterrent against the commission of criminal acts.' S. Rep. 100–109, at 5 (1987), *reprinted in* 1987 U.S.C.C.A.N. 682, 686," and also stating that "[t]he statute does not require that the 'fraud' be fraud perpetrated against the government—just that it be 'fraud' and that it be 'in connection with the delivery of a health care item or service.'").

While Petitioner was not harshly punished by the criminal justice system, this does not render him a trustworthy individual for purposes of having access to the public fisc and treating health care program beneficiaries.[5] *See Henry L. Gupton*, DAB No. 2058 at 7 (2007) (explaining that while an IG exclusion aims to protect beneficiaries of health care programs and the federal fisc, a criminal law proceeding involves "punishment, rehabilitation, and the deterrence of future misconduct"); *see also Henry L. Gupton*, DAB Ruling 2007-1 at 4 (2007) (Board stating, in denying reconsideration of its previous *Gupton* decision, that the "federal exclusion law aims to protect beneficiaries of health care programs and the federal fisc through remedial actions such as exclusions"). Petitioner's willingness to commit a scheme that involved the submission of false claims for intra-operative nerve monitoring services that were not provided to his surgical patients underscores his untrustworthiness in dealing with health care programs. Congress made it clear that it sought to exclude untrustworthy individuals such as Petitioner from participating in federal health care programs in order to deter health care fraud in those programs. Congress sought to exclude individuals who were convicted of felony offenses and whose crimes were "connected to" the delivery of *any* health care

[5] The maximum period of imprisonment for wire fraud, under the instance circumstance, is 20 years. 18 U.S.C. § 1343.

item or service and were "relating to" fraud. Nothing in Congress's language limited such an exclusion to offenses that involved federal funds or government programs.

The plain language of the title of the subsection states that it pertains to a conviction "related to health care fraud," and language within the subsection addresses a felony conviction "relating to" fraud. Further, Petitioner has not demonstrated any congressional intent to the contrary. Petitioner entered a plea of guilty to the offense of wire fraud, and admitted that in carrying out his scheme, he caused funds to be electronically submitted across state lines when he billed insurance companies for services that he falsely represented were performed during surgery. IG Ex. 4 at 4. Petitioner's commission of wire fraud was certainly related to health care fraud, and there is no doubt it was "related to fraud" as contemplated by section 1128(a)(3).

Not only does Petitioner argue that he "was convicted only of wire fraud (18 U.S.C. § 1343), not health care fraud (18 U.S.C. § 1347) . . . " (P. Br. at 2), but he also argues that the IG has failed to show that his "conviction was 'in connection with a health care item or service,' so the exclusion is not triggered and cannot be imposed." P. Br. at 7. Petitioner explains that his conviction for wire fraud "makes no reference to health care items or services whatsoever." P. Br. at 7.

Petitioner undoubtedly committed his felony offense in connection with the delivery of a health care item or service. The statute states that an exclusion is warranted when the conviction is for an offense "in connection with" the delivery of a health care item or service, meaning that a criminal offense warranting exclusion is not limited only to the actual delivery or provision of such an item or service. 42 U.S.C. § 1320a-7(a)(3); *see Charice D. Curtis*, DAB No. 2430 at 4 (2011) ("[T]he plain language of section 1128(a)(3) encompasses felonies 'relating to' fraud . . . not just to felonies that constitute fraud or one of the other listed offenses."). The Board has also explained that an ALJ does not need to limit review to the elements of an offense, but may consider the extrinsic evidence surrounding the conviction to determine whether it is "relating to" fraud and done "in connection with" the delivery of a health care item or service. *See Narendra M. Patel, M.D.*, DAB No. 1736 at 6 (2000), *aff'd, Patel v. Thompson*, 319 F.3d 1317 (11th Cir. 2003).

The Board has explained that the submission of claims for payment for health care services is done "in connection with," and necessarily follows, the delivery of those services. *See Jack W. Greene*, DAB No. 1078 at 7-8 (1989). The Board has also explained that there should be a "common sense connection" between the underlying crime and the delivery of a health care item or service in order to meet the statutory basis for exclusion. *Eric D. DeSimone, R.Ph.*, DAB No. 1932 at 5 (2004). When applying a common sense analysis to the underlying facts of this case, I conclude that Petitioner's commission of wire fraud was "in connection with" the delivery of such health care services to Petitioner's patients. The crux of Petitioner's criminal scheme was he claimed

another doctor was present to perform intra-operative nerve monitoring when he performed neurosurgery on his patients, and Petitioner billed insurance companies for those services even though no doctor performed intra-operative nerve monitoring during those surgeries. The narrative description of the offense conduct underlying his conviction contained in both the indictment and the information is essentially identical, even though the charged criminal offenses, health care fraud and wire fraud, are different. Petitioner's criminal conduct in committing the offense of wire fraud unquestionably occurred in connection of the delivery of a heath care item of service, namely neurosurgery. Petitioner's arguments are utterly unpersuasive, and his commission of wire fraud is clearly related to the delivery of a health care item or service.

Based on the foregoing discussion, I conclude that Petitioner's felony criminal conviction for wire fraud mandates his exclusion from all federal health care programs pursuant to 42 U.S.C. § 1320a-7(a)(3).

2. A five-year minimum period of exclusion is mandated, effective August 18, 2016.

The Act requires a minimum exclusion period of five years when the exclusion is mandated under section 1320a-7(a). 42 U.S.C. § 1320a-7(c)(3)(B). In this case, exclusion is required under section 1320a-7(a)(3); therefore, Petitioner must be excluded for a minimum of five years. The effective date of the exclusion, August 18, 2016, is established by regulation, and I am bound by that provision. 42 C.F.R. §§ 1001.2002(b), 1005.4(c)(1).

V. Conclusion

For the foregoing reasons, I affirm the IG's decision to exclude Petitioner from participation in Medicare, Medicaid, and all federal health care programs for a minimum period of five years.

/s/
Leslie C. Rogall
Administrative Law Judge